Colorado Access Advantage H0621
Dual Eligible (Dual Subset) Special Needs Plan

Model of Care Score: 93.75%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Members are dually eligible for Medicaid and the average age of members is 57, with 64 percent under age 65. The top five clinical conditions from medical claims include respiratory disorders, hypertension, diabetes, mental health disorders including schizophrenia and depression. The majority of members have multiple clinical conditions, and at least 40 percent have some diagnosis of mental illness. Members' health conditions are often complicated by socioeconomic issues.

Provider Network

The network includes providers with specialized expertise in treating this vulnerable population and the plan employs physicians, nurse practitioners and other health care personnel. To expand the provider network beyond these entities, Colorado Access contracts with other community providers that are committed to serving low-income populations. As a Medicaid plan, the network contains primary care providers (PCP), specialists, including but not limited to, cardiologists, nephrologists, psychiatrists, geriatricians, pulmonologists and immunologists. In addition, there are inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, and radiology/imaging providers who see Medicaid and dual-eligible patients. Allied health professionals include registered nurses, nurse practitioners, occupational, speech and physical therapists, pharmacists and other professionals.

Care management and coordination

Colorado Access implements an initial health risk assessment (HRA) that captures the health status (including condition specific issues), ability to perform activities of daily living and available support, mental health status, including cognitive functions, evaluation of caregiver availability, relationship with medical home and utilization of services, and completion of life planning activities, such as advance directives or living wills. The care management team's goal is to complete the initial HRA for each member within 90 days of enrollment and at least annually thereafter. Upon enrollment, the member is mailed the assessment for completion. Those members who do not complete the mailed assessment are routed to the assigned care manager for additional attempts to successfully complete an assessment. When intense needs are identified during the initial assessment, the care manager will advise the member as soon as possible for timely and appropriate interventions, with guidance as appropriate, from the manager or other members of the interdisciplinary care team (ICT).

The ICT includes the member, family members, caregivers, providers and community resources/agencies. In addition, the multi- disciplinary model incorporates medical directors (Geriatrics, Psychiatry), registered nurses, social workers, a pharmacist and care managers. The member, family members and/or legal representatives, as applicable, are involved in the development and implementation of the care plan. The care manager also acts as an advocate for the member and brings the member's issues and concerns to the ICT. Members also have the option to participate in care conferences as they wish and may request copies of the care plan at any time. The ICT is scheduled to meet twice a week, however, evaluation and updating of the care plan is conducted on an ongoing basis. Updates and changes are communicated by the care manager to all stakeholders involved in the member's care.

Individualized care plans (ICP) are developed by the care manager and member based on information provided by the member, the initial, comprehensive and disease /utilization HRAs, clinical analytics, internal reporting and ICT feedback. The data collected from the HRA will auto generate opportunities, short and long term goals and interventions utilizing evidence based guidelines within the plan's system. The ICP includes self- management goals and empowerment, early identification of problems or worsening symptoms and appropriate responses, focused disease education, coordination of needed health care services and actions to reduce or eliminate barriers to achieving satisfactory health status and functioning. The ICPs are reviewed and modified as member needs change, as new opportunities are identified through the analytics within the SNPs system and at least annually.

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 beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.coaccess.com/access-advantage