H2034 Community Care Health Plan, Inc.
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 95.00 %

3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Community Care Health Plan's (also known as Community Care Family Care Partnership) eligibility criteria are those who are 55years of age or older, reside in Washington, Ozaukee, Calumet, Outagamie or Waupaca, and those who are 18-54 years of age and reside in Milwaukee, Racine, Kenosha and Waukesha counties. The member must meet a nursing home level of care as determined by the Long Term Care Functional Screen, be eligible for Medicaid and be enrolled in Medicare Parts A, B and D. The three target populations served are the frail elderly, physically disabled, and intellectually/developmentally disabled. Fifty-two percent of members live in their home, 17.3 percent live in some sort of Community Based Residential Facility (CBRF), 14.8 percent live in Adult Family Homes (AFH) and 2.7 percent live in other residential facilities such as residential care apartment complexes, Intermediate Care Facility for Intellectually Disabled (ICF/ID) or state centers. The most common health conditions include lipid disorders, falls, hypertension, diabetes, obesity, arthritis, incontinence, depression and coronary artery disease.

Provider Network

Community Care Health Plan is a staff model special needs plan. In parts of the service area, employed staff, including physicians, nurse practitioners, rehabilitation staff, behavioral health professionals, and pharmacists provide direct care to the beneficiaries, Community Care also contracts with providers in the community, including acute/primary care providers and facilities such as but not limited to: allergy/immunology, endocrinology, neurology, podiatry, obstetrics/gynecology, in-patient hospitals, oncology, nephrology, cardiology, mammography, physical therapy, speech therapy, durable medical equipment, and skilled nursing facilities. As long-term care providers are much needed for this population, other employed or contracted providers may include adult day care, self-directed supports, nursing services, occupational therapy, speech and language pathology, transportation, daily living skills training, care/case management and residential services of both adult family home and community based residential facilities (CBRF).

Care Management and Coordination

The health risk assessment (HRA) process begins within ten calendar days of member enrollment and is conducted in person with the member and his/her representative if requested and typically takes place in the member's home. The assessment includes a review of the beneficiary's status for any immediate health or safety concerns and the effectiveness of any supports or services currently in place. Formal team meetings are managed by a trained facilitator who leads discussion, keeps meetings on track, identifies actions or tasks for specific

team members, and takes notes. HRA's are completed upon enrollment, every 6 months and if any changes occur in the member's health. The results are then shared with the Interdisciplinary Care Team (ICT) and updates are made to the member's Individualized Care Plan (ICP) which is reflective of the assessment to ensure it mirrors the member's needs and goals.

Each member is assigned to an ICT immediately following enrollment. The contract with Wisconsin Dept. of Health Services (DHS) establishes the composition of the ICT and the minimum amount of staff that must be part of the team. This includes the member, a licensed primary care physician, a licensed nurse practitioner, a licensed registered nurse, and a social service coordinator/care manager. Family members or the member's authorized representative and any other persons identified by the member are also part of the team. Additional disciplines are added to the team as appropriate or changed after each semi-annual assessment or reassessment and at the member's request. The ICT meets no less than weekly and includes at least, the primary care representative, registered nurse, social worker and team facilitator.

The ICP incorporates the following components: member-centered, current, with discipline specific assessments and plans; behavioral support or behavioral intervention plan; risk agreement; fall care plan and in-home assessment tool. The combined components of the ICP identifies all of the personal experience outcomes, long term care outcomes, interventions, services and supports whether paid, provided or coordinated, formal or informal, that are consistent with information collected in the comprehensive assessment, and are sufficient to assure the member's health, safety, and well-being, consistent with the nature and severity of the member's disability or frailty and support the member's 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 member needs.

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