CarePlus Health Plans, INC. H1019
Dual Eligible Subset Medicare Zero Cost Sharing Special Needs Plan

Model of Care Score: 96.25%

Three Year Approval **January 1, 2014-December 31, 2016**

Target Population

The targeted SNP population are those dually eligible (DE) for Medicare and Medicaid. These members may have complex medical needs and increased psychosocial needs that impact compliance with care plans and health outcomes. DE members are more likely to be over 85 years of age or disabled, under 65 and eligible for Medicare due to disability, and have greater limitations in Activities of Daily Living (ADL), with one third reporting impairment in three to six ADLs. This population also demonstrates higher rates of mental illness, cognitive impairment, and higher incidence of diabetes, stroke, and Alzheimer's. CarePlus's DE SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum.

Provider Network

CarePlus offers a comprehensive network of care centered on primary care with medical and surgical specialists available to augment and support primary care providers (PCPs) as well as the needs of the targeted populations. This network includes, but is not limited to, acute care facilities, long-term care facilities, skilled nursing facilities, laboratories, radiography facilities, rehab facilities, rehabilitative specialists, mental and social health specialists, home health specialists, and end of life care specialists. Although CarePlus offers a comprehensive network of physicians and providers, should members develop needs for services outside the current network, CarePlus may grant approval for utilization of out-of-network facilities when appropriate.

Care Management and Coordination

CarePlus utilizes a health risk assessment Tool (HRA) tool that is provided to members as part of their enrollment information. The member returns a completed HRA to the plan for review and evaluation by CarePlus staff. This includes an analysis of current membership status with CarePlus, changes in risk scores, changes to cost, and changes to HRA scores. Only change in membership status with CarePlus is a potential disqualifier. The remaining criteria are used to determine level of intervention. Member claims are grouped by risk using predictive modeling software on a monthly basis. The HRA scores risk across seven health domains: functional,

social, cognitive, financial, health, behavioral, and environmental risk. A complete profile is built on each member using the HRA, the predictive model of claims risk score, and historical claims data. Annual reassessment using the same tool is performed within one year (365 days) of the previous assessment. Reassessment can also be completed more frequently in the event of hospitalization as deemed appropriate by the individual member's care manager.

The CarePlus Team is responsible for coordinating care in a seamless manner across the care continuum focusing on acute and chronic needs as well as health promotion and crisis intervention. The interdisciplinary care team's (ICT) overall care management role includes enrollee and caregiver assessment, reassessment, care planning and plan implementation, enrollee advocacy, health support, health coaching and education, and support of the enrollee's self-care management and care plan evaluation and care plan modification as appropriate.

All SNP members are required to have an active, individualized care plan (ICP) that addresses the gaps identified through the assessment process and planned interventions, such as connections to benefits and special services in order to meet specific goals and objectives. Care plans are created, reviewed, and updated with each member encounter by the CarePlus care manager. The care plan can be accessed through CarePlus' secure documentation system and is available to internal clinical associates only. Copies of the care plan are mailed to the member upon request, and providers may also receive copies of care plans. The care manager, in conjunction with the enrollee and ICT, coordinates efforts to make the ICP actionable.

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.care-plus-health-plans.com/medicare-plans/2014.asp