H5141 CarePoint Insurance Company
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

The target population for CarePoint Insurance Company (CP) Dual Eligible Special Needs Plan (DSNP) consists of members who are over 21 years of age, enrolled in Medicare Part A and Part B, and Medicaid eligibility category. These members reside in Hudson, Union, Bergen, Passaic, Middlesex, Somerset and Essex Counties.

Of the approximately 80,000 full dual eligible individuals in the CP service area, 34 percent are under age of 65, and 66 percent are age 65 or older and 18 percent of these members are over age 85. The majority are females (65 percent), and 43 percent are likely to be disabled. Approximately 43 percent are minorities (African American, Hispanic, Asian and other groups). Fifty-one percent have three or more chronic conditions. On average, 31 percent of the population was born outside the US, 30 percent speak a language other than English and 11 percent have incomes below the poverty level.

Finally, 82 percent of the population has at least one chronic condition and 51 percent have three or more. The most prevalent conditions include: heart disease, diabetes, congestive heart failure, depression, arthritis, osteoporosis and dementia.

Provider Network

CP's primary care network includes: 250 primary care physicians, 20 skilled and long term care nursing facilities, 6 contracted acute care facilities, 1 tertiary care acute care facility and hundreds of pharmacies. Members also have access to: home health agencies, outpatient rehabilitation facilities, multi-specialty clinics, surgery centers, medical transportation, hospice, durable medical equipment, and orthotics and prosthetics providers. The network also encompasses a wide range of safety net providers, including the Hudson County public hospital and clinic system.

Care Management and Coordination

In addition to capturing medical and mental health histories of every CP member at enrollment and annually thereafter, a nurse case manager (NCM) administers a 38-question, health risk assessment tool (HRAT) by phone or at home to identify the medical, psychosocial, functional, and cognitive needs of members that were identified as high risk on the initial health screening

and the comprehensive needs assessment. The NCM assigns them to an interdisciplinary care team (ICT). Assessments are analyzed in order to identify the most vulnerable members.

The assessment results are used to construct the individualized care plan (ICP). The ICP components must include, but are not limited to: the member's self-management goals and objectives; the member's healthcare preferences; description of services specifically tailored to the member's needs; and identification of goals met or not met. As long as the member's condition remains low or medium risk, the ICP is updated annually. Any CPHP member, regardless of risk stratification, experiencing a change in health care status or a care transition requires a review and revision of ICP.

The usual members of the are: the member/caregiver, PCP, NCM, medical social workers or social services representative, behavioral health representative and other identified health professionals, as applicable. The PCP serves as primary gatekeeper and the coordinator of care for his/her patients. The NCM serves as the point of contact between the provider network and the ICT to facilitate and authorize all needed services. Based on member needs, the ICT can expand to include, but is not limited to: rehabilitation specialists, physician specialists, nutritional services, licensed clinical social workers or medical social workers from community agencies.

The PCP and NCM maintain contact via phone or e-mail with documented updates available to all ICT team members via a HIPAA compliant, cloud-based, case management system. CP's internal ICT meets no less frequently than biweekly and more often if needed. In between visits to the physician office, the NCM communicates regularly to check in with the member about ongoing care including specialized care delivery. The NCM also ensures that the member knows what care is planned, is in agreement with this care and the care is delivered as scheduled.

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.carepointadvantage.org.