MEMBER PROFILE:

Commonwealth Care Alliance

Massachusetts has long been a place of innovation in health care science and delivery. This history, combined with active consumer advocacy, particularly for individuals with complex care needs, led to the development of a care model that puts the individual at the center of a multidisciplinary team. This model – driven by Boston's Community Medical Group, Commonwealth Community Care, Community Catalyst, Health Care for All, and Boston Center for Independent Living – involves the individual in important care decisions, and emphasizes care planning and supports to ensure the best possible health and quality of life. The model drew the attention of local and national health policy groups, legislators, and consumer advocacy organizations, and its guiding principles later became imbedded in the Affordable Care Act.

In 2003, the four organizations at the forefront of implementing this care model collaborated to establish the Commonwealth Care Alliance (CCA). The mission of this nonprofit organization is to create a more equitable and person-centered health care delivery system for individuals in Massachusetts with complex needs. Today, CCA is a consumer-governed health plan and care delivery system that provides integrated health care and social services and supports to nearly 6,000 Medicare-Medicaid enrollees age 65 and older through its Senior Care Options program. It also serves 7,500 Medicare-Medicaid enrollees age 64 and younger through Massachusetts' financial alignment demonstration, the One Care program. As a consumer-governed health plan, CCA's board of trustees includes individuals who care deeply about the populations that CCA serves. Trustees are selected by CCA's consumer advocacy member organizations, a unique organizational attribute that helps embed the community-driven approach throughout CCA's work.

QUICK FACTS

- **Organization type:** Managed care and health care delivery organization
- **Tax status:** Non-profit
- **Year founded:** 2003
- **Integration models:** Senior Care Options and One Care Financial Alignment Demonstration
- **Senior Care Options enrollment:** Approximately 6,000 Medicare-Medicaid enrollees age 65 and older
- **One Care demonstration enrollment:** 7,500 Medicare-Medicaid enrollees under age 65
- **Service area:** Senior Care Options, 8 of 14 Massachusetts counties; One Care, 9 of 14 counties

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Medicare-Medicaid Integration Status

As of October 2013, CCA became one of three plans in Massachusetts to implement the One Care program for younger Medicare-Medicaid enrollees. CCA's approach to One Care is modeled on its Senior Care Options program that focuses on making home- and community-based services and supports an integral part of individualized care planning for its older members. This strategic approach has been effective in improving the health, independence, and quality of life of CCA's members for more than 10 years. CCA will continue to incorporate this emphasis on home- and community-based, person-centered care as it expands to serve a larger dually eligible population under One Care.

The Promoting Integrated Care for Dual Eligibles (PRIDE) initiative, made possible by The Commonwealth Fund, is a consortium of high-performing health care organizations focused on improving the care of individuals dually eligible for Medicare and Medicaid. The Center for Health Care Strategies (CHCS) is helping PRIDE members to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees. CHCS is a nonprofit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care. For more information, visit www.chcs.org.

Key to Success: A Comprehensive and Flexible Approach

CCA's care model is person-centered and team-based, focusing on enhanced primary care, care coordination/management, and individualized care planning. The model is both comprehensive and flexible, and is designed to help members achieve their goals for improved quality of life. Each member is assigned an individualized team of health care practitioners who work collaboratively to meet his or her individual needs and provide ongoing health management, early intervention, and response to episodic and urgent care. Interdisciplinary teams provide medical care and support services 24/7, wherever members need them – at home or in a doctor's office, a hospital or other location in the community. Each individualized care plan is based on an assessment and is specifically tailored, with care decisions made collaboratively by the team, the member, and the member's family or guardian. The team can make and approve decisions about medical tests, medications, durable medical equipment, dental care, eyeglasses and transportation based on each member's needs. For those with physical disabilities, CCA uses an individualized, integrated durable medical equipment clinical assessment, management, and allocation process that greatly simplifies access to these services. For those with mental illness and behavioral health needs, behavioral health clinicians are integrated into the interdisciplinary teams providing individualized care plan development and management across physical and behavioral health needs. For members requiring long-term services and supports, CCA brings in staff from a community-based agency partner (e.g., Area Agency on Aging (AAA) or Independent Living Center, Recovery Learning Center) to work with the member and interdisciplinary team.

INTEGRATED CARE IN ACTION

CCA's comprehensive and flexible approach to care is illustrated by an 80 year old member who had been in a nursing home for three months and wanted to go home. Her daughter wanted to care for her mother, but needed support to make that happen. The member enrolled in CCA's Senior Care Options program and was supported by an interdisciplinary care team including a nurse practitioner (and team manager) with home visiting capabilities, a social worker, a geriatric services and support coordinator from the local Aging Service Access Point, a primary care physician, a personal care assistant/homemaker, and a visiting nurse.

Her interdisciplinary care team had the ability to authorize all needed services, an autonomy that enabled immediate medical intervention, seamless delivery of care, and avoided unnecessary emergency department visits and hospital admissions. This ability to act quickly meant that any acute episode that she experienced, such as a urinary tract infection, was treated and resolved before it became a more complicated and more expensive-to-treat condition. The role of the nurse practitioner was to provide care to the member in her home, and this included ordering labs and prescribing needed medication, eliminating the need for transportation to a doctor's office or emergency department. Other services included personal care attendant services, escort to appointments, transportation to appointments, and attendance at a day care program that got the member out of her house and kept her socially engaged.

A year later, the member passed away peacefully in her own home. Because of her daughter and CCA, she was able to live in familiar, comfortable surroundings for almost a year after her discharge from a nursing home.