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

Model of Care Score: 98.33%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

Easy Choice Health Plan's (ECHP) Dual Eligible SNP target population resides in Los Angeles County. As of December 2013, the ECHP dual-eligible SNP membership was 15,245, of whom 18.4 percent were younger than 65 years of age and 55 percent were female. About 28 percent of members are Hispanic or Latino, 26 percent are Asian or Pacific Islander, 22 percent are White and 10 percent are Black. Spanish is the primary language spoken by 41 percent of members, 32 percent of members primarily speak English while eight percent speak Korean and eight percent speak Vietnamese.

The dual-eligible, special needs population suffer from a high rate of mental and physical disability, advanced age and impoverishment. This population also has a high prevalence of chronic conditions such as heart disease, diabetes, arthritis, depression and congestive heart failure. Some of the top diagnoses among the ECHP population include low back pain, chest pain, diabetes and congestive heart failure (CHF). About 44 percent of ECHP D SNP members have two or more identified health care conditions and 27 percent of members have behavioral health conditions.

Provider Network

ECHP maintains a comprehensive network of multidisciplinary practitioners and ancillary providers to meet the extensive acute, chronic and preventive medical, surgical, behavioral and psychosocial needs of the dual-eligible special needs population. Services are available in the home, community and hospital settings.

Care Management and Coordination

The health risk assessment (HRA) provides an opportunity to offer case management services to D-SNP members. HRAs are conducted for all members within 90 days of enrollment. Scores on the HRA stratify members according to level of need (high, medium or low). All members are offered case management services regardless of HRA risk stratification level. A comprehensive assessment is conducted on all members who consent to case management services. Health or functional deficits identified on the HRA, as well as those identified by other assessments and interactions, become specific elements of the member's individualized care plan (ICP). The HRA

is re-administered annually or as needed depending on both planned and unplanned care transitions.

The case manager (CM) develops the ICP with the member using the comprehensive assessment information gathered during communications with the member or caregiver and pertinent follow-up information. The CM identifies and reviews the problems with the member, and both parties agree upon goals and interventions that address the member's unique needs. At a minimum, the CM, member, caregiver and primary care physician (PCP) review the ICP. Additional reviews of the ICP are performed by specific specialists. The CM coordinates services across the continuum of care, promotes effective utilization of services and monitors health care resources.

The CM also assumes a leadership role within the interdisciplinary care team (ICT) and under the direction of the medical director and case management supervisor, determines the membership of the ICT based on individual member needs and team requests for certain specialists. As a result, the composition of the ICT may vary for each member. The ICT is comprised of core internal health plan staff), and external members (delegated vendors, community representatives, and external providers). The core members of the ICT are the member/caregiver, CM and member's PCP. Additional plan-based members may include the ECHP state medical director, corporate behavioral medical director (psychiatrist), utilization management (UM)/case management (CM) nurse manager, CM supervisor, UM care managers, social worker and pharmacist.

Members with more complex and or acute needs will have more frequent ICT meetings and scheduled reviews based upon the ICP. The ICT uses health care outcomes, such as re-admission rates, to evaluate the member's current ICP and establish interventions. The responsibilities of the ICT include: managing the medical, cognitive, psychosocial and functional needs of the member; incorporating health-risk assessment findings in the development of the ICP; collaborating with team members in the coordination, development and review of the ICP and maintaining open lines of communication with team members for care coordination.

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/