Easy Choice Health Plan Inc., H5087
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Easy Choice Health Plan (ECHP) has a dual-eligible Special Needs Plan (SNP) that serves members in Los Angeles, Riverside and Orange counties in California. Members are predominately age 66 or older and females comprise the majority of the population (52.5%).

Provider Network

ECHP and its delegated Independent Physician Associations (IPAs) have a network of contracted and/or employed providers and health facilities with the specialized clinical expertise to deliver care to the target population. The primary care provider (PCP) serves as a gatekeeper and ensures that the member receives all necessary services. The network includes: acute care hospitals, laboratories, long term care and skilled nursing facilities, radiology/diagnostic facilities, rehabilitative facilities, home health providers, pharmacies, social workers, physical, occupational and speech therapists, specialists pertinent to targeted chronic and co-morbid conditions, oral health specialists, mental health providers, psychiatric facilities, mid-level practitioners, LVN and RN nurses and pharmacists.

Care Management and Coordination

The health risk assessment (HRA) is a tool to ensure that an individualized care plan (ICP) can be generated to meet members' care needs. The tool includes information on members' medical, mental, health history, psychosocial, functional, and cognitive needs. ECHP sends an HRA to all new members within 7 days of enrollment and at least 12 months from the time of the last assessment. A licensed care manager or quality improvement nurse reviews the questionnaires and manually stratifies by risk into high, moderate or low levels. The PCP also completes an initial health assessment (IHA) within the first 90 days of enrollment unless the member was recently seen by the PCP.

ECHP uses the HRA and IHA findings, along with the medical history and current clinical diagnostics and assessments to develop and update the ICP. The interdisciplinary care team (ICT), along with the care manager, the member or caregiver when feasible, develop and implement a comprehensive ICP. The member receives a letter explaining the care planning process, including how to communicate with the ECHP care management team and introduces the ICT team and how to contact members.

The ICP is based on preventive health care, since at time of enrollment members may not have disease specific or chronic care needs identified until they see their PCP. The ICP contains basic

demographic and contact information about the member, a copy of the IHA, if completed, a HRA, a copy of any specific goals and objectives agreed upon by the ICT and the member, member preferences for care – including advanced directives, and any other specific information which can assist with special needs or requirements of the member. The ICP includes long and short term goals, barriers to meeting these goals and his/her progress to meeting goals will be monitored. The ICP integrates add-on benefits to serve this vulnerable population that include but are not limited to: transportation, nutritional screening, dental, vision, gym membership and multilingual customer service in the medical management and customer service department.

The SNP updates the ICP and goals at least annually with each re-assessment; however, it may be more frequent depending on changes in the member's health status or needs.

ECHP and its delegated IPAs currently have a clinical ICT that works together and communicates with each other to manage the members care by developing and implementing the ICP, conducting or observing care coordination meetings or case rounds via phone, face-to-face, a conference call or a web based interface and maintaining a call line or other mechanism for member inquiries and input. It consists of: a RN or LVN care manager, pharmacist, utilization management coordinator, PCP or mid-level practitioner, specialists/board certified specialists, behavioral health provider, therapists (PT/OT/speech), dietician/nutritionist, ancillary providers, community resource specialists, pharmacist, disease management specialist, pastoral specialist, the caregiver and the member whenever feasible.

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://www.easychoicehealthplan.com/index.php