

Community Care Health Plan, INC. H2034, H5207
Dual Eligible (Medicaid Subset - \$0 Cost Share) Special Needs Plan

Model of Care Score: 88.75%

3-Year Approval

January 1, 2012 – December 31, 2014

Target Population

Community Care's dual eligible Special Needs (SNP) Medicare Advantage Plan is called Family Care Partnership (Partnership) by the Wisconsin Department of Health Services (DHS). The program may be referred to as Family Care Partnership or Partnership. Community Care is a dual-eligible Medicaid Subset - \$0 cost share SNP that covers adults who are at least 18 years old, reside in the approved service area, are financially eligible for Wisconsin Medicaid and meet a level of care as determined by the Wisconsin Long-Term Care Functional Screen. Members are physically and/or developmentally disabled adults or frail elders and reside in the following Wisconsin counties: Calumet, Outagamie, Waupaca, Kenosha, Racine, Milwaukee, Washington, Ozaukee, and Waukesha.

Provider Network

Community Care provides comprehensive services for three populations: frail elderly, physically disabled, and developmentally disabled. As such, an extensive network of providers is necessary to ensure access to all necessary services. In addition to the providers and facilities that are necessary to provide services under the standard Medicare benefit, Community Care contracts with providers and facilities to provide additional services, such as dental, vision, and hearing benefits. Having obtained a waiver to provide services for members with end-stage renal disease (ESRD), Community Care also maintains a network that includes specialists and dialysis services to meet the complex medical needs of these individuals. Our provider network includes but are not limited to the following provider types: acute and primary care providers, cardiology, gastroenterology, general surgery, palliative/end of life care and physical medicine, long term care providers, nursing services and occupational therapy.

Care Management and Coordination

The health risk assessment (HRA) process begins within 10 days of enrollment. Community Care utilizes an electronic HRA tool which is comprised of three distinct tools, primary care, nursing and social work. In addition to the primary ICT members, additional ICT resources are available to provide assessment including physical and occupational therapies, nutrition services, and behavioral health. The interdisciplinary team (ICT) assesses, develops, implements, and evaluates the treatment plan of each member enrolled in Community Care Partnership Program.

The team conducts a comprehensive assessment of the member upon entry into the program, periodically thereafter, but no less than every 6 months and with significant change of condition. This assessment covers all areas of need: primary care, nursing, social services, and may include community integration, physical and occupational therapy, and nutrition services.

Creation of the individualized care plan (ICP) begins with the comprehensive assessment process to which the member is central. Each of the disciplines represented on the member's ICT conducts an assessment with the member to establish the member's medical history, current conditions, goals and desired outcomes, as each of these pertains to the discipline of the team member conducting the assessment. The assessments are combined to serve as the foundation for the care plan. By consensus, a plan of care is developed for each member within 10 days of enrollment and periodically thereafter.

The member receives care management through designated ICT staff, which includes at a minimum, the member and/or member's representative, a nurse practitioner, a registered nurse, a social worker and other staff representing additional professional disciplines as appropriate to the member's needs and condition. The ICT also includes additional people identified by the member, such as family members or friends. Community Care's contract with the Wisconsin DHS specifies the minimum composition of the ICT. However, the composition of the ICT for a specific member is determined by the member's health condition(s), functional limitations and desired outcomes.

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.communitycareinc.org/flash.html>