Inland Empire Health Plan (IEHP) Health Access Dual-Eligible H5640
Dual Eligible (Medicaid Subset Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Inland Empire Health Plan (IEHP) offers a Medicaid Subset dual eligible (D-SNP) special needs plan known as IEHP Health Access to any: dual-eligible member. IEHP has 11,482 members for whom the average age is 57 years old. Currently, females comprise 54.14% of the population and males make up 45.86%. Over 72% of the membership speaks English, 27.76% speak Spanish and 0.02% of members speak Cambodian or Vietnamese. The top five most populated cities the plan's service area include: San Bernardino, Riverside, Hemet, Moreno Valley and Fontana, California. In addition, the five most common conditions in the population consist of: Diabetes Mellitus, Hypertension, Asthma, Affective Psychoses and Schizophrenia, and Back Pain.

Provider Network

IEHP's network of providers and facilities have the specialized clinical expertise to meet the target population's care needs. IEHP's provider service and contracts departments are responsible for ensuring that the network has sufficient clinical expertise to deliver healthcare services to the membership**.** The network collaborates with the interdisciplinary care team (ICT), assists in the development of care plans, provides clinical consultation as needed and adheres to nationally recognized clinical practice guidelines.

Care Management and Coordination

All newly enrolled dual-eligible members receive a comprehensive initial health risk assessment (HRA) to evaluate their medical, psychosocial, cognitive and functional needs. IEHP develops a care plan for each member, which includes results of the HRA, goals, objectives, interventions/services and measurable outcomes. The member's healthcare preferences are incorporated into the care plan, taking into consideration his/her medical history, add-on benefits and services needed. The care management staff specifies how to determine which goals are met and what actions will be taken if goals are not met. Members that opt out of the care management program have a standard care plan developed to manage any specific needs that may arise and IEHP monitors them for any change in health status.

The ICT utilizes a multi-disciplinary approach to assessing and monitoring the target population. The ICT strives to address the multiple issues that affect the population (e.g. medical, behavioral health, psychosocial, cognitive and functional issues). If it is determined that a Member requires a case conference, the Member will be presented at the meeting that is held no less than monthly and when indicated, or on an ad hoc basis. The team participates in these meetings in-person or

by telephone. All meetings are documented in minutes and maintained as part of the member record through notes made in the medical management database.

The plan assigns each member to an ICT composed of staff, the primary care provider, ancillary providers and specialty care providers pertinent to the member's needs. Monthly, a report of all new members with hierarchy category codes, risk factors, facility admission and discharge reports are submitted to the ICT for review and recommendations. The composition of each member's ICT based on their individual needs.

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: www.iehp.org