H0630 Kaiser Foundation Health Plan of Colorado
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 91.67%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The target population of the Kaiser Foundation Health Plan of Colorado (KPCO) is dual eligible Medicare and Medicaid members who live in the Denver Metropolitan service area. The majority of members are female (69 percent) and 62.5 percent of members are older than 65 years. More than half of members are White, 19 percent are Hispanic and 8 percent are Black. English is preferred by 89.7 percent of members. Half of members receive supplemental security income (SSI). Sixty-eight percent live in their own home and 26 percent do not have a high school diploma. The target population suffers from a number of chronic conditions, most notably 37 percent of members are diagnosed with a mental health condition, 22 percent have been diagnosed with diabetes, 20 percent have chronic kidney disease and 14.8 percent have dementia. Only 41 percent of members have normal blood pressure and almost half of members have a body mass index (BMI) over 30.

Provider Network

KPCO operates an integrated delivery network that links care delivery and the health plan to provide direct care to all members. KPCO contracts with hospitals, dialysis facilities and affiliated providers. KPCO's specialist network provided by Colorado Permanente Medical Group (CPMG) and affiliated community providers includes but is not limited to, behavioral health, cardiology, pain management, urology, neurology, otolaryngology, nephrology, gastroenterology, ophthalmology, orthopedics, general surgery, rheumatology, pulmonology and endocrinology.

Physicians with expertise and certification in medical subspecialties such as geriatric medicine and palliative care are part of KPCO's network in order to care for the following: the elderly, frail, members at end of life and those with chronic conditions. KPCO operates disease management, care coordination and community specialist programs for high risk members.

Care Management and Coordination

A member of the SNP interdisciplinary care team (ICT) conducts an assessment with every member. The assessment is done within 90 days of enrollment and annually or within one year of the last health risk assessment (HRA).

The member is risk stratified based on the results of the HRA. At enrollment, all members are assigned a SNP care coordinator (SNP-CC), who conducts a comprehensive review of the member's HRA. The SNP-CC collaborates with the member to produce an individualized, prioritized care treatment plan based on the assessment findings. Member preferences are taken into consideration to optimize the member's response and engagement in the assessment and care planning process. An individual care plan (ICP) is developed by a registered nurse (RN) from the SNP care coordination team. Interventions are incorporated into the ICP based on the risk stratification. This allows the SNP-CC to target member outreach and support members through significant health changes and reduce overall transition risk through education and targeted interventions.

Each member has a primary care physician (PCP) who is responsible for providing medical care for preventive, acute and chronic conditions. The PCP's role is integral to the ICT. The PCP is responsible for providing direction, recommendations and/or approval of the member's ICP. The ICT actively engages the PCP to coordinate care based on the member's assessment. The SNP care management ICT is comprised of staff within the medical, nursing and social service disciplines that assist and manage this patient population. The SNP ICT meets regularly to discuss member-individualized cases. The SNP CC RN collaborates with the PCP, other members of the ICT such as the medical director, licensed clinical social worker (LCSW), community specialist and ad hoc health care teams (for example, diabetes care team or cardiac care team) to provide support services to the member.

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: https://medicare.kaiserpermanente.org