South Country Health Alliance, H5703
Dual Eligible (Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

South Country Health Alliance (SCHA) AbilityCare is a Medicare Advantage fully-integrated Dual-Eligible, Medicaid Subset - $0 Cost Share Special Needs Plan. To be eligible for this plan, members must be 18 years through 64 years of age. Members must also be eligible for Medical Assistance, residing within SHCA's service area and be either of the following: 1. certified disabled through the Social Security Administration or the State Medical Review Team OR a person with Developmental Disability for the purpose of the DD waiver, as determined by the Local Agency.

Provider Network

SCHA has a comprehensive and geographically dispersed medical and social services provider network created to meet the health and wellbeing needs of enrollees throughout the twelve participating counties. Specific contracted provider networks include referral/tertiary hospitals, licensed physicians, such as primary care physicians, geriatricians and mental health providers, skilled nursing facilities, home health care, durable and specialty equipment providers, state-wide pharmacy networks, and dental.

Care Management and Coordination

SCHA utilizes either the State of Minnesota Long Term Care Consultation (LTCC) or a SCHA-specific health assessment form (which is a condensed version of the Minnesota LTCC form). The assessments include: member's health status including condition specific issues; supports and services based on the member's strengths, needs, choices, and preferences in life domain areas; documentation of clinical history and medications; activities of daily living and independent activities of daily living; mental health/cognitive functioning, and life planning activities. The care coordinator will arrange for an initial face-to-face comprehensive health assessment of the member's strengths, needs, choices, and preferences in life domain areas within 30 days of enrollment and annually thereafter. Members identified as high-risk are discussed at monthly interdisciplinary care team (ICT)/care coordination meetings at each local care coordination agency with the clinical facilitators.

The care coordinator will work with the member to develop and update annually an individual comprehensive care plan (ICP) that addresses a member's goals, interventions, services and benefits provided, and measurable outcomes and is relevant to the ongoing assessment of the member. The member's comprehensive care plan must be developed within 30 days of the health assessment and updated annually. Members have the choice to participate in developing their care plan. If the member chooses not to participate, they are still assigned a care coordinator and

receive care coordination services. Members are encouraged to complete a care plan upon a change in condition, setting, or provider. Care coordinators use the care plan to assist them in monitoring the progress of the member towards achieving the member's outcomes in order to evaluate and adjust the timeliness and adequacy of services and identify any barriers to meeting goals or in complying with the care plan's goals and interventions.

SCHA member counties develop ICTs at the county level to ensure that members have access to both a registered nurse and social worker. SCHA utilizes county based case managers to provide the overall care coordination of member's needs. Care coordinators work together with all other identified primary care, specialty care, home care, other community support and human service providers and SCHA staff to ensure that member care is provided as needed. The clinical facilitators provide direction and support to the care coordinator, acting as the clinical resource for all members of the health care delivery team including other SCHA staff, county staff and individual or physician provider groups. The ICT meets with the clinical facilitators on a monthly basis and minutes from meetings are kept in an electronic interface which allows monthly newsletters with information to care coordination staff.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses member needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.mnscha.org/