Cuatro LLC H4866
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 90.63%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Access Medicare targets full dual eligible members who are: suffering from mental illness that prevents them from receiving consistent, comprehensive treatment; unable to access medical care due to their disability; and have complicated illnesses that require coordination of care between a number of different specialists. These members are more likely to have complex medical conditions that have not been fully or consistently treated or be disabled and have few resources.

Provider Network

Access Medicare contracts with a variety of physicians with appropriate expertise. The cornerstone of its care management program is collaboration with participating primary care physicians (PCPs), who along with care managers serve as the gatekeeper for services.

Access Medicare has contracts with facilities necessary for the care of members that include: inpatient, psychiatric and rehabilitation hospitals, skilled nursing facilities, dialysis facilities, laboratories and radiology/imaging facilities. The SNP also contracts with numerous medical specialists that include: allergy and immunology, ambulatory surgery, cardiology, chiropractor, dermatology, ENT, endocrinology, gastroenterology, general surgery, geriatric specialist, gynecology, hematology, infectious disease, nephrology, neurology, oncology, ophthalmology, orthopedics, pain management, physical medicine and rehabilitation, podiatry, pulmonology, radiation oncology, rheumatology and vascular surgery. In addition, Access Medicare contracts with behavioral and mental health specialists and clinical psychologists, as well as physical therapists, occupational therapists, speech pathologists, certified home care agencies, nurse practitioners, RN care managers and pharmacists.

Care Management and Coordination

Access Medicare developed a risk assessment tool that is designed to evaluate the medical, functional, psychosocial and cognitive needs of members and while obtaining a medical and mental health history. The health risk assessment (HRA) includes questions to identify: members who are likely to be frail/disabled, have multiple chronic illnesses or those near the end of life. It asks questions about health history, medications, emergency and hospital visits, understanding of medications, psychiatric issues and social issues.

Access Medicare sends the HRA to all members upon enrollment and each year thereafter. If a completed form is not returned within 30 days, a telephone assessment is completed. The care manager reassesses members at least every six months to track any changes in their condition

and progress toward goals or more frequently if there is a change in the member's condition or the member is deemed to be at high or moderate risk.

The care manager develops the initial care plan (ICP) in conjunction with the member and others on the interdisciplinary care team (ICT). The ICT reviews the member's active diagnoses and the plan for addressing those diagnoses and determines long term and short term goals related to the member's problems, which are included in the ICP, along with interventions to meet them. These goals include outcome measures whenever possible and there is a time frame for reevaluation.

The care manager gives the member the number for her direct line and encourages the member to call if he/she wants to change something in the care plan or if he/she needs additional services.

The care manager is the center of the ICT and is responsible for maintaining documentation of communication, including problems identified, short term and long term goals, proposed interventions, responsible parties to follow-up, and date for review in the care management system. When changes in condition result in new problems, short term or long term goals or treatment plans, the care manager updates the care plan as needed and distributes the necessary information to the ICT.

The ICT at a minimum consists of the care manager, PCP, specialists as determined by the member's condition and the member/family. If the member's condition requires additional expertise, Access Medicare adds other individuals to the team. The core members of ICT are an integral part of the member's care and therefore are most appropriate for 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 beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at:

http://accessmedicareny.com/plans/pearl/