Mercy Maricopa Integrated Care, H9685
Dual Eligible (Dual Subset) Special Needs Plan

Model of Care Score: 78.13%
2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

Mercy Maricopa Integrated Care (MMIC) is a Dual-Eligible SNP for members who are: eligible for the Arizona Medicaid Acute program, designated as seriously mentally ill by the Arizona Department of Health Services, eligible for Medicare Parts A and B and who reside in MMIC's service area. These members have: compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions and/or end-of-life issues. Furthermore, the population in Arizona served by this plan includes members: who are suffering from serious mental illness, have functional status limitations, long term chronic illness and are indigent.

Under the Medicaid program, the State of Arizona designates individuals who have a qualifying SMI diagnosis and functional impairment as a result of the diagnosis to be seriously mentally ill. These qualifying diagnoses include specific psychotic disorders, bipolar disorders and obsessive compulsive disorders.

Provider Network

Special attention is given to developing and contracting with providers who offer specialized services targeted to the needs of MMIC's population. These physicians often have expertise in chronic conditions and possess specialties addressing issues related to the frail/disabled or individuals near the end of life. Additionally, the chief medical officer (a licensed psychiatrist), deputy medical officer and other associate medical directors have significant involvement in the identification and recruitment of providers. When needed, members are assigned directly to a specialist for ongoing primary care. The medical director reviews and approves treatment to appropriate facilities and effective medical services. The plan has written agreements with an array of provider types to meet the needs of its membership. Examples of these providers include: inpatient acute care, long term care and rehabilitation facilities, outpatient services, primary care physicians, specialty providers, behavioral health providers, ancillary services and nursing professionals.

Care Management and Coordination

The individual care plan (ICP) is the focal point of all the interventions and education provided to members. ICPs are created utilizing a combination of information including: the health risk assessment (HRA), other clinical and environmental assessments, comprehensive medical evaluations, reviews of medical records, provider diagnoses, cultural and linguistic needs, identified formal/informal supports and utilization data. The ICP involves a multi-disciplinary effort between the case manager or other care coordination staff, primary care physician (PCP), behavioral health provider, specialists and other care providers as applicable, the member and family/caregiver. The ICP promotes communication between the member's PCP and other specialists, encourages members to follow their treatment plans, educates members about their conditions, provides community resources and supports members in achieving their healthcare goals.

MMIC develops an interdisciplinary care team (ICT) as a function of the risk-level and illness burden to address the different needs of members. Team composition reflects the need for a multi-specialty approach and includes: a medical director, behavioral health medical director, care management director, pharmacist, case manager and the assigned care manager/care coordinator who is actively working with the member. Staff from other departments such as concurrent review or prior authorization are invited as needed. MMIC invites the member to participate in any ICT meeting where his/her care is reviewed. The care manager works closely with the member and caregiver to encourage participation in the ICT meeting, explain the ICT process, roles and responsibilities of members and the ICT, and address any questions or concerns regarding attendance. If the member cannot attend the ICT in person, the care manager attempts to conduct the meeting from the member's home and connect the other ICT members by conference call, to help ensure member participation.

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: www.MercyMaricopaAdvantage.org.