Community Care Alliance of Illinois, NFP H3071
Dual-Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 100%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Community Care Alliance of Illinois, NFP (CCAI) serves the full benefits dual eligible population in Cook, Kankakee, Kane, Will, DuPage, Lake, Boone, Ogle, McHenry and Winnebago Counties in Illinois. 46 percent of the members are over the age of 65 and 52 percent of this population are individuals with disabilities. More than 95 percent of the target population is classified as seniors and adults with physical disabilities. Members that have five or more chronic conditions make up 25 percent of the population and they tend to have a higher incidence of heart disease, diabetes, depression, COPD, Alzheimer's disease, dementia and stroke.

Provider Network

CCAI's network is comprised of providers that include, but are not limited to: primary care practitioners (PCP), geriatricians, specialized mental health network and physiatrists. In addition to these core areas of specialty, CCAI is continuously expanding the network to increase the services and relationships that will be necessary to supplement the care required for its membership, such as the relationship already established with advocacy and social service groups. The provider network includes 1,139 PCPs that act as gatekeepers and CCAI's specialty network has 4,437 physicians.

Care Management and Coordination

CCAI conducts a health risk assessment (HRA) with every member within 90 days of enrollment. This survey is designed to capture essential aspects of the member's health status, including key information in all six domains of the bio-psycho-ecological model (medical, functional, environmental, financial, social supports and psychological health). It is also used for member risk stratification. High risk members may need to be re-assessed as often as weekly or monthly based on their progress, but at minimum CCAI reassesses them once a month. The plan reassesses medium risk members at a minimum every six months and low risk members at least every year. The care coordinator is responsible for communicating the results of the HRA and risk stratification to interdisciplinary care team (ICT) members.

The care coordinator (RN/MSW) on the member's ICT is responsible for the initiation of the care plan. It is the responsibility of the PCP on the ICT and the member to agree upon the final

plan of care with input from the care coordinator. The care coordinator is responsible for ensuring that the processes are documented in the care management system. ICT members make recommendations that are used to refine the care plan. In addition to verbal communication between the member and the care coordinator, the care coordinator sends the member a letter encouraging them to call at any time for assistance. The ICT integrates the results from the HRA and essential elements for the care plan to produce an ever-evolving plan of action for each patient. The care coordinator reviews and if appropriate, revises the care plan in particular situations such as PCP visits or member contacts.

CCAI aligns the composition of the ICT with the risk status of members. There will be three levels of ICTs based on the health risk survey and composition will vary at each level. Essential ICT members at all levels will be the member, if feasible, the PCP, care coordinator (RN) and a long term services and supports (LTSS) coordinator who is a social worker. Other members will participate on the ICT as needed and may include specialists, the medical director or health educators. If a member is unable to attend an ICT meeting in person, he/she may be able to participate by phone. Home-bound members may allow the ICT to meet at their residence. If not in attendance, the PCP and the care coordinator will keep the member informed of the care planning discussions held by the ICT.

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:

https://www.ccaillinois.com/