H9689 Health Alliance Connect Inc.
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 96.67%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Health Alliance Connect (Health Alliance) Dual Eligible Special Needs Plan (D-SNP) intends to provide comprehensive, integrated services to dual eligible disabled and elderly Illinois residents in the following three primary service areas: 1) Champaign, which includes the counties of: Champaign, Dewitt, Ford, Macon, Piatt and Vermilion; 2) Peoria, which includes the counties of: Knox, McLean, Peoria, Stark and Tazewell; and 3) Springfield, which includes the counties of: Christian, Logan, Macon, Menard and Sangamon. Macon County is split between the Champaign and Springfield areas. To be enrolled in Health Alliance's D-SNP, prospective members must be eligible for Medicaid and Medicare and entitled to/or enrolled in Medicare Part A, Part B, Part D and as well as Medicaid.

Health Alliance anticipates serving adults with: physical disabilities; serious and persistent mental illness; chronic substance abuse disorders; multiple chronic illnesses, functional or cognitive limitations; adults who are homeless; elderly adults with multiple activity of daily living (ADL) or instrumental activity of daily living (IADL) deficits; elderly adults with dementia and elderly adults with multiple co-morbid chronic conditions. Health Alliance expects 55 percent of members to be disabled and 45 percent to be elderly duals.

Provider Network

Health Alliance contracts with all major medical systems and services including: the Carle Foundation Hospital and Physician Services; Presence Medical Center in the Champaign region; Memorial Medical Center and Decatur Memorial Hospital in the Springfield region and OSF St. Francis Medical Center, Methodist Medical Center and Advocate Bromenn Medical Center in the Peoria region.

The Health Alliance network includes the following specialties: allergy, cardiology, dermatology, endocrinology, gastroenterology, geriatrics, hematology, oncology, nephrology, home health care, neurology, occupational therapy, ophthalmology, orthopedics, podiatry, pulmonary medicine, rheumatology and urology. Health Alliance's behavioral health network includes psychiatrists, clinical psychologists, independently licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, certified addiction counselors, community support providers and nurses who provide behavioral health and substance abuse services.

Health Alliance has a skilled nursing facility (SNF) provider network that provides transitional care from the hospital and offers comprehensive services that include but are not limited to rehabilitative services, custodial care, physical therapy, dietary counseling and medications.

Care Management and Coordination

Health Alliance uses a proprietary health risk assessment (HRA) to identify member needs and serve the as the foundation for the member's individualized care plan (ICP). The HRA specifically looks at the following domains: medical history, psychosocial history, ADLs, IADLs, caregiver profile, employment and financial profile and member concerns and current needs.

Health Alliance conducts an initial risk stratification during the welcome call made to members within 60 days of enrollment to preliminarily stratify members as high, moderate or low risk and determine the priority of conducting the comprehensive assessment. The comprehensive assessment is completed within 90 days or 180 days of enrollment to evaluate current and historical medical and psychosocial needs and is also used to develop the member's ICP. Reassessments are performed at least annually, upon change in member status or at the request of the member. Health Alliance reviews ICPs on a routine basis to identify potential changes and a need for reassessment. All ICPs follow a standard format that includes: problem, goal, intervention/services authorized, outcome expected, target date and responsible person(s) for intervention.

The comprehensive assessment results are communicated by the member's nurse care manager (NCM) to the interdisciplinary care team (ICT). NCMs, are licensed registered nurses (RN) who are responsible for providing coordination of care for Health Alliance members and ensuring their health needs are met. The ICT consists of the following: the member and/or caregiver/legal guardian, primary care provider (PCP), NCM and member resource coordinator (MRC). Behavioral health, pharmacy and other specialists can also be included. After the completion of the ICP, the ICT will use healthcare outcomes to assess progress and to evaluate the appropriateness of the goals. Outcome evaluations include: hospitalizations, emergency room and other unplanned visits, diagnosis of a new health condition, improvement or decline in ADLs and IADLs, member compliance with medical appointments and medications and member safety and support

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://medicaid.healthalliance.org/index