Alameda Alliance Joint Powers Authority H7292
Dual-Eligible Subset (Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 73.75%
1-Year Approval **January 1, 2014 – December 31, 2014**

Target Population

Alliance CompleteCare (ACC) is a Medicare + Choice plan focusing on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual-eligible, and beneficiaries with severe or disabling chronic conditions. ACC has approximately 39,000 full dual eligible beneficiaries, specifically those eligible for Medicare Parts C and D and full scope Medi-Cal. These beneficiaries are typically older, with multiple co-morbid conditions, at risk for poor outcomes and high costs due to inefficient and inadequate access to care. The age range of current members varies from 20 to 85+; the majority of members are between the ages of 45-54, 65-69 and 70-74. The ACC membership consists of slightly more females that are primarily over 65 years of age. Large ethnic subgroups in ACC include African Americans, Asian/Pacific Islanders, particularly, Chinese and Filipinos and Hispanic populations.

Provider Network

ACC maintains a robust network of providers, including medical specialists, behavioral specialists, nursing professionals, allied health professionals, long term service and support (LTSS) providers and mental health specialists in addition to acute care, radiography/imaging, long-term care, rehab facilities and specialty outpatient clinics to ensure that ACC members have access to providers with the expertise necessary to treat their medical and mental conditions as well as their functional and social needs.

Care management and Coordination

ACC uses a health risk assessment (HRA) tool that includes a Hierarchical Condition Codes (HCC) assessment to determine a member's current health status and also utilizes data from California's LTSS programs to assess member's behavioral health and social needs. The tool is comprehensive and assesses members who are stratified as high risk based on Medicaid/Medicare data and who agree to an in-home assessment. Following an outbound verification call, ACC intake staff, care advisors and/or physician home assessment vendor will contact ACC enrollees to schedule the initial HRA. If possible, AAC will conduct the HRA on a face-to-face basis in the member's home or in a community setting of the member's choice. For

those members who do not wish to have a face-to-face assessment, AAC completes the HRA by phone. The HRA outreach and completion occurs within 90 days of member enrollment.

The core members of each interdisciplinary care team (ICT) will include the ACC member, their primary care physician (PCP), and a lead person-centered care coordinator (PCCC), which can be an Alliance case manager, an Alliance care coordinator or a contracted care coordinator. In addition to the core members, others involved on the ICT are based on the members' disease condition as well as their functional and psychosocial needs. The ICT may include member/patient, family/caregivers, other physicians, behavioral health/substance abuse providers, a social worker and case managers, dentists, pharmacists, speech/physical/occupation therapists and dieticians.

An individualized care plan (ICP) is carefully put together which prioritizes the member's needs and is placed into a framework which specifies a step by step approach to address the member's goals in a meaningful, patient centric approach. Activities of the care plan use established evidence-based national and state clinical guidelines incorporated into case management software used for ICP development. Under the guidance and expertise of the ICT, the case manager has primary responsibility for development of the ICP. However, the ICP is negotiated between member and case manager in order to encourage member active participation and empowerment. Case managers work collaboratively with Alliance LTSS staff, behavioral health contracted providers, and utilization management unit staff to ensure that medical, behavioral health, social service, and transition of care needs are appropriately managed and assigned to the department best equipped to handle each member's needs. AAC uses licensed California registered nurses and masters prepared social workers as case managers.

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: **https://www.alamedaalliance.org/**