H5640 Inland Empire Health Plan Medicare DualChoice,
Dual Eligible Subset (Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 81.67%
2-Year Approval **January 1, 2015 to December 31, 2016**

Target Population

Inland Empire Health Plan (IEHP) DualChoice serves 11,428 members who qualify for Medicare and Medicaid based on age or disability. The IEHP membership is diverse and represents multiple races and ethnicities. Most members speak English, Spanish, Vietnamese or Arabic. The average age of members is 57, and more than half are female. The most common conditions are diabetes mellitus, hypertension, asthma, affective psychoses and schizophrenia, back, abdomen, pelvic and joint pain, hyperlipidemia, urinary tract infections and head and neck pain. IEHP encounter data from 2013 shows that affective disorders rank third only to diabetes and hypertension as a primary diagnosis for inpatient and outpatient services in the delivery system. Approximately 42 percent of members need help with at least one activity of daily living (ADL), and 25 percent of members need help with two to four ADLs.

Provider Network

The IEHP provider network includes primary care physicians (PCP), family practitioners, general practitioners, internal medicine providers, nurse practitioners (NP), midwives, physician assistants (PA), general surgeons, mental health providers, OB/GYNs, orthopedists and physical therapists. IEHP contracts with Medicaid home and community based service providers. Since 2004, through the Inland Empire Disabilities Collaborative (IEDC), IEHP has collaborated with the Aging and Disability Resource Connection (ADRC) that administers the Multipurpose Senior Services Program (MSSP), and also collaborates with over 300 organizations that serve seniors and persons with disabilities. IEHP is participating in state-sponsored stakeholder work groups on in-home supportive services (IHSS).

IEHP provider services and contracts departments are responsible for ensuring members have access to the following services: acute care facilities, hospitals, medical centers; urgent care; labs; long term care and/or skilled nursing facilities; home health agencies; hospice agencies; pharmacies and pharmacists for medication management; radiography facilities; rehabilitation facilities and rehabilitation/restorative therapy specialists; nursing professionals; medical specialists pertinent to targeted chronic conditions and identified co-morbid conditions; oral health specialists; specialty outpatient centers; dialysis facilities; disease management specialists and health education specialists.

Care Management and Coordination

IEHP reaches out to all members to conduct a comprehensive initial health risk assessment (HRA) within 90 days of enrollment. Members are enrolled in the care management program and assigned a risk stratification level: episodic, basic, general or complex. The healthcare analytics and reporting department and the care management and health administration departments reach out to new members to complete the initial HRA and re-assess members at least annually thereafter or as needed based on health status changes.

The nurse care manager (CM) reviews and analyzes results along with an interdisciplinary care team (ICT). The clinical team follows the stratification protocol to ensure referrals are made to the appropriate disciplines or clinical specialties. ICTs include at a minimum, the member and/or caregiver, the CM and the PCP or other acting primary care providers. An ICT case conference, which meets regularly, is offered to all members. The CM, in consultation with the medical director, determines who is included on the ICT based on individual member needs. Additional ICT members might include: a family member, PCP, board certified specialists, NP, PA and mid-level or ancillary providers, care coordinators, community resource specialists, a restorative health specialist, registered dieticians or nutritionists, health educators, clinical pharmacologists, disability program representatives, dentists and pastoral care.

Based on recommendations from the ICT, input from the member and HRA results, an individualized care plan (ICP) is developed. CMs and the ICT encourage member input relating to goals and barriers to develop a meaningful ICP. The member's ICP is updated during regular follow-up contacts when the CM reviews and discusses the member's goals and interventions. Should the member's health status change, the CM and the member will determine new goals and interventions.

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: www.iehp.org