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

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

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 in Massachusetts. One hundred percent of CCA's members meet Medicaid eligibility criteria, all of which, by definition, are impoverished. Ninety-four percent of members are dually eligible for Medicare and Medicaid and the remaining 6 percent of members are eligible for Medicaid only.

CCA's membership is 71.5 percent female and 28 percent male with the majority of members between 65 and 79 years old (66 percent). Forty-seven percent are Hispanic or Latino, 13 percent are black or African American, and 5 percent are Asian. Members are typically afflicted with multiple chronic conditions - hypertension (78 percent), arthritis (62 percent), diabetes (65 percent), osteoporosis (37 percent), sciatica (35 percent) and pulmonary disease (23 percent). In addition to the high prevalence of chronic conditions, members' health status is significantly impacted by multiple chronic conditions on activities of daily living (ADL). Ninety-one percent of members have more than one chronic condition and 59 percent have four or more chronic conditions. Members are also at increased risk for mental illness.

The vast majority of members have significant socio-economic needs, with many who also experience 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 as well as language barriers. Among CCA's members, 72 percent are functionally homebound and 62 percent speak a primary language other than English.

Provider Network

CCA's delivers wellness interventions to the homes of these persons who would otherwise be prevented from accessing health care services. In addition to the typical network of providers for a Medicare Advantage population, CCA contracts with or employs nurse practitioners, elder services organizations, outpatient behavioral health facilities and social workers. CCS's network of providers includes, but is not limited to: physicians in family medicine, geriatrics, internal

medicine or other physician specialties. Its facilities include 31 acute care, 186 skilled nursing facilities and 104 home health agencies.

Care Coordination and Management

Within 30 day of enrollment, the assigned nurse care manager (NCM) completes an initial comprehensive, face-to-face health risk assessment (HRA) with each member. The HRA is an evaluation of the member's clinical, functional, nutritional and physical status. The patient care team (PCT) performs ongoing assessments of each member's needs at least semi-annually, or whenever the member experiences a major health status change that is not temporary, impacts more than one area of living, and/or requires interdisciplinary review or revision of the individualized care plan (ICP). The PCT also completes an expanded comprehensive geriatric assessment at least annually.

The (ICP) is a detailed written description of the scope, frequency and duration of all clinical services to be provided to the member. The NCM is ultimately responsible for the development of the ICP with input from multiple disciplines and in partnership with and meaningful involvement of the member and their caregiver/family. The NCM communicates the member's needs by phone or email to the rest of the PCT and ensures the delivery of services as outlined in the ICP. The NCM also documents all ICP changes as well as all PCT communications in the member's electronic medical record.

PCT composition varies depending upon the member's clinical needs. All core members are experienced in geriatric care and include: a NCM (nurse practitioner, registered nurse, or physician's assistant), a primary care physician and a geriatric support services coordinator. Other professional and support disciplines join the PCT as necessary and may 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: http://commonwealthcaresco.org/