Commonwealth Care Alliance, INC., H2225
Dual Eligible (Subset – Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 88.13%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Commonwealth Care Alliance's (CCA) target population includes members who live mostly in communities that experience significant disparities in access to health care services within the Greater Boston and Greater Springfield areas. The average age of CCA's members is 77.2 years. The vast majority of enrollees have significant socio-economic needs, with many also experiencing problems related to housing, nutrition, transportation, and/or family or relationship issues. Moreover, members' access to essential healthcare services is frequently challenged by their inability to leave home to seek medical care (72% are functionally homebound), as well as by language barriers. Sixty-two percent speak a primary language other than English. The membership is composed of 68% females and 32% males, and is typically afflicted with multiple chronic conditions e.g., diabetes, heart failure, chronic obstructive pulmonary disease (COPD) and asthma, and is at increased risk for mental illness.

Provider Network

CCA's Model of Care brings wellness interventions to the homes of these persons who would otherwise be prevented from accessing health care services. The typical network of providers for its Medicare Advantage population includes but is not limited to physicians, of which approximately 95% are board certified in Family Medicine, Geriatrics, Internal Medicine or other physician specialties e.g., cardiologists, oncologists, pulmonologists, endocrinologists and rheumatologists. CCA also contracts with elder services organizations and outpatient behavioral health facilities and employs a relatively large number of nurse practitioners and social workers. Its facilities include acute care and skilled nursing facilities, outpatient laboratory and radiologic services, and home health agencies.

Care Management and Coordination

CCA's health risk assessment (HRA) tool includes the following components: the medical history of the member, including relevant family members and illnesses, an evaluation of medical, functional, mental health and psychosocial status, current medications, screening for tobacco, alcohol and drug use and abuse; and an assessment of existing services and the need for long term care services, including the availability of informal supports. Primary care physicians/primary care teams perform ongoing assessments of each member's needs at least once every six months, or whenever members experience a major health status change that is not temporary, impacts more than one area of living, or requires interdisciplinary review or revision of the individualized plan of care (ICP).

The ICP is a detailed written description of the scope, frequency and duration of all clinical and service needs to be provided on behalf of a member. In CCA's care system, ICP's are determined

solely by the patient care team (PCT) in partnership with and meaningful involvement of members and their families. Only members of the PCT have the authority to change, increase, modify, or decrease the services outlined in the ICP. The member's nurse practitioner/nurse care manager is ultimately responsible for the development of the ICP with input from multiple disciplines and ensures that goals are informed by the individual's desires and preferences.

Each of CCAs members is assigned a primary care physician as a part of an interdisciplinary care team known as the PCT. The composition of the patient's team may vary depending upon their clinical needs. PCTs are required to complete an initial comprehensive, face-to-face assessment of every member within 30 days of enrollment. In addition to the ongoing assessments performed at a minimum of every 6 months, the PCT completes an expanded comprehensive geriatric assessment at least once per year supported by a customized geriatric assessment tool in the CCA care management system. All PCT members are experienced in geriatric care and include a geriatric support services coordinator (GSSC), and a care manager (nurse practitioner, registered nurse, or physician's assistant). Other professional and support disciplines join the PCT as necessary. The care coordination team may also include social workers, medical assistants, specialty physicians, home-based personal care attendants, hospitalists, geriatricians, care coordinators, psychologists, and psychiatrists.

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: www.commonwealthcarealliance.org