H2593 Texas/ Arizona

2020 C-SNP MOC

Chronic Lung

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MOC 1: Description of SNP Population (General Population)

MOC 1: Element A: Description of Overall SNP Population

Our Special Needs Plan (SNP) management is regulated by CMS program requirements, as outlined in the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). The SNP Model of Care (MOC) Program Description describes our MOC processes and requirements. Anthem provides services to members enrolled in D-SNPs, C-SNPs, and I-SNPs. We currently have over 129,000 members in our Special Needs Plans across the country. Our Chronic Special Needs Plan (C-SNP) targets those members who are living with chronic lung disorders. Our evidenced based model of care (MOC) has been designed to provide improved management of the condition which includes disease education, coordinated care, access to services and continuity of care as addressed through our programs and the clinical management provided by our network of providers. In our C-SNP plans we have designed the primary care provider network have fewer providers to better collaborate and coordinate the care provided to our members. Chronic Conditions such as diabetes, cardiovascular and COPD have multiple co-morbidities resulting in an overall complex and high-risk member. While some of the population enrolled in the C-SNP may not be over 65 due to a disability status, the majority of the population is elderly and may have been diagnosed for a long period of time and have many of the co-morbidities and complications related to the condition. We measure the effectiveness of the MOC, annually, as part of our evaluation process.

MOC 1 A.1: Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

The plan receives enrollment applications directly from beneficiaries or through sales agents. Upon receipt of the application, the membership enrollment representatives review the applications and review the CMS approved pre-enrollment qualification assessment tool (currently Anthem's application) prior to enrollment and obtain verification of the condition from the provider or provider's office on a post-enrollment basis. Additionally, Anthem will be contacting the provider or provider's office and obtain verification of the condition. Anthem has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP. If it cannot confirm that the that the enrollee has the qualifying condition within that time, Anthem has the first seven calendar days of the following month in which to send the beneficiary notice of his/her disenrollment at the end of that month for not having the qualifying condition. Disenrollment is effective at the end of the second month of enrollment; however, the organization must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of enrollment.

MOC 1A.2: Describe the social, cognitive, and environmental factors, living conditions, and co-morbidities associated with the SNP population.

Lung Disorders include a variety of conditions and referred to as Chronic Obstructive Pulmonary Disease (COPD), which refers to a group of diseases that cause airflow blockage and breathing-related problems. It is primarily caused by an exposure to tobacco smoke. Other exposure to air pollutants, genetic factors

and infections play a small role in the development. This includes emphysema and chronic bronchitis. Other conditions considered part of the chronic lung C-SNP include asthma, pulmonary fibrosis and pulmonary hypertension. All of these conditions impact the lungs in similar ways, can create additional health issues and are progressive. Those diagnosed with COPD will have progression of their conditions and potentially will get worse over time and may experience additional health problems due to their COPD. According to the CDC, COPD is the 3rd leading cause of death in the United States with almost 15.7 million or 6.4% having the condition. The following situations/classifications created a higher risk of developing COPD:

- People 65 and older
- Women and some cultural such as American Indians/Alaska Natives
- Women
- Lower education level
- Social isolation (unemployed, retired, widowed, lived alone)
- Smoking (current or previous)
- History of Asthma

COPD is a progressive disease and will eventually lead to death, there is no cure and the management is targeted to slowing the progression, comfort measures and improvement in the quality of life.
Anthem has been administering a Medicare Advantage program for many years and specifically a Dual Special Needs Plan for over ten years we also have experience in several chronic condition special needs plans. We have a long standing presence in our Texas market for Medicare and have chosen to implement a chronic lung SNP in this market. Some of the members in our Texas program may also be dual eligible members and may even qualify for Managed Long Term Services and Supports (MLTSS). For those members that have both our programs for Medicare and Medicaid we have processes to coordinate the care to provide more holistic process. Members in a C-SNP plan do not have the requirement to be dual eligible but some of our members are either disabled or qualify for some level of Medicaid benefits due to financial qualifiers. Arizona is also represented in this contract and we have had a Lung C-SNP for several years.

The detailed description of our population is developed using data collected from a variety of sources and may include any of the following:

- Demographic reports from multiple external and internal sources
- Disease specific information and other analysis from external sources such as: websites, reports such as KFF.org, CMS.org, healthypeople.gov, and census.gov
- Reports from the community resources used as part of the case management program
- Feedback from our case management team on major needs and deficits identified during care planning and assessment process
- Data from delegates and providers
- The Medicare Health Outcomes Survey (HOS) or CAHPS Survey
- Diagnosis information from claims reports
- Additional reports from claims data or utilization
- Data captured from historical information gathered from our experience in managing the population including trends from case managers or clinicians

- Experience working within the special needs plan population including information gathered from our health risk assessment (HRA) or other areas that interact with the members

We use information from our own internal systems to evaluate specific membership characteristics and supplement this data with national or other state statistics to provide a comprehensive assessment of the population we currently provide services to or for new markets where we may not have experience. A comparison between our data and data from other sources allows us to evaluate our membership and determine if there are variances and how we align to the general Medicare data that is available on similar members and/or Medicare beneficiaries. This process is especially helpful for new markets where we may not have experience or baseline data in that service area. When we are preparing our population assessment in new markets or where we have minimal membership, we focus our research on established market data from CMS or state sources. Because we have extensive experience managing special needs members we use data we have gathered on our current members in different markets to provide a baseline and our targets until adequate market specific data is available. We may also supplement our data with information obtained from our delegates. We use data from our case management process and information gathered directly from our case managers to determine needs of the population directly from those interacting with the members and providers. Once we have experience in the specific market we are able to replace this initial review with information and reports specific to the population we continue to use supplemental data in our markets with lower membership and to compare our experience with other valuable results on the Medicare beneficiaries.

When Anthem has delegated responsibilities to a provider or vendor, the type of information we receive to support our population evaluation may look the same as what we are able to obtain from our internal systems. The analysis may not have the same level of detail or be in the same format.

The demographics below represent the two states, Arizona and Texas. Some of the data provided applies to all of our markets addressed in this model of care, if the information listed does not apply to all markets the applicable market will be listed.

ARIZONA

Language

Language	Arizona*
English	86.75%
Spanish	13.25%
All Other Languages	0.00%

Race/Ethnicity

Race/Ethnicity	Arizona**	National**
White	88.90%	77.50%
Black or African American	2.50%	12.10%
Other/Unknown	8.60%	10.40%

Gender

Gender	Arizona*	National**
Female	53.60%	58.50%
Male	46.40%	41.50%

Age

Age	Arizona*	All of CareMore*
Membership 65 and older	86.99%	87.12%
Membership Under 65	13.01%	12.88%

TEXAS

Language

	Texas D-SNP	Medicare Texas
English	63.39%	English
Spanish	22.56%	
Vietnamese	7.83%	
All Other Languages	1.2%	Spanish Vietnamese Chinese Korean

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Race/Ethnicity

	All D-SNP	Texas Medicare
White	65.47%	13.78%
Black or African American	20.68%	18.15%
Hispanic	11.96%	46.21%
Asian/Pacific Islander	1.73%	21.77%
Unknown	0.08%	0.02%
Two +Races/Ethnicities	0.05%	0.06%
American Indian or Alaska Native	0.03%	-

Gender

	All D-SNP	Texas MA	Texas DSNP	FFS Medicare
Female	62.08%	53.39%	62.75%	54%
Male	37.92%	46.61%	37.25%	46%

Age

	All D-SNP plans	Texas Medicare
Membership 65 and older	62.67%	71.11%
Membership Under 65	37.33%	28.89%

The average age of Medicare fee for service enrollees in Texas 71.13 years of age and the average age in Arizona is 72.95. Below is a further breakdown of the age percentages comparing our current D-SNP plan and general Texas and Arizona markets:

Age	Arizona	Delegate programs
Under 40	0.81%	1.07%
40-49	1.42%	1.66%
50-59	5.39%	5.02%
60-64	5.40%	5.13%
65-69	23.14%	21.18%
70-79	41.71%	41.07%
80-89	17.48%	19.31%
90-99	4.49%	5.38%
100 and Over	0.16%	0.18%

Age	All D-SNP	Texas
Under 40	5.23%	4.97%
40-49	6.57%	5.40%
50-59	14.92%	10.93%
60-64	9.41%	7.59%
65-69	22.08%	20.99%
70-79	28.47%	34.89%
80-89	11.07%	13.05%
90-99	2.17%	2.15%
100 and Over	0.07%	0.03%

Basic Demographic Summary

Arizona: The most recent market information showed we had approximately 13,809 members. Our overall Arizona population is predominantly female at 53% with males comprising 46%. For the national market the breakdown is 58% female and 42% male. Comparison between the national market specific data and overall Arizona membership is consistent with female exceeding the males. The Race/Ethnicity distribution for all of our Arizona plans was white at 89% followed by Other/Unknown 8.6%, and Black or African American 2.5%. The national Market specific data indicated white at

77.50%, followed by Black or African American 12.10%, and Other/Unknown 10.40%. The age distribution of the population is 87% 65 and over and 13% under 65. For all of CareMore this market the results are 87% over 65 and 13% under 65. Language distribution was identified based on the responses obtained from the members completing the HRA. Based on these results gathered from all of the Arizona members confirmed 87% of the population contacted speak English and 13% reported having a preference for Spanish with other languages comprising less than 8%. When looking at all of our D-SNP plans, Korean, Chinese, and Vietnamese are represented in small numbers. The market specific information on language confirms the language preference is 98.61% preferring to speak in English. We are able to assist the member through translation services regardless of the preferred language.

The most recent American Health Rankings Annual Report has compiled the following detailed information;

- **Race** (American Indian 20.9%, Asian 8.6%, Black 11.2%, Hispanic 10.9%,Multi-Racial 6.0%, Others 13.2%, White 9.8%)
- **Age Group** (Age 18-44: 2.9%, Age 45-64: 15.0%, Age 65+: 19.7%)
- **Location** (Rural: 16.9%, Suburban: 14.5%, Urban: 14.1%)
- **Education** (< HS – 16.3%, HS Grad – 12.1%, Some College – 12.3%, College Grad – 8.5%)
- **Income** (< 25k – 16.8%, $25-49,999 – 12.5%, $50-74,999 – 9.6%, >$75 – 7.7%)

Texas: The most recent market information showed we had approximately 27,000 Medicare SNP members in our Texas market. Our baseline year for this C-SNP is 2019. Medicare fee for service membership volume in Texas indicates Harris County has over 277,000 beneficiaries. The percentage over 65 is approximately 75%. All of the statistics including our D-SNP population is predominately female with percentages ranging from 53.39% to 63.40%. Comparing the Race/Ethnicity information from multiple sources on Texas, showed the following results: white ranging from 43-64%, Hispanic 21-25% and black at 11-21%. For our existing D-SNP membership 46.21% are Hispanic, 18.15% Black, 21.77% Asian, and 13.78% white. The age distribution of Texas was reviewed using multiple sources. A different range was present based on review of Medicare beneficiaries in Texas or our internal experience with our D-SNP plan. The general Medicare population is reported with an age range of 85% over 65 and 16% under 65 years of age. In our D-SNP experience in Texas 71% is over and 28.89% is under and for all of our D-SNP members 62.67 is over 65 with 37.33 under. In our D-SNP plan in Texas 68.39% prefer English with 22.56% Spanish and 7.83% Vietnamese. In the Medicare population in Texas the language was similar with the language prevalence indicating the top five languages of English, Spanish, Vietnamese, Chinese, and Korean. We are able to assist the member through translation services regardless of the preferred language.

Texas and Arizona: We perform additional analysis in several different areas to get a more holistic view of our population. Our members can have multiple medical or behavioral conditions creating a higher complexity but also experience comorbidities that are social or environmental as reported below.

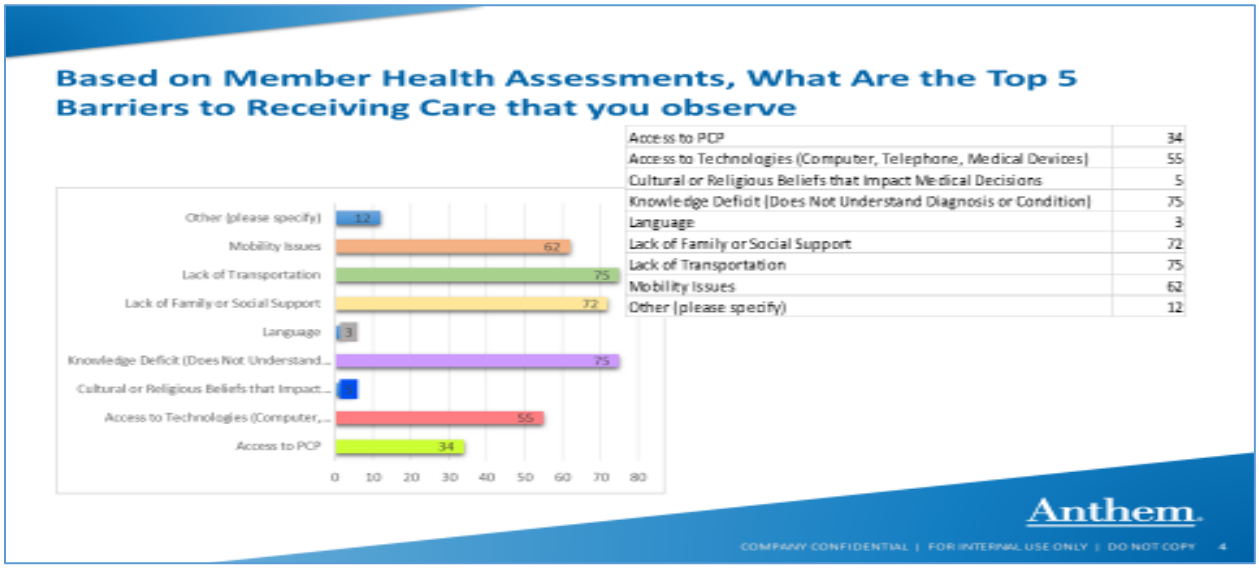
By using a variety of internal and some external information we identified some general needs of our population. While we consider members in our SNP programs to be at a higher risk than the general population there are some situations that we feel elevates the risk.

Social determinants of health and other environmental issues create a higher complexity and can create barriers or limitations as we assist the member in meeting the care needs identified during our assessment and care planning process. The following issues and comorbidities were identified by our case management team as the most frequent risk factors and/or social issues impacting management:

- Low income, limited financial resources and/or poverty level
- Lives alone or has few social supports
- Loss of interest/feelings of depression
- Housing instability or transient (no stable environment) resulting in inconsistent or unreliable contact information or telephones, unable to reach
- Communication issues
- Low health literacy or education level, difficulty in understanding health information
- Lack of transportation or barriers to transportation
- Issues with activities of daily living (ADLs) and instrumental activities of daily living (IADLs)

We poll our case managers and other areas that interact the most with our SNP population and can represent the issues that add the most challenge to their management.

Our case management team understands the care needs of this population and provides valuable information that may be used to determine if there is a network or program need. We are also able to evaluate the community resources available to address some of these social needs in order to prevent the issues from creating barriers in management.



We have collected and reviewed outcome data obtained from the results of questions answered in our health risk assessment. We are able to obtain this level of information at the state level of those completing our HRA. Below is market specific information obtained from the results of our health risk assessment (HRA) gathered from our current SNP membership in Texas to use as a baseline and comparison to the information we have on our existing members in our C-SNP plans:

Arizona:

- 9.45% indicated they have had a fall in the month prior to completing the HRA.
- 53.97% indicated they are using community resources to assist them with their daily activities.
- Cognitive issues seem to not be an issue based on the HRA questions or the nurses' evaluation.
- 21.59% report they have slightly to more difficulty than last year performing daily activities.
- 7.12% of members indicated they do have problems accessing their PCP or specialists. Transportation issues is the primary reason.
- 65.20% indicate they are independent with performing functions in the home
- 15.12% indicate they have some assistance with ADL or IADL
- 99% indicate they are not in an abusive situation
- 91.38% stated they do not need any assistance taking their medications
- 97.80% stated they feel safe where they live
- 28.11% have discussed their health care wishes with a provider

Texas:

- 10.08% indicated they have had a fall in the month prior to completing the health risk assessment.
- 53.32% indicated they are using community resources to assist them with their daily activities.
- Cognitive issues seem to not be an issue based on the health risk assessment questions or the nurses' evaluation.
- 32.65% report they have slightly to more difficulty than last year performing daily activities.
- 95.51% of members indicated they do not have problems accessing their PCP or specialists however those that do have problems indicate one reason is due to transportation.

- 46.58% indicate they are independent with performing functions in the home
- 36.70% indicate they have assistance with some or all ADLs
- 98.96% indicate they are not in an abusive situation
- 82.44% stated they do not need any assistance taking their medications
- 97.83% stated they feel safe where they live
- 25.25% have discussed their health care wishes with a provider

The following outcomes were collected from our D-SNP members that completed the HRA in all markets to use as a comparison and to plan for a new service area for our C-SNP plan. If we have market specific information, we compare those results to our overall program responses and perform further analysis to determine if there are trends that may be different across our plans. By using all responses from our D-SNP members we are able to use or experience to make assumptions for new markets and those markets that has very low membership to determine if there are any variances by market that may need to be addressed. In our experience, we find the responses to be consistent for our D-SNP plans.

- 9% indicated they have had a fall in the month prior to completing the HRA.
- 50.53% indicated they are using community resources to assist them with their daily activities.
- Cognitive issues seem to not be an issue based on the HRA questions or the nurses' evaluation with a measurement of 3%.
- 26.25% report they have slightly to more difficulty than last year performing daily activities.
- Most members indicated they do not have problems accessing their PCP or specialists however those that do have problems indicate one reason is due to transportation.
- 62.26% indicate they are independent with performing functions in the home
- 14.6% indicate they have some assistance with ADL or IADL
- 99.05% indicate they are not in an abusive situation
- 86.74% stated they do not need any assistance taking their medications
- 97.88% stated they feel safe where they live
- 28.98% have discussed their health care wishes with a provider

Health Outcomes Survey (HOS):

The HOS results below help us to identify those environmental, social and co-morbidities the special needs plan population may experience based on responses from all of our Medicare membership completing the survey.

Arizona

- 61% have an income less than 30,000 a year
- 26.3% did not complete high school
- 27.1% of males and 37.5% of females are obese
- 45.5% have 4 or more chronic conditions
- 10.8% have impairments in 3 or more activities of daily living
- <1% have impairments in 3instrumental activities of daily living (IADL)
- 27.7% consider their health fair or poor
- 22.23% accomplish less due to physical difficulties all or most of the time

- 23.5% indicates pain interferes with normal activity very much or a good bit of time
- 2.5% feel downhearted and blue most or a good bit of the time
- 13.0% have a hearing issue
- 7.4% smoke
- 25.2% have experienced a fall in the last year

Texas

- 89.33% have an income less than 30,000 a year
- 43.68% did not complete high school
- 29.27% are obese
- 54.55% have 4 or more chronic conditions
- 34.44% have impairments in 3 or more activities of daily living
- 6.98% have impairments in 3 instrumental activities of daily living (IADL)
- 54.35% consider their health fair or poor
- 31.11% accomplish less due to physical difficulties all or most of the time
- 28.89% indicates pain interferes with normal activity very much or a good bit of time
- 20% feel downhearted and blue most or a good bit of the time
- 10.07% have a hearing issue
- 10.59% smoke

When we compare this information to our responses from all Medicare members completing the HOS survey, we see a higher volume with less education, obese remains high and a higher volume of chronic conditions are identified. When we compare the information from HOS surveys in the markets as compared with all respondents (from both our delegate and Anthem) we see that more members have limitations in measures that would be aligned with functional issues such as activities of daily living, IADLs, accomplishing less due to limitations, and pain.

Represents all of the respondents from our delegate which has a higher volume of C-SNP members in existing and established markets:

- 42.5% have an income less than 30,000 a year
- 17.3% did not complete high school
- 28.5% are obese
- 40.5% have 4 or more chronic conditions
- 12.4% have impairments in 3 or more activities of daily living
- 0.9% have impairments in 3instrumental activities of daily living (IADL)
- 24.6% consider their health fair or poor
- 31.34% accomplish less due to physical difficulties all of the time
- 20.6% indicates pain interferes with normal activity quite a bit or extreme of time
- 2.4% feel downhearted and blue most or a good bit of the time

Below represents responses from all of our Medicare membership in Anthem completing the Health Outcome Survey. Because or SNP members are included in these results we use this data in addition to other information to provide some social measurements not otherwise available to us.

- 64.07% have an income less than 30,000 a year
- 18.05% did not complete high school
- 26.91% are obese
- 37.44% have 4 or more chronic conditions
- 12.56% have impairments in 3 or more activities of daily living
- 1.48% have impairments in 3instrumental activities of daily living (IADL)
- 24.54% consider their health fair or poor
- 18.14% accomplish less due to physical difficulties all of the time
- 16.68% indicates pain interferes with normal activity quite a bit or extreme of time
- 8.56% feel downhearted and blue most or a good bit of the time
- 8.16% have a hearing issue
- 8.30% smoke
- 15.40% have experienced a fall in the last year

MOC 1A.3: Identify and describe the medical and health conditions impacting SNP Beneficiaries.

The target population of the CHP SNP are beneficiaries who have been diagnosed with chronic obstructive lung disorders, including long-term bronchitis, emphysema and/or COPD and their associated conditions. Those diagnosed with COPD gradually have their conditions get worse over time and experience other health problems stemming from their COPD. Including, but not limited to:

- Increased shortness of breath and difficulty breathing
- More frequent lung infections, such as pneumonia
- An increased risk of thinning bones (osteoporosis), especially due to use of oral corticosteroids
- Increased risk of Heart failure
- Sleep disorders due to decreased oxygen levels in lungs

Smoking is the leading cause of preventable death in the United States according to America's Health Ranking publication. 4.2 million or 8.7% over the age of 65 smoke which causes damage almost every organ in the body and is linked to respiratory disease, heart disease, stroke and cancer. Someone who stops smoking can have positive impact on current and long term health outcomes. In seniors 8.7% in Arizona smoke and 10% in Texas. 5.3% of Arizona residents and 5.4% in Texas have been told by a health care professional they have COPD. Chronic lung diseases including conditions such as asthma and emphysema and the complications associated, are listed in some of the most prevalent causes of death in Texas. Complications or the effect of COPD include the following:

- Limitations on activity including difficulty walking or climbing
- Unable to work
- Require oxygen or other equipment
- Limited engagement in social activities
- Increase in confusion or suffer from memory loss
- Have frequent admissions to the hospital or have more emergency room visits

- Have more chronic conditions including arthritis, congestive heart failure, heart disease or diabetes
- Indicate their health status is fair or poor

Some of the care plan elements based on the individuals condition and health status may include any of the following:

- Assistance with managing transitions
- Smoking cessation
- Education on the following:
    - Diet, exercise, nutrition, and self-management skills
    - Breathing exercises or possible pulmonary rehabilitation
    - Disease management including symptom management (cough)
- Screen for other co-morbid conditions such as depression
- Management techniques or education on the following:
- Use of oxygen
- Medication compliance
- Preventive services or monitoring of condition measures as outlined in clinical practice guidelines (CPG) including preventing lung infections by taking vaccines (including flu or pneumococcal)
- Monitoring signs of complications such as shortness of breath
- The frequency and intensity of patient monitoring (regular provider visits)

Using claim and utilization data, as well as information from external sources we are able to identify the most prevalent conditions among our SNP members. A summary of the conditions and the comorbidities our membership provides us the details necessary to make assumptions about the types of programs or type of providers we may require to effectively manage the needs of our members. Based on our case management (CM) stratification process, we are able to evaluate the volume of members that are ranked as the highest risk. By comparing year over year results during our program evaluation process we are able to evaluate the trend of severity using the volume in each or our stratification levels. Monthly, our CM stratification report allows us to risk rank those members that are the most complex and identifies possible eligibility for our complex case management program.

Based on data obtained from CMS.gov, Medicare beneficiary information the population have multiple chronic conditions. Those with 4-6 chronic conditions account for 76% of the total Medicare spend and 92% of the hospital readmissions.

Number of chronic conditions	Total population	Less than 65 years	65 years and older	Men	Women	Dual	Non-dual
0 to 1 condition	34%	45%	32%	37%	32%	29%	36%
2 to 3 conditions	29%	27%	30%	28%	31%	26%	30%
4 to 5 conditions	21%	17%	22%	20%	21%	22%	20%
6+ conditions	15%	11%	16%	15%	16%	24%	13%

Based on CMS information from CMS.gov, the chronic conditions experienced most frequently by Medicare Beneficiaries. Most of the conditions were consistent between those over and under 65 with the exception of depression. For those under 65 depression is a more frequent condition.

Chronic Condition	Total population	Less than 65 years	65 years and older	Men	Women	Dual	Non-dual
Hypertension	55%	40%	58%	53%	57%	58%	54%
Hyperlipidemia	45%	30%	48%	44%	45%	40%	46%
Arthritis	30%	24%	31%	24%	35%	33%	29%
Diabetes	27%	25%	27%	28%	25%	35%	25%
Ischemic Heart Disease	26%	16%	29%	31%	22%	28%	26%
Chronic Kidney Disease	18%	15%	19%	19%	17%	24%	17%
Depression	17%	29%	14%	12%	21%	30%	13%
Heart Failure	13%	9%	14%	14%	13%	19%	12%
COPD	11%	11%	11%	11%	11%	17%	10%

Medicare data from CMS.gov, also confirms the prevalence of comorbidities among those with chronic conditions

Chronic Condition	1 to 2 other conditions	3 to 4 other conditions	5+ other conditions
Heart failure	9%	26%	64%
Stroke	12%	27%	60%
Atrial fibrillation	14%	28%	56%
Chronic kidney disease	15%	32%	51%
COPD	15%	26%	57%
Asthma	16%	26%	56%
Ischemic heart disease	19%	35%	43%
Diabetes	25%	35%	35%
Hyperlipidemia	34%	33%	28%
Osteoporosis	25%	30%	40%
Alzheimer's disease	18%	27%	50%
Hypertension	35%	33%	27%
Hepatitis (Chronic Viral B & C)	29%	28%	36%
Cancer	26%	31%	36%
Depression	25%	28%	39%
Arthritis	29%	32%	32%
Schizophrenia	21%	22%	48%
HIV/AIDS	36%	26%	24%

The data above from CMS.gov show the percent of comorbidities based on the number of chronic medical conditions. Many of the complications from chronic conditions appear on the list including

stroke, kidney disease, and cardiac related conditions. The most prevalent chronic conditions in the Medicare population include:

- Heart failure
- Cardiac or respiratory related conditions
- Chronic Kidney Disease and Diabetes
- Hypertension
- Stroke

Texas and Arizona: 5.4% of those in Texas have been told they have COPD and of those over 65 the volume increases to 11.9% and at 75 and over 14.9 (according to the CDC) and in **Arizona,** 5.3 of the population have COPD and in those over 65, 12.1% and 75 and over 11.1%. The prevalence of multiple chronic conditions and especially COPD (since there is no cure and it is a progressive condition) contributes to the complexity of the population. COPD and complications resulting from the condition or comorbidities are represented in diagnosis information prevalence from multiple sources in Texas, and in Medicare beneficiaries. Because of the prevalence of targeted C-SNP chronic conditions in our existing membership, we used both information from our experience working with our D-SNP members and general Medicare information to evaluate the population.

Number Chronic Conditions	Medicare	Arizona	Texas
0 – 1	33.58%	38.59%	34.47%
2 - 3	27.62%	28.81%	29.47%
3 - 4	21.14%	19.49%	20.72%
6 or more	17.66%	12.11%	15.34%

The more chronic conditions the higher the complexity and the potential to have poorer outcomes The conditions targeted in our C-SNP plans are also conditions our D-SNP members experience as verified in our diagnosis and condition information.

While the diabetes, CVD and CHF diagnoses are often correlated, members having these conditions also share other common comorbidities including cerebrovascular disease, lung disease and injury such as amputation, fracture and fractures. Below is a snapshot of common HCC's for one of our largest Combined C-SNP populations developed as part of our annual population analysis.

HCC	DESCRIPTION	SYSTEM	COUNT	% of HCCs
HCC108	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**	**LUNG**	**12,390**	**52.4%**
HCC111	ASPIRATION AND SPECIFIED BACTERIAL PNEUMONIAS	LUNG	7,044	29.8%
HCC100	HEMIPLEGIA/HEMIPARESIS	CEREBROVASCULAR DISEASE	1,464	6.2%
HCC107	**CYSTIC FIBROSIS**	**LUNG**	**1,064**	**4.5%**
HCC161	TRAUMATIC AMPUTATION	INJURY	786	3.3%
HCC176	ARTIFICIAL OPENINGS FOR FEEDING OR ELIMINATION	OPENINGS	528	2.2%
HCC112	PNEUMOCOCCAL PNEUMONIA, EMPHYSEMA, LUNG ABSCESS	LUNG	253	1.1%
HCC104	**VASCULAR DISEASE WITH COMPLICATIONS**	**VASCULAR**	**63**	**0.3%**
HCC158	HIP FRACTURE/DISLOCATION	INJURY	40	0.2%
HCC157	VERTEBRAL FRACTURES WITHOUT SPINAL CORD INJURY	INJURY	7	0.0%

Chronic lung disease (COPD) is a complex progressive condition that if not managed effectively or when members experience complications and have comorbidities will lead to hospitalizations, emergency room visits and other medical services.

The national Medicare readmission rate is 17.93% in 30 days, Texas members experience a rate of 17.70% and Arizona 16.19%. Emergency room utilization is 657/1000 as compared to the national rate of 661/1000 for Texas and 552/1000 in Arizona. This information is helpful in determining if the utilization is above the National average for admissions and for emergency room. Each member receives an in-depth assessment of their unique circumstances and state of health in these areas since they are considered triggers for transitions in care and possible need for immediate interventions to assist with condition management.

Arizona: The most prevalent disease cohorts after CHF for the SNP population in Pima included diabetes and related disorders (34%); chronic kidney disease (17%); pulmonary and related lung disorders (11%); psychiatric (including schizophrenia, bipolar, major depression) (7%); and post enrollment renal failure (less than .1%). Approximately 30% of the population having 2 or more comorbidities. This creates difficulty for our members when competing priorities exist due to their multiple co-morbidities and often inter-related effects of those. For example, members may feel overwhelmed with information and their ability to manage insulin levels when at risk for depression creates an adverse impact on disease outcomes.

Clinical Demographics

Based on claims data, we identified the most frequent diagnosis and the most frequent comorbidity conditions. The analysis included both inpatient and outpatient place of service. Many of the conditions were the same or similar conditions, as noted on our other diagnosis analysis. Cognitive deficits are not reports as a high volume issue for our members, based on the health risk assessment questions or the Case Managers' evaluations however, if present this issue further complicates the management.
Behavioral Health diagnoses was not represented as one of the top 5 conditions but experience in case management and during interactions, behavioral health issues either chronic or situational do impact the management of the members.

Information from CMS on the Medicare population was reviewed to supplement data from our internal systems. Using data from other sources such as CMS or Healthy People 2020 allow us to compare the conditions and needs of our members to the larger volume of Medicare beneficiaries as well as validate that we are targeting areas of importance during our health risk assessment and care planning process.

Texas and Arizona according to the Medicare condition information as reported by CMS indicate the following as the most prevalent conditions:

- Hypertension
- Hyperlipidemia
- Arthritis
- Heart Disease
- Diabetes
- Chronic Kidney Disease

- Heart Failure
- Depression
- COPD

Based on data obtained on Medicare beneficiaries from the Healthy People 2020 results, 60% had 2 or more medical conditions. The most common conditions reported included heart disease, cancer, chronic bronchitis or emphysema, stroke diabetes and cognitive issues. Additional demographics and statistics include the following:

- Less than 60% of older adults engage in physical activity and strength training. In most of our plans we encourage members to get active, as approved by their provider through benefits for exercise.
- Fall related injuries result in frequent ER visits and 1 in 3 do not inform a health care provider they have fallen. For our membership we assess the risk for falls during our HRA and if the member has experienced a fall and include interventions in our care plan to assist with safety. Additionally, we review the results of our HRA outcomes on falls and information from the HOS survey to evaluate our membership in this area.
- 25% of adults over 18 report providing care or assistance to older or disabled related to a long term illness. Due to the volume of members that are aging and require assistance from family members or care givers, we assess this need during our assessment and care planning process. We also assist with providing information on community resources that may help to provide support.

Clinical Demographics Summary

Based on claims data, we identified the most frequent diagnosis and the most frequent comorbidity conditions. The analysis as seen below, includes both inpatient and outpatient place of service. Many of the conditions were the same or similar conditions, as noted on our other diagnosis analysis. Cognitive deficits are not reports as a high volume issue for our members, based on the health risk assessment questions or the Case Managers' evaluations however, if present this issue further complicates the management.

Behavioral Health diagnoses was not represented as one of the top 5 conditions but experience in case management and during interactions, behavioral health issues either chronic or situational do impact the management of the members.

The most frequently occurring Outpatient Primary Diagnosis from all of our D-SNP members was hypertension and diabetes accounting for the highest volume of total visits. The top conditions are also consistent when we look at other reports on condition categories and when comparing information to the overall Medicare population. Comorbid conditions that are secondary to the most frequent outpatient conditions are hypertension, hyperlipidemia and shortness of breath.

In Texas and Arizona, the most frequently occurring Outpatient Primary Diagnosis was Hypertension and Diabetes accounting for the highest volume of total visits. The top conditions are also consistent when we look at other reports on condition categories and when comparing information to the overall Medicare

population. Comorbid conditions that are secondary to the most frequent outpatient conditions are hypertension and hyperlipidemia.

Outpatient Diagnosis for Arizona	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
ESSENTIAL PRIMARY HYPERTENSION	4,470	10,853	HYPERLIPIDEMIA UNSPECIFIED	495	719
TYPE 2 DM WITHOUT COMPLICATIONS	2,426	5,860	ESSENTIAL PRIMARY HYPERTENSION	787	1,315
CHEST PAIN UNSPECIFIED	2,024	6,209	SHORTNESS OF BREATH	236	305
COPD UNSPECIFIED	1,758	10,384	ESSENTIAL PRIMARY HYPERTENSION	201	354
SHORTNESS OF BREATH	1,709	4,051	COUGH	162	191

Outpatient Diagnosis for all Arizona membership	SNP Member Count	SNP Visit Count	Outpatient Diagnosis (Secondary)	SNP Member Count (Secondary)	SNP Visit Count (Secondary)
ESSENTIAL PRIMARY HYPERTENSION	39,824	258,261	HYPERLIPIDEMIA UNSPECIFIED	49,527	145,587
TYPE 2 DM WITHOUT COMPLICATIONS	22,838	95,613	ESSENTIAL PRIMARY HYPERTENSION	30,803	63,368
ENC GEN ADULT EXAM W/O ABNORM FIND	18,822	23,340	ESSENTIAL PRIMARY HYPERTENSION	18,120	18,232
CHEST PAIN UNSPECIFIED	13,765	37,118	SHORTNESS OF BREATH	4,721	5,844
SHORTNESS OF BREATH	11,456	25,529	COUGH	3,306	3,751
HYPERLIPIDEMIA UNSPECIFIED	8,530	15,484	ESSENTIAL PRIMARY HYPERTENSION	14,689	19,865
COPD UNSPECIFIED	8,948	53,938	ESSENTIAL PRIMARY HYPERTENSION	3,768	7,257
ASHD NATIVE CA W/O ANGINA PECTORIS	7,499	21,159	ESSENTIAL PRIMARY HYPERTENSION	14,467	22,188

Texas SNP					
Outpatient Visits	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
ESSENTIAL PRIMARY HYPERTENSION	13,274	30,390	HYPERLIPIDEMIA UNSPECIFIED	6,479	3,412
ENC GEN ADULT EXAM W/O ABNORM FIND	7,993	8,577	ESSENTIAL PRIMARY HYPERTENSION	783	552
TYPE 2 DM WITHOUT COMPLICATIONS	7,053	15,767	ESSENTIAL PRIMARY HYPERTENSION	2,010	3,046
ENCOUNTER FOR IMMUNIZATION	5,753	1,520	ESSENTIAL PRIMARY HYPERTENSION	44	28
ENC SCR MAMMO MALIG NEOPLASM BREAST	3,966	3,886	AGE-REL OSTEOPOR W/O CURR PATH FX	135	137

CHEST PAIN UNSPECIFIED	3,548	7,698	ESSENTIAL PRIMARY HYPERTENSION	435	536
SHORTNESS OF BREATH	2,515	4,525	NEED FOR CONTINUOUS SUPERVISION	227	324
ASHD NATIVE CA W/O ANGINA PECTORIS	1,927	4,176	ESSENTIAL PRIMARY HYPERTENSION	515	686
COPD UNSPECIFIED	1,926	7,189	ESSENTIAL PRIMARY HYPERTENSION	208	271
OBSTRUCTIVE SLEEP APNEA	1,277	5,767	ESSENTIAL PRIMARY HYPERTENSION	1,103	4,608

Outpatient Diagnosis All SNP	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
ESSENTIAL PRIMARY HYPERTENSION	49,641	129,100	HYPERLIPEDEMIA UNSPECIFIED	4841	6870
ENC GEN ADULT EXAM W/O ABNORM FIND	26,879	24,761	ESSENTIAL PRIMARY HYPERTENSION	1849	1294
TYPE 2 DM WITHOUT COMPLICATIONS	22,023	46,342	ESSENTIAL PRIMARY HYPERTENSION	5216	8926
ENCOUNTER FOR IMMUNIZATION	25,090	10,012	ESSENTIAL PRIMARY HYPERTENSION	114	57
ENC SCR MAMMO MALIG NEOPLASM BREAST	17,034	19,823	AGE-REL OSTEOPOROSIS W/O CURR PATH FX	223	220
CHEST PAIN UNSPECIFIED	10,598	19,274	ESSENTIAL PRIMARY HYPERTENSION	981	1201
SHORTNESS OF BREATH	9,452	14,577	NEED FOR CONTINUOS SUPERVISION	473	558
ASHD NATIVE CA W/O ANGINA PECTORIS	9,133	16,074	ESSENTIAL PRIMARY HYPERTENSION	1388	2017
COPD UNSPECIFIED	7,849	26,887	ESSENTIAL PRIMARY HYPERTENSION	532	832

Inpatient diagnosis based on claims data provides a look at the most frequent admission diagnosis and the associated secondary condition. Overall in our SNP plans, sepsis, acute kidney failure, hypertension and respiratory conditions are the most frequent reported with pneumonia, heart disease related conditions and stroke conditions in the top 10. The top comorbidity for inpatient also reports pneumonia, UTI, other respiratory, and cardiac. In Texas and Arizona for Inpatient the top diagnosis were sepsis, kidney disease, heart disease and respiratory and the comorbidities included respiratory, and heart conditions.

Inpatient Diagnosis for Arizona	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
SEPSIS UNSPECIFIED ORGANISM	173	195	PNEUMONIA UNSPECIFIED ORGANISM	32	34
COPD WITH ACUTE EXACERBATION	117	137	ACUTE CHRONIC RESPIRATORY FAIL W/HYPOXIA	19	21
ACUTE KIDNEY FAILURE UNSPECIFIED	88	103	UTI SITE NOT SPECIFIED	7	7

HTN HRT CKD W/HF STAGE 1-4/UNS CKD	85	112	ACUTE ON CHRONIC DIASTOLIC CHF	26	31
PNEUMONIA UNSPECIFIED ORGANISM	71	78	ACUTE CHRONIC RESPIRATORY FAIL W/HYPOXIA	8	7

Texas SNP					
Inpatient Visits	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
SEPSIS UNSPECIFIED ORGANISM	373	397	PNEUMONIA UNSPECIFIED ORGANISM	51	50
ACUTE KIDNEY FAILURE UNSPECIFIED	130	130	ACIDOSIS	14	12
HTN HRT CKD W/HF STAGE 1-4/UNS CKD	125	153	ACUTE CHRON SYSTOLIC HEART FAILURE	39	46
HTN HEART DISEASE W/HEART FAIL	98	113	ACUTE RESPIRATORY FAIL W/HYPOXIA	20	22
COPD WITH ACUTE EXACERBATION	93	98	ACUTE CHRONIC RESP FAIL W/HYPOXIA	15	15
PNEUMONIA UNSPECIFIED ORGANISM	93	87	ACUTE RESPIRATORY FAIL W/HYPOXIA	19	19
UTI SITE NOT SPECIFIED	82	78	METABOLIC ENCEPHALOPATHY	14	17
NON-ST ELEVATION MYOCARDIAL INFARCT	78	78	ACUTE CHRON SYSTOLIC HEART FAILURE	10	9
CEREBRAL INFARCTION UNSPECIFIED	57	60	HEMIPL UNS AFFECT LT NONDOM SIDE	12	10
ACUTE CHRONIC RESP FAIL W/HYPOXIA	35	29	COPD WITH ACUTE EXACERBATION	6	4

Inpatient Diagnosis All SNP	Member Count	Visit Count	Top Comorbidity for DX	Member Count	Visit Count
SEPSIS UNSPECIFIED ORGANISM	1,231	1,073	PNEUMONIA UNSPECIFIED ORGANISM	172	139
ACUTE KIDNEY FAILURE UNSPECIFIED	442	373	UTI SITE NOT SPECIFIED	31	31
COPD WITH ACUTE EXACERBATION	391	333	ACUTE CHRONIC RESP FAIL W/HYPOXIA	39	32
HTN HRT CKD W/HF STAGE 1-4/UNS CKD	426	406	ACUTE CHRON SYSTOLIC HEART FAILURE	90	89
HTN HEART DISEASE W/HEART FAIL	361	325	ACUTE RESPIRATORY FAIL W/HYPOXIA	36	35
PNEUMONIA UNSPECIFIED ORGANISM	375	308	ACUTE RESPIRATORY FAIL W/HYPOXIA	36	31
NON-ST ELEVATION MYOCARDIAL INFARCT	313	277	ACUTE CHRON SYSTOLIC HEART FAILURE	23	20
UTI SITE NOT SPECIFIED	263	203	METABOLIC ENCEPHALOPATHY	28	23
CEREBRAL INFARCTION UNSPECIFIED	194	172	HEMIPL UNS AFFECT LT NONDOM SIDE	23	18

ACUTE CHRONIC RESP FAIL W/HYPOXIA	136	118	COPD WITH ACUTE EXACERBATION	18	15

In addition to this data from claims, the aggregate condition count was also evaluated to provide information on the most prevalent conditions our SNP members' experience. By reviewing information from multiple data sources and comparing to local or national Medicare beneficiary information we find similar results. We use the condition information to verify our programs are targeting the most frequent conditions.

We reviewed all of our Texas Medicare membership and our D-SNP membership to obtain a clinical picture of the population. Based on the high incidence of Heart Disease, or cardiovascular, Respiratory and chronic lung conditions and Diabetes, we are would expect many of this population may qualify for our new C-SNP programs for these conditions. In the overall Medicare population in our Texas Market we see the following when evaluating the top condition prevalence: nutritional and metabolic, cardiovascular, musculoskeletal and connective tissue, gastrointestinal and diabetes. For all of our D-SNP members, cardiovascular conditions continue to be the highest category followed by nutritional and metabolic, muscular and connective tissue, gastrointestinal, and diabetes. Psychiatric conditions are not in the top 5, but is represented in the top 10 for all D-SNP members.

In Texas D-SNP, nutritional and metabolic, cardiovascular, muscular and skeletal conditions, gastrointestinal, ophthalmic, and diabetes are the most frequent conditions. From experience managing the population having a persistent psychiatric condition as a comorbidity may increase the complexity and impact the management. In the overall Medicare population in our Texas Market we see the following when evaluating the top condition prevalence: nutritional and metabolic, cardiovascular, musculoskeletal and connective tissue, gastrointestinal and diabetes. Based on this information, many of the comorbidities related to chronic conditions are represented.

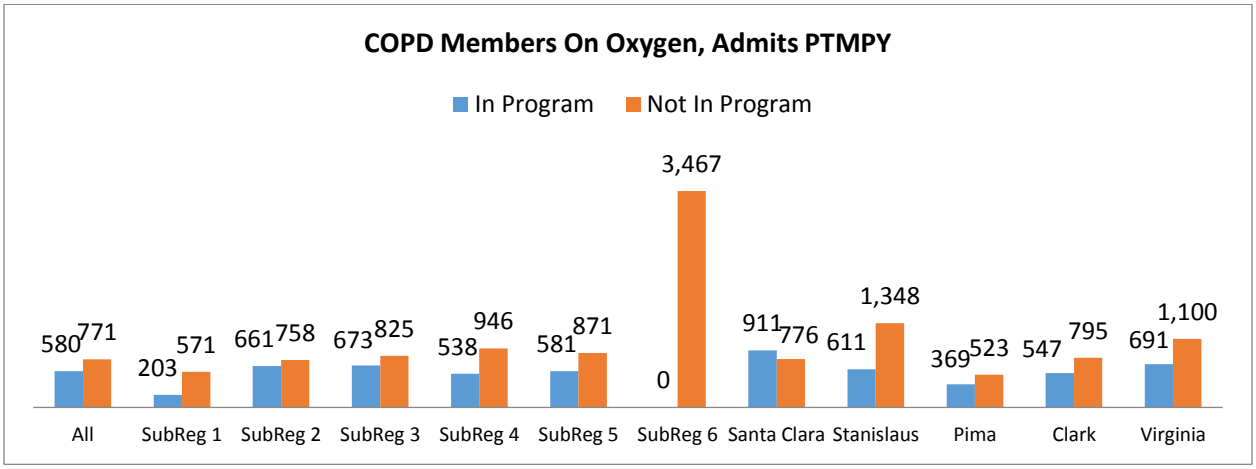
Behavioral Health conditions further complicate the management of a member. The condition may be situational or chronic. Screening during the HRA process helps to identify if there is a condition that would benefit from complex case management from our behavioral health trained case management team or if further evaluation from the primary provider may be needed.

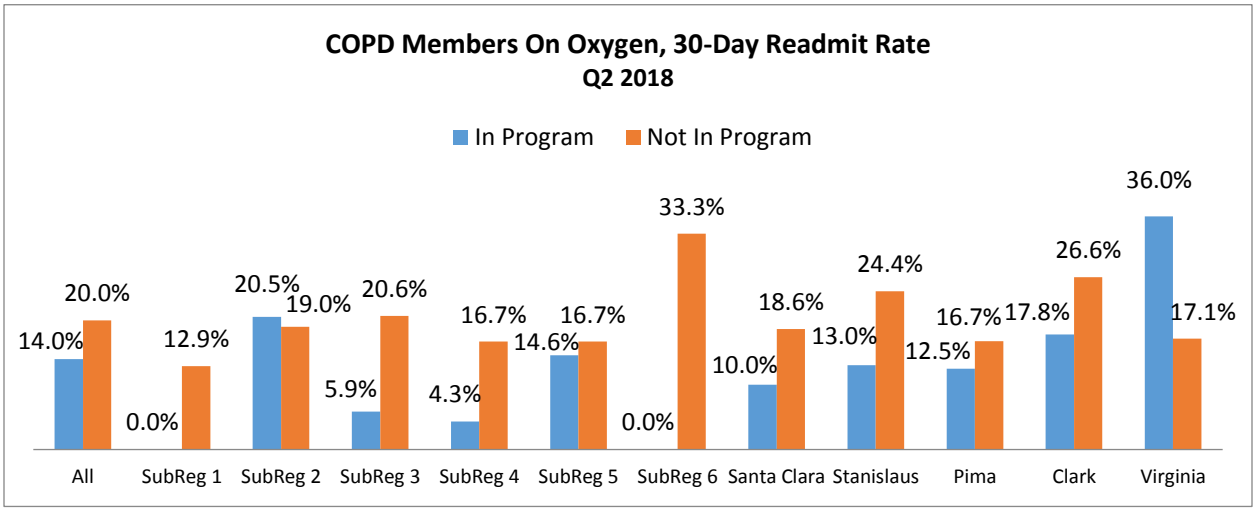
COPD is a condition that will continue to progress. Below displays the volume of members on Oxygen within this market in Arizona and other Lung C-SNP as well as those members we manage in existing C-SNP) that are enrolled in other programs but on Oxygen.

COPD Members on Oxygen Program Enrollment

Metrics	All	SubRegions						Santa Clara	Stanislaus	Pima	Clark	Virginia
		1	2	3	4	5	6					
In Program	557	47	61	106	46	91	0	22	40	25	82	37
Not In Program	1,611	64	110	153	53	211	5	58	75	484	289	109
Total COPD Members	2,168	111	171	259	99	302	5	80	115	509	371	146
In Program % to TTL	26%	42%	36%	41%	46%	30%	0%	28%	35%	5%	22%	25%

The volume of admissions and readmission for those with COPD using Oxygen as compared to other CSNP Lung members and those that are not enrolled in a CSNP help to evaluate the population and assist in measuring severity of illness resulting in admissions or readmissions.





We have data from our existing C-SNP plan on the volume of members in the service area in Arizona that have some of our targeted chronic conditions, as follows: COPD 4%; CHF 4%, Diabetes 32%, and ESRD - 0.4%. Comorbidities add another layer of complexity to those that have multiple chronic conditions.

In our current C-SNP plans we track the following comorbidities and the % of our population that have the condition:

- Chronic Kidney Disease
- ESRD
- Diabetes
- Congestive Heart Failure
- Atrial Fibrillation

These conditions are targeted in our C-SNP plans and are considered complications of the disease processes or will significantly contribute to the severity of illness. Our delegate has additional programs and interventions in place to address the targeted comorbidities. In addition those with two or more chronic conditions (24%) are tracked as the most complex.

MOC 1A.4: Define the unique characteristics of the SNP population served.

Anthem reviewed past reports regarding diagnosis, co-morbidities, social and environmental impacts in all SNP plan types. We are able to make comparisons due to some of the similarities between the SNP members in all of our markets and as compared to Medicare beneficiaries to identify the unique health needs of our members. This data provides a holistic view of the SNP membership and identifies their unique characteristics that may impact the delivery of health care services for members with the chronic medical condition. Information below is based on experience working with those members in our Arizona C-SNP and applied to those with the qualifying chronic condition in our new Texas C-SNP as well as our existing D-SNP experience in the Texas market. As indicated above, in the population assessment, similar issues exist based on the condition and population targeted for this C-SNP. Annually we perform a population assessment to identify changes in the population, including if needs have changed or new opportunities have been identified. We update our program to address any new targeted areas.

The members enrolled in the C-SNP are at a higher risk of potential barriers or challenges due to the complications, and severity of illness, and social impacts. The information in factors 1-3 highlight potential limitations and barriers that pose potential challenges for beneficiaries in both of our markets included the following:

- Multiple Complex Chronic Medical Conditions including
- Complications and co-morbidities related to cardiovascular disorders: diabetes, stroke, kidney damage including chronic kidney disease and failure, visual impairment including blindness, and amputations of the legs and feet related to vascular insufficiency.
- Coordination of benefits between Medicare and Medicaid if a dual member or disabilities
- Need for community resources or care giver issues
- Obtaining preventive or screening for other chronic medical conditions (vision, cardiovascular, renal, lab specific for diabetes)
- Managing transitions including admissions and readmissions
- Coordination of care complexities due to seeing multiple specialty providers
- Health literacy and financial concerns
- Physical limitations
- Functional limitations
- Potential for access to care issues, including transportation issues
- Socioeconomic factors related to low income and/or housing
- Multiple medications and adherence issues

The chronic conditions experienced by this population in both Texas and Arizona included heart disease and hyperlipidemia, hypertension, respiratory, kidney failure and diabetes.

MOC 1B: Subpopulation- Most Vulnerable Beneficiaries

MOC 1: Element B: Factor 1: Define most vulnerable beneficiaries

The definition of the most vulnerable is "intensive management of frail and chronically ill members, identified through predictive models, data scans, pharmacy utilization reports, PCP referrals, and/or member self-identification." The SNP is designed to cover care for the most complex and chronically ill, in other words, the most vulnerable. We consider all members at a higher risk when they qualify for a SNP however within our population we stratify further and customize the level of intensive management for those most vulnerable.

Vulnerable populations are at risk of poor medical, behavioral, and/or social health. Being at risk assumes there is a chance that an adverse health-related issue will occur. Community and or social issues can exacerbate circumstances creating more risks.

Our most vulnerable members include many of the following characteristics:

- Have multiple chronic, comorbid, and complex medical and/or behavioral health conditions which may lead to frequent emergency room utilization and multiple hospitalizations or readmissions for the same condition within 30 days.
- Experience functional, environmental, or social issues that may further create barriers to obtaining access to the appropriate services necessary to manage their conditions
- Take multiple medications due to their chronic conditions and may have issues with adherence and compliance with treatment regimens
- Have disabilities or end of life situations further complicating their medical condition management. We consider members as they age, exhibit a functional decline or have disabilities more frail and require additional support
- Complications from the chronic cardiovascular conditions or CHF adds additional complexity to managing the population and requires a partnership with the physicians addressing the clinical needs.

Complications from the chronic condition adds additional complexity to managing the population and requires a partnership with the physicians addressing the clinical needs. Our case management team works collaboratively with the providers to share information and to support the education of the member about their condition and working to make sure the member is engaged with the treating provider, especially the PCP. Information on Medicare beneficiaries show that over 30% of all costs are paid on inpatient hospital care. Many members experience functional, environmental, or social issues that may further create barriers to obtaining access to the appropriate services necessary to manage their conditions.

We also work with our members and assist them in accessing those services that are most appropriate to meet the needs identified. Members may be identified as most vulnerable through any of the following processes: data mining based on criteria, completion of the health risk assessment tools (core HRA and disease specific HRA), during the utilization review process including the inpatient daily census, stratification scores from HRA tools or CI3 process, internal or external referral including the member or the member's care giver, and from the interdisciplinary care team (ICT). Members, care givers, providers, or internal teams can make referrals to be evaluated for case management services.
The services or programs below are used to manage or provide support to our must vulnerable populations as described above:

Members Identified a risk levels 3 or 4 in our case management risk ranking process:

Identification: We use a proprietary stratification system to identify those members that we consider most vulnerable and highest risk for entry into one of our complex case management programs. This is a core part of our program which includes an analysis performed by our reporting team. Data, from a combination of the following sources, is used to assign a risk score to all eligible members:

- Claim or encounter data
- Hospital discharge data
- UM data
- Pharmacy Data
- Emergency room (ER) utilization
- Readmission data

This stratification is called our Chronic Illness Intensity Index (CI3) process and is completed monthly, allowing our teams to see updated information on each member. Members are assigned into a risk category from 0-4. In order to accurately predict complexity and admission risk among Group 2, 3 and 4 members, an additional measure is used to further stratify these members, the Likelihood of Inpatient Admission (LIPA) scale. The LIPA measure uses a combination of variables across a variety of data inputs including but not limited to:

- Utilization data (e.g. claims, encounter, pharmacy, authorization data),
- Demographic factors, and
- Diagnostic data

This information is used to predict the likelihood of an unplanned inpatient admission within 30 days of an admission. This allows the clinical team to focus resources on members with the highest immediate risk, among Group 3 or 4 members.

Members in Groups 3 and 4 are considered our most vulnerable because they have multiple chronic conditions, high medical costs, more frequent admissions and/or readmissions, frequent visitors to the ER and/ or have the conditions we have determined in this population makes them most vulnerable for adverse events. The conditions we target are linked back to some of the most frequent conditions our members experience including diabetes, depression, COPD, and/or cardiac conditions of CHF and CAD. These may be targeted conditions however, comorbidities are displayed to provide a comprehensive evaluation of the member.

In addition to the description above, members who are ranked as a 3 or 4 in our CI3 list and also have a co-morbidity that includes a behavioral health condition are also considered high risk. These members may also be identified during the initial HRA process.

Specially Tailored Services:

Physical and Behavioral Case Management: Members that are categorized as Group 3 and 4 are eligible for evaluation for our complex case management program or, if available, a home intensive management program. The home intensive management program, if available is provided by a contracted vendor or provider, includes home visits and communication directly with the primary care provider. Some of our network provider make home visits for those members that are the most complicated and cannot come into the office. Our case managers help to facilitate linking members to providers that offer this service when needed. If a home provider or an intensive program is not available, home health services may be used to perform assessments and provider home care. Our Case Management Program is developed with an "integrated" approach to meeting the needs of members. The program considers the "whole person", including the full range of each member's physical, behavioral, cognitive, functional, and social needs. The roles of the case manager are to engage members and to monitor their condition and needs across healthcare settings and collaborate with other health care team members to determine goals, and provide access to and monitor utilization of resources. The case manager works with the member and the interdisciplinary care team (ICT) to identify specific needs and interfaces with the member's providers, with the goal of facilitating access to quality, necessary, cost-effective care. Members with multiple chronic conditions that meet the guidelines for our program are referred for possible complex case management or other case management programs. Some of the initial triggers include: frequent hospital admissions and readmissions, ER visits or serious chronic or acute conditions (such as diabetes, congestive heart failure, hypertension, mental health conditions).

Additional programs may be appropriate for this population based on the severity of the illness and co-morbid conditions or situations that impact the other factors identified during the assessment process. For those members that also have a behavioral health co-morbidity, our case management team focusing on behavioral health manage the members independently or as part of a team working closely with the physical health case manager. The determination of who is the primary case manager is based on the driver of the risk ranking (behavioral or physical condition). Members referred for possible inclusion in our BH case management program are further assessed to determine eligibility for that program. In addition to our internal processes to identify potential candidates for our complex case management programs. Referrals from multiple sources are also accepted. Providers, members, and other internal departments such as member services, appeals team, prior authorization or discharge planning/inpatient management, can refer a member for possible inclusion in our program. Additional evaluation and assessments occur to determine the appropriate type of program for those referred to Case Management.

Frequent Admissions/Readmissions:

Readmissions are not only costly but could be prevented. Information on Medicare beneficiaries show that over 30% of all costs are paid on inpatient hospital care. We target avoidable readmissions (unplanned) to improve quality of care and increase the safety of our members. Members experiencing

readmissions are identified as part of our CI3, Likelihood of Admission (LIPA) scores and include the following criteria:

- Multiple claims data input (utilization, condition, medication history, comorbidity based risk)
- Current inpatient authorization, authorization history
- Catastrophic illnesses and injuries in the targeted condition list
- Members in Group 3-4 with RAS (readmission) scores over 14 (based on the CI3 report)

Specially Tailored Services:
We monitor hospital readmission rates and identify trends that may require further evaluation. Members who are re-admitted to the acute care hospital within 30 days of a discharge are considered high risk. The post discharge program was developed to address opportunities for improvement in readmission rates by providing outreach post discharge to those members that are determined to be the highest risk for readmission. Members with high readmission rates and determined to be most at risk for readmission are targeted for post discharge care outreach, possible complex case management and/or referral to one of our intensive care vendor or provider programs. Coaches outreach to those targeted for the post discharge program and work to build member skills and provide tools to support self-care. Outreach begins as close to discharge as possible including prior to leaving the facility and may include home visits and telephonic outreach. While all members are followed by our inpatient team members who work closely with the facilities to assist in discharge planning, continued stay reviews and coordination of care, only those at the highest risk receive additional post discharge interactions.

Multiple Part D Medications:

Identification: Annually, the Medication Therapy Management Program (MTMP) program is reviewed and approved by CMS. This description defines the criteria for eligibility for this program. This MTMP eligibility criterion is applied to our SNP membership using the member eligibility and claims data. Criteria includes those with

- 3 or more of selected chronic conditions (CHF, diabetes, hypertension, hyperlipidemia, and Rheumatoid Arthritis),
- 8 or more chronic part D drugs and have a high dollar annual spend on Part D drugs as identified by CMS criteria.

Interventions: Members that fall into the criteria outlined above are enrolled into the MTMP. Multiple outreach attempts are made by telephone and through mailings to ensure we reach the targeted population. The MTMP clinical pharmacist evaluates members' medication use and member-reported issues related to this use to identify drug therapy problems and provides follow-up as appropriate. In addition to follow up by the clinical pharmacist, if more intensive coordination of care is required the clinical pharmacist makes a referral to the care management team on behalf of the member.

Additional pharmacy programs tailored to this vulnerable SNP population include high-risk medication initiatives, adherence to medications with outreach to the members, and opioid overutilization monitoring as adjuncts to the MTMP.

Members with Complex Medical Conditions:

Cardiovascular conditions such as hypertension and respiratory conditions, as well as other complex conditions such as diabetes, are in our top diagnosis list and can contribute to multiple and frequent admissions if the condition is not adequately managed and considered under control.

Identification: Members with complex medical conditions are identified through claims reports and through our algorithm used for case management stratification.

Specially Tailored Services:
In some of our SNP markets, we offer enrollment in a home telemonitoring program after approval from the members' attending physician. If the program is available, it includes telemonitoring equipment in the home, monitoring of vital signs including weight, and support from nurses. Daily weights are monitored, as part of the program through equipment placed in the home. If a member experiences a change in condition that is outside of the acceptable parameters, a call is made to both the member and the provider through the vendor to intervene prior to a deterioration of status that would potentially require an ER or hospitalization.

If this vendor managed program is not available in a market, if a member was ranked high on the stratification list additional evaluation would take place through case management and if determined to be high risk, members are enrolled in our complex case management program. Congestive heart failure is one of our conditions in our stratification tool considered high risk. Other intensive home management programs through providers or vendors may also be available in limited areas where a high concentration of high risk members may reside.

Functional Impairment and high risk for falls:
Many of our members have functional impairment, may have circulatory issues, age related instability or other reasons they are at a higher risk for falls. During our HRA process we assess if the member has had a recent fall.

Specialty Tailored Services:
We offer a personal emergency response (PERS) benefit for our SNP members which allows them the safety of being able to contact a team by pressing a button who will call emergency services or the member's next of kin or contact for assistance. This benefit does not require a provider referral and can be requested by the member, a care giver or family member or anyone on the care team including customer service.

End of Life or Palliative Care Programs

Identification: Members, who are in their final months of life, are offered telephonic or face-to-face interventions through the palliative care program. Through engagement with trained counselors, members or caregivers, are assisted with; the types of documents which should be completed, care options available, how to have difficult conversations and other concerns. In most of our markets we

have two vendors that are available to assist with the education. Data is reviewed and a vendor specific algorithm is applied to the data to identify those that may be targeted for these programs.

Specialty Tailored Services:
We contract with vendors to assist members around how to make decisions on their treatment and have conversations with the provider managing the care and/or family members. The program focus is on education, counseling and communication.

Members with complex and rare medical conditions:

Some chronic conditions are considered rare and are not supported by our internal case management program. Members with these conditions are difficult to proactively identify, resource intensive to manage, and if not closely monitored result in high ER and hospitalization. Diabetes, cardiovascular, COPD and other comorbidities are all prevalent conditions in our Medicare population and the complications of that disease impact many body systems.

Social issues:

Our members experience situations that create barriers or risks that impact management of any of the above situations. In many instances, unless social issues impacting care are identified and addressed, a member is unable to focus on other healthcare needs. Some of these barriers are related to the following: low income, disabilities, transportation, insufficient food, lack of or inconsistent care giver support, coordination between Medicare and Medicaid services, and/or access to care issues. While these issues may impact a high volume of our members when they are combined with other triggers, they create a potentially high risk situation that may require specialized or targeted interventions. These interventions are implemented during any of our other activities.

Identification: Screening during case management activities, and/or early intervention health risk assessments (initial and reassessment) help to identify those members who may have social issues that are identified as complicating the management of their medical condition. Members with advanced illness or elderly may find themselves in a situation where they may no longer drive either temporarily or permanently, in addition some of our markets have areas that are very rural. Transportation to access care may be an issue and require assistance to access needed care.

Specially Tailored Services:
Many of these situations that create challenges with our membership are managed with the use of community resources or by ensuring members are utilizing benefits available to them such as transportation. If applicable, the member is assisted in coordinating benefits between Medicare and Medicaid. Some Medicaid benefits are available when Medicare may not provide coverage for a certain type of service (custodial care). Caregiver education is critical since many of our member's caregivers have his or her own medical or physical issues that impact the ability to provide the right level of needed care to the member. For our members that may have access issues, a program called Live Health On-Line (LHO) is available in most of our areas to provide a video visit with board certified physicians using a smart phone, tablet of computer with a webcam. Through this program members can get quick medical care for common (flu, cold and fever, etc.) health problems and also provides convenient access to mental

health care. If the plan does not offer the Live Health On Line services members still have access to the primary care provider office after hours which includes access to a physician or sometimes a nurse practitioner to discuss treatment options and provide direction similar to the live health online services. Members also have access to a 24 hours nurse help line. While this does not replace the relationship with the PCP this allows a member to speak to a nurse and receive education or advice on accessing care or general information about a condition. Education is provided during case management activities and care is coordinated to actively link the member's up with the appropriate services and resources. Outreach to our population is impacted by both the stability of their environment as well as unreliable contact information. We use multiple ways to outreach to our members including by telephone and outreach by mail.

Transportation: we offer a supplemental transportation benefit to medical appointments or the pharmacy

Meals: We offer meals post discharge and some plans may have additional benefits after a qualifying condition. Nutrition after an illness or surgery helps in the healing process.

Our Medicare Community Resource benefit help members bridge the gap between their medical needs/benefits and the resources available in their community. This benefit is available to our SNP members and is designed to help in the following ways:

- Bridging the gap between healthcare benefits and non-healthcare covered needs
- Educational programs for members with chronic illnesses
- General Assistance programs that help members with caregiver services, elder services, household expenses, food assistance, legal aid, etc.
- Programs supporting basic needs including clothing, food and shelter

The goal is to provide information and education about community-based services and support programs in the member's local area so they can get additional support, education, and services when needed. Our case managers and other departments are able to refer a member to the Medicare Education & Outreach (MEO) team for additional support.

Cultural, Hearing or Linguistic Barriers:

During our interaction with members or during the enrollment process, member's language preference is identified. We are also able to identify members that may have a hearing deficit. Each market has multiple languages represented and additionally cultural preferences may be prevalent. Our Case Managers identify during interactions with the member any specific preferences in order create an effective care plan.

Specially tailored services:

In our provider directory our case managers are able to identify language and culture of providers to assist members in obtaining care from a network trained in the linguistic or cultural preferences our membership has. This allows our member's to discuss healthcare changes and concerns with a provider that has an increased understanding of specific cultural values and traditions that may not be as familiar

with other providers. For members that have difficulty hearing or require translation services, we have both a language line to assist with translation services as well as TTY services.

MOC 1B.2 & 3: Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries and illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.

Certain characteristics exist based on the demographics and needs of the SNP population. We use, not only, demographics, but other characteristics that are significant and require attention to effective manage the SNP members. The following information applies to our membership in both Texas and Arizona.

Unique Clinical Needs Based on Population for our most vulnerable	Demographic Characteristics	Effects on Health Outcomes of the Most Vulnerable
Communication, including understanding the treatment plan and benefits (coordination) Recognizing signs and symptoms that may identify worsening as well as how to manage Managing transitions between health care providers (to and from the hospital) Managing access issues Disabilities or mobility impairments impacting care Managing activities of daily living and fall management Co-morbid conditions and high risk behaviors	Age and Gender	As age increases, there is a higher potential for a functional decline resulting in the need for more assistance. Disabilities and aging contributes to functional decline. In addition, as the age increases so does the potential for cognitive impairments and fewer social supports. Gender related conditions have not been identified however, gender specific preventive care remains a focus to ensure access to these services. We promote preventive services including those that are specific for a certain gender or age.
	Ethnicity and Language barriers Low Health Literacy	Our SNP members primarily speak English in most of our areas; however, those that do have language barriers related to language and/or literacy require support to ensure understanding. The situations that can contribute to difficulties for our most vulnerable is the inability to understand directions or treatment plans. While there may not be a language barrier with ethnicity or non-English speaking members, there could be a problem with low health literacy and being able to understand complex treatment plans. This most vulnerable population may have complications related to inability to follow directions from their health care providers. We are able to translate using translation services and our correspondence is written at an appropriate grade level or where it is easily understandable.
	Functional Impairments	Based on results of HRA, as well as Health Outcome Surveys (HOS), there is a higher incidence for falls as well as more members are accessing community resources to assist with needs. In addition there is a higher incidence of members indicating they need some help with activities of daily living. The older a member is the more likely they are to have

		degenerative diseases such as failing vision , hearing impairment , impaired cognition and loss of mobility all impacting the functional ability.
	Poor socioeconomic status	There could be a decreased understanding of health education and instructions leading to compliance issues with treatment plans and disease management. Our most vulnerable membership has multiple chronic conditions that education about management of the conditions is critical to minimizing complications and increasing compliance with complicated treatment plans
	Admissions or readmissions, transition management	Chronic conditions and co-morbidities lead to an increase in admissions and readmissions. Chronic conditions and severity of illness leads to frequent transitions between health care providers contribution to gaps in care. Our most vulnerable members experience multiple transitions due to their severity of illness and having multiple chronic conditions.
	Smoking	Smoking increases the risk of complications and can exacerbate the disease processes in our CSNP plans. Conditions such as diabetes, chronic lung and cardiovascular including CHF can be severely impacted resulting in complications, admissions and emergency room visits. Smoking cessation is a benefit to address this and help with behavioral modifications.

Age, language, health literacy and poor socioeconomic status can potentially impact health outcomes in this population. While English speaking is overwhelming the highest spoken/understood language, Spanish is next prevalent. In addition, the older the population there is a higher incidence of hearing impairments. We have both a language line to assist with translation services as well as TTY services.

Functional impairments and disabilities are also linked to the demographics. This puts our members at a higher risk for falls and the need for assistance in the home. We have the ability to coordinate a home assessment and offer use of community resources and/or coordinate services offered by Medicaid if the member is a dual member to assist those with functional impairments requiring additional help. Supplemental benefits, offered as part of our plan, provide additional services such as dental, vision, transportation, physical fitness, and/or over the counter medication. This is not an exclusive list and benefits can vary according to health plan.

Cognitive issues when present add to the complexity of a member and significantly impacts all domains of care including physical, functional and social. We screen each member through questions in our HRA to identify if there are memory issues. This population may experience forgetfulness or attitudes or preference that may not be conducive to change or effective management of the debilitating or progressive condition. If the case manager during interactions or when assessing during the HRA process identifies there may be a cognitive issues, the Case Manager would coordinate with the provider if a more intensive exam is needed, recommend a possible home assessment, and work closely with care givers to help the member and minimize complications and injuries that may be exacerbated by the level of impairment.

Smoking cessation
We offer smoking cessation education and medications for those members interested in becoming smoke free.

MOC 1B.4: Identify and establish relationships with community partners

If social needs are identified, the case manager or the Interdisciplinary Care Team (ICT) links members to social workers. These professionals are Anthem associates or are employed through home health agencies and community organizations. Social Workers assist members in navigating the health care environment and accessing community resources.

The clinical team also coordinates with other case managers who may be involved with the member, including long term services and supports (LTSS) case managers/service coordinators if the member is a dual member or may qualify for Medicaid benefits. This coordination may take place electronically, verbal contact, and as part of the ICT. During our interactions with the member we ask for information on other programs the member may be enrolled in or be receiving benefits through. Community-based organizations and local social service offices are also engaged, when appropriate, to help address member's financial resource and housing needs. The member's case manager may assist the member by contacting the LTSS case manager/service coordinator regularly to coordinate benefits in order to comprehensively meet the member's medical and non-medical needs. Comprehensive coordination of Medicare and Medicaid benefits, as well as non-medical (social/environmental) support, enables members to receive the best care in the most appropriate setting while maintaining as much independence as possible. When a member has any of the triggers for possible inclusion in a MLTSS program, referrals may be made or discussion with the member and/or provider occurs to assist in coordination. Unaligned coverage when we are not responsible for a portion of the benefits adds a level of complexity to assisting with coordination of benefits. Outreach to providers and working closely with the member as part of our case management program helps the member coordinate needed care. If the member is not a dual member, community resources are essential to bridge the gap between needs and what Medicare would cover.

Below is a list of frequently used resources in the community to assist the ICT with coordinating services and meeting the needs of the population. Many of the resources below help us support the needs of those members that are identified as the most vulnerable. Our most vulnerable population have multiple chronic conditions, have social and functional issues or qualify based on a disability and other comorbidities that further complicate their management. In order to address holistic needs of this population we have to include resources identified below to supplement medical or behavioral care in order to provide support of the needs identified as gaps in care/resources that if not addressed would otherwise go unmet. For our most vulnerable, the support of organizations or resources listed below are critical in helping with the management of this population.

Organization or Resource	Focus or Support

Caregiver Resources	Services offered through these community resources included providing information, support groups, care planning, legal and financial support, respite care, education, counseling and professional training. These services are generally free or at a very low cost and part of our care planning process.
Alzheimer's Association	For our members that may have cognitive impairments, this organization provides care and support as well as education.
Adult Day Health Centers	Centers are designed to provide support through social and health-related services.
Facilities	Skilled nursing facilities, assisted living facilities, shelters, partial psychiatric, Veterans, rehabilitation, dialysis, ancillary
Hospices	Hospice is available through Medicare fee-for-service or through Medicaid benefits. These agencies focus on palliative care for terminally ill or seriously ill members and help to manage pain and symptoms. They, also, support the patient and the family with emotional and spiritual counseling.
Disease-Specific Organizations (American Kidney Foundation, American Diabetes Association, American Lung Association, American Heart Association)	These organizations and websites have resources and support available for some of our more frequent disease conditions. They offer education, training and community resources.
Adult Protective Services (APS)	We screen for abuse or neglect during our health risk assessments and, if identified, we reach out to APS for support, as needed.
Community-Based Services	Unique community services are available in each of our markets. These community programs and organizations generally provider free or low-cost services. May include agencies such as Department of Aging, Area Agencies on Aging, Charitable organizations, places of worship, community mental health centers
Drug Companies	Some of our members are unable to pay for all of the medications. Drug companies are a source of support to help provide needed therapies.
Healthways-Silver Sneakers Fitness	This program is offered as a supplemental benefit to maintain physical activity that is so essential in retaining functional activity.
Food banks and home delivery of food	Nutrition can be an issue for our members based on their income. Local food banks or agencies such as meals on wheels are recommended to meet these needs.
Transportation	Many of our members live in rural areas or have limited access to public transportation. Community resources that specialize in transportation at low or no cost are coordinated, when needed.
Medicaid resources	Some of our members are dually eligible; however, not all understand or have the ability to coordinate their own care between carriers. Assistance is provided to members to connect them to agencies or benefits that may be available to them under Medicaid. Some members, if they qualify, have services available under their Medicaid managed long term services and supports (MLTSS) benefits. This program is a critical need for those that have significant functional impairments and may need assistance in the home to remain in the community or need placement, due to custodial issues.

Dental and Vision Services	Access to our dental and/or vision vendors for exams, or preventive dental services or in some contracts restorative dental services or vision hardware coverage as part of supplemental benefits. Access to Medicaid services for these needs as applicable.
Physicians and Practitioners	PCP, specialists, nursing, behavioral health, therapists, pain management, wound care facilities, pharmacies, home health agencies. Network of providers with the training to care for the population is essential in meeting the medical and behavioral health needs.
Social Service Organizations	Socioeconomic status- members who are on a fixed income or have finance issues have difficulties paying for services needed including housing, food and other basic necessities. For those in poor health, social issues can impact the stability of their condition. By using social workers, internally or if not available through agencies help link the members to services they may not otherwise know how to access.

Anthem may allow some of the processes within the model of care (MOC) to be delegated to providers or vendors. In order for a vendor or provider to be allowed to take over a responsibility outlined in the MOC a pre-delegation audit occurs. A committee reviews all results and makes the final determination about any delegation. Oversight is conducted at intervals defined by the oversight team. The delegates have to comply with the CMS guidelines and the model of care and must have policies and procedures that clearly define how they are going to meet the expectations. A delegate may enhance any of the requirements by doing more than Anthem outlines in the MOC or performing the tasks and requirements in a different way. Anthem works collaboratively with our delegates and supportive documentation is available through our provider portal as outlined later in the MOC. For example: the stratification scores used internally in Anthem are available to the provider through the portal. The provider may have a unique stratification process to prioritize and determine complexity or those members that qualify for any special program offered by the delegate. All delegates must comply with the MOC guidelines as outlined in the manual, the Anthem Model of care, the delegation agreement with division of responsibilities, CMS audit guidelines, any Part C reporting requirements, and the contract that outlines accountability.

MOC 2: Care Coordination

MOC 2A: SNP Staff Structure

MOC 2A.1: Administrative Staff Roles and Responsibilities including oversight functions

Enrollment and Eligibility

The Medicare enrollment team is responsible for processing all member applications including eligibility verification for both Medicare and Medicaid benefits. The enrollment team processes any demographic changes sent from the CMS, the state or from the member. The enrollment team processes any enrollment, disenrollment/cancellation requests, transactions from CMS such as disenrollment due to

enrolling in another plan, changes in residency, acceptance of enrollment and other transactions that impact a member's eligibility.

- **Manager I Membership** is responsible for establishing departmental policies and procedures and providing oversight of the enrollment and billing staff. Essential duties include, but are not limited to conducts audits to monitor efficiency and compliance with policies; prepares specialized reports, serves as mentor to lower leveled managers; serves as subject matter expert for other areas of the company as well as within the department; has accountability for deliverables of a third party or vendor; manages multiple functions requiring unique sets of knowledge or has significant fiscal accountability over and above routine people/equipment costs. May be assigned to special project work consistent with the role and dictated by the needs of the business.

- **Membership Rep I's** are responsible for enrollment, billing activities and/or maintaining assigned accounts. Primary duties may include, but are not limited to: Responds to incoming calls and may initiate outgoing calls, providing customer service to plan members and providers by answering benefit questions, resolving issues and educating callers. Verifies enrollment status, makes changes to records, researches and resolves enrollment system rejections; addresses a variety of enrollment questions and/or concerns received by phone or mail. May be responsible for billing and delinquency processes for assigned groups. Ensures accuracy and timeliness of the membership and billing function. Responds to inquiries concerning enrollment processes. Maintains enrollment database. May order identification cards. Determines eligibility and applies contract language for each case assigned. Performs error output resolution for electronic eligibility and processes error discrepancy list. Bills, collects premiums and reconciles payments. Maintains and reconciles premium bill, self-bill and individual billed accounts. Notifies clients of premium discrepancies through payment adjustment notices and detailed audits. Screens all forms and data for all paperwork received from Sales and/or underwriting for new group and/or group re-classing benefits. Makes request to Underwriting, Sales or Brokers for missing information and/or forms needed for new group or re-class of existing group. May be responsible for loading rates to new groups and renewal/re-class groups within the appropriate system. Screens group for benefits to determine if existing or new, recognizing when benefits are not standard and handling as appropriate. Thoroughly documents inquiry outcomes for accurate tracking and analysis. Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer requests and questions are handled appropriately and in a timely manner. Performs basic job functions with help from co-workers, specialists and managers on non-basic issues.

- **Membership Rep II's** are responsible for enrollment, billing activities and/or maintaining assigned accounts. Must be able to successfully perform all the duties of the Membership Rep I. Primary duties may include, but are not limited to: Responds to incoming calls and may initiate outgoing calls, providing customer service to plan members and providers by answering benefit questions, resolving issues and educating callers. Verifies enrollment status, makes changes to records, researches and resolves enrollment system rejections; addresses a variety of enrollment questions and/or concerns received by phone or mail. May be responsible for billing and delinquency processes for assigned groups. Ensures accuracy and timeliness of the membership

and billing function. Responds to inquiries concerning enrollment processes. Maintains enrollment database. May order identification cards. Determines eligibility and applies contract language for each case assigned. Performs error output resolution for electronic eligibility and processes error discrepancy lists. Maintains and reconciles premium bill, self-bill and individual billed accounts. Notifies clients of premium discrepancies through payment adjustment notices and detailed audits. Screens all forms and data for all paperwork received from Sales and/or underwriting for new group and/or group re-classing benefits. Makes request to Underwriting, Sales or Brokers for missing information and/or forms needed for new group or re-class of existing group. May be responsible for loading rates for new groups and renewal/re-class groups within the appropriate system. Screens group for benefits to determine if existing or new, recognizing when benefits are not standard and handling as appropriate. Thoroughly documents inquiry outcomes for accurate tracking and analysis. Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer requests and questions are handled appropriately and in a timely manner.

- **Membership Rep III's** are responsible for enrollment, billing activities and maintaining assigned accounts. Must be able to successfully perform all the duties of the Membership Rep II. Primary duties may include, but are not limited to: Responds to incoming calls and may initiate outgoing calls, providing customer service to plan members and providers by answering benefit questions, resolving issues and educating callers. Verifies enrollment status, makes changes to records, researches and resolves enrollment system rejections; addresses a variety of enrollment questions or concerns received by phone or mail. Responsible for all billing and delinquency processes for assigned groups. Ensures accuracy and timeliness of the membership and billing function. Responds to inquiries concerning enrollment processes. Maintains enrollment database. Orders Identification Cards. Determines eligibility and applies contract language for each case assigned. Performs error output resolution for electronic eligibility and processes error discrepancy list. Bills, collects premiums and reconciles payments. Maintains and reconciles premium bill, self-bill and individual billed accounts. Notifies clients of premium discrepancies through payment adjustment notices and detailed audits. Fully proficient in all key areas; performs most complex work.

Medicare Network Management

The Medicare Network Management team works independently and in conjunction with the National Provider Services Organization within each Health Plan related to provider relations and contracting functions to build and manage healthcare delivery service networks. This includes a focus on network adequacy and competitiveness, identification and recruitment of key service areas for expansion as well as training and collaboration for local Health Plan functions on matters pertaining to servicing Medicare providers. Medicare Provider Relations/Network Management also supports Medicare provider communication, quality of care initiatives and enterprise-wide provider engagement strategies.

- **Regional Vice President Network Management** is responsible for overseeing network at a local, state level; directs enterprise strategic initiatives to ensure Medicare Advantage networks are competitive in regards to network access, discounts, and quality, in order to retain, support and grow

membership; works with National Provider Services team in the state to ensure Medicare Advantage priorities are prioritized and worked accordingly; develops Provider Collaboration relationships with large IPAs in the market and helps manage and support these relationships; and works with Regional Healthcare Management Team to ensure market goals are achieved; grows and retains business through competitive network access, discounts and quality; leads initiatives to incorporate industry network developments to enhance network competitive standing; leads national committees and groups to share best practices among partners and implement consistent processes to improve network efficiencies; and directs the seamless delivery of network services in collaboration with Health Care Management.

- **Director/Manager Provider Network Management/Relations** is responsible for handling all or some of the following for a region, within Government Services Division including: manages Hospital Contracting functions; develops implements and maintains the hospital relations program at the Health Plan; develops and expands physician, physician groups, IPAs and ancillary networks; manages the servicing and contracting of providers with standard contracts. Primary duties may include, but are not limited to: coordinates provider network related activities in conjunction with the appropriate home office and local health plan staff; develops and implements provider agreements. Negotiates contracts with providers statewide. In conjunction with leadership, develops strategy to develop the provider network for the health plan. Manages provider relations issue resolution, education/orientation, evaluation of network adequacy, recruitment and marketing related to providers.

- **Network Relations Consultants** develop and maintain positive relationships with providers and develops strategies for recruitment and contracting. Primary duties may include, but are not limited to: develops and maintains positive relationships with the provider community by periodic on-site visits, communicating administrative or programmatic changes and facilitating the resolution of provider issues; recruits providers to build a cost effective, high quality provider network; conducts negotiations and leads contracting efforts with providers to build and maintain a cost effective, accessible provider network; researches, analyzes and recommends resolution for contract dispute, non-routine claim issues, billing questions and other practices; coordinates communication process on such issues as administrative and medical policy, reimbursement and provider utilization patterns conducts seminars to support the understanding of managed care and Blue Cross and Blue Shield policies and procedures; identifies network access and deficiencies and develops recruitment and contracting strategies; and coordinates and conducts provider training.

Member and Provider Customer Services

The Customer Service team is responsible for handling member and provider telephone inquiries. The team handles calls related to benefits, authorizations, provider selection, eligibility and other general questions.

- **Customer Care Representatives 1, 2 and 3** respond to customer questions via telephone and written correspondence regarding insurance benefits, provider contracts, eligibility and claims. Proficient in all basic customer service areas performs some but not all types of moderately complex

function. Primary duties may include, but are not limited to: analyzes problems and provides information/solutions; operates a PC/image station to obtain and extract information; documents information, activities and changes in the database; documents inquiry outcomes for accurate tracking and analysis; develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer requests and questions are handled appropriately and in a timely manner; researches and analyzes data to address operational challenges and customer service issues provides external and internal customers with requested information. Proficient in all basic customer service functions. Receives and places follow-up telephone calls/e-mails to answer customer questions. May require deviation from standard practices and procedures with the assistance of a computerized system. Requires general knowledge of company services, products, insurance benefits, provider contracts and claims. Seeks, understands and responds to the needs and expectations of internal and external customers. Required to meet department goals and expectations.

- **Operations Expert Calls** provides technical direction, guidance and resources to claims, customer service, or membership associates on a day-to-day basis. Primary duties may include, but are not limited to: serves as a first line resource for operation associates for workflow and technical related processes; provides operational training; assists associates by answering day-to-day technical questions; encourages a teamwork environment; monitors inventory to ensure workflow remains uninterrupted; handles complex case research and resolution; reviews, interprets and maintains records of service level, quality, accuracy, and productivity; reviews department policy and procedure manuals for accuracy; perform quality audits on associates; works with training department to ensure procedures and policies are accurate and complete.

Claims

The Claims Team is responsible for the processing and adjustment of claims submitted by providers and members. The team is responsible for the review and accurate adjudication of all claims submitted electronically, via CMS 1500 and UB04.

- **Director Claims** directs processing and payment of claims and provides guidance on the most complex claims. Responsible for providing a broad range of services needed by members/providers needed to maintain in-force policies or new business including develops/implements complaint resolution procedures; develops short/long-term claims objectives and continuously monitors procedures to ensure these are met by staff; ensures area is staffed and trained to handle inquiries from members and providers; stays abreast of state and federal regulations and their impact on the industry.

- **Manager Claims** provides oversight for claims staff. Primary duties may include, but are not limited to: establishes departmental policies and procedures; provides quality control services by monitoring work results of direct reports; performs audits to monitor efficiency and compliance with policies; and hires, trains, coaches, counsels, and evaluates performance of direct reports.

- **Operations Expert Claims** provides technical direction, guidance and resources to claims associates on a day-to-day basis. Primary duties may include, but are not limited to: serves as a first line

resource for operation associates for workflow and technical related processes; provides operational training; assists associates by answering day-to-day technical questions; encourages a teamwork environment; monitors inventory to ensure workflow remains uninterrupted; handles complex case research and resolution; reviews, interprets and maintains records of service level, quality, accuracy, and productivity; reviews department policy and procedure manuals for accuracy; works with training department to ensure procedures and policies are accurate and complete.

- **Claims Representative I** completed basic training and perform basic job functions. Their primary duties may include, but are not limited to: learning activities/tasks associated with his/her role. Works under direct supervision. Rely on others for instruction, guidance and direction. Codes and processes claim forms for payment ensuring all information is supplied before eligible payments are made. Researches and analyzes claim issues.

- **Claims Representative II:** keys, processes and/or adjusts health claims in accordance with claims policies and procedures. Works without significant guidance with basic understanding of multiple products. Must be able to successfully perform all the duties of the Claims Rep I. Their primary duties may include, but are not limited to: handling more complex claims; understands the application of benefit contracts, pricing, processing, policies, procedures, government regulations, coordination of benefits, and healthcare terminology. Understand grievance and/or re-consideration process. Reviews, analyzes and processes claims/policies and claim issues. Responds to inquiries involving customer/client contact.

- **Claims Representative III** keys, processes and/or adjusts health claims in accordance with claims policies and procedures. Must be able to successfully perform all the duties of the Claims Rep II. Primary duties may include, but are not limited to: participate in claims workflow projects, respond to written inquiries and initiate steps to assist with issues relating to the content or interpretations of benefits, policies and procedures, provider contracts, and adjudication of claims. Adjusts, voids, and reopens claims on-line within guidelines to ensure proper adjudication. May have customer/client contact. May assist training staff. Works without significant guidance.

- **Provider Payment Reconsideration Analyst I** investigates & processes member and provider claim payment disputes in accordance with claims policies and procedures. Must be able to successfully perform all the duties of the Claims Rep II or III. Primary duties may include but are not limited to: completes disputes through the NextGen workflow including generating tasks as needed, determining decision, claim adjustment/adjudication and generating correspondence. Manually intake new requests and view progress of existing items. Maintains an acceptable number of open items in their workbasket. May have customer/client contact. May assist training staff. Works without significant guidance.

- **Provider Payment Reconsideration Analyst II** investigates & processes member and provider claim payment disputes in accordance with claims policies and procedures. Must be able to successfully perform all the duties of the Provider Payment Reconsideration Analyst I. Primary duties may include but are not limited to: completes more complex disputes through the NextGen workflow, participate in claim payment dispute projects, and provides direction and guidance to

Provider Payment Reconsideration Analyst I. Assists Operation Experts. May have customer/client contact. May assist training staff. Works without significant guidance.

Clinical Quality Management Department

The Clinical Quality Management Department is responsible for improving the quality of care and health outcomes of Medicare Advantage and Dual Eligible Special Needs members. The QM Program systematically monitors the quality, appropriateness, accessibility, and availability and safety of medical and behavioral health care as well as essential infrastructures, resources and processes to impact desired health outcomes

- **Corporate Staff Vice President- Clinical Quality Management** is responsible for overseeing the development of quality improvement strategies for the enterprise and/or clinical development for population-based clinical quality measures. Primary duties may include, but are not limited to: directs the development of a national quality plan and the integration of quality into the overall business process; evaluates industry best practices, medical research, and other resources to develop clinical programs and tools which facilitate and support quality, cost-effective care; develops and implements an annual plan detailing the strategies, programs and tools to be implemented; assures compliance with QI work plans; assures that all QI activities are relevant to the needs of targeted population maintains documentation of research programs to meet regulatory and Accreditation Standards; provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis; tracks program performance and results and reviews objectives and prioritizes projects according to corporate, regional and departmental goals; hires, trains, coaches, counsels, and evaluates performance of direct reports.

- **Corporate Staff Vice President- Clinical Quality Strategy & Insights** is responsible for analyzing, reporting and developing recommendations on data related to multiple, varied business metrics. Primary duties may include, but are not limited to: creates and maintains databases to track business performance; analyzes data and summarizes performance using summary statistical procedures; develops and analyzes business performance reports (e.g. for claims data, provider data, utilization data) and provides notations of performance deviations and anomalies and creates and publishes periodic reports, makes necessary recommendations, and develops ad hoc reports as needed. May require taking business issue and devising best way to develop appropriate diagnostic and/or tracking data that will translate business requirements into usable decision support tools. The team is also responsible for creating strategies and interventions for improvement based on data outcomes and decision support tools. This include managing interventions including analysis, monitoring and reporting of the effectiveness of interventions through intervention program evaluations, as applicable.

- **Regional Directors Clinical Quality** are responsible for all regional quality activities and strategy. Primary duties may include, but are not limited to, member and provider strategies focusing on improving quality scores that result in increased revenues and growth; monitors clinical quality measures and trends and formulates strategies with business partners to improve clinical outcomes and reduce/manage costs; develops, reviews and evaluates Quality Management programs at the

market level; maintains compliance and accreditation as appropriate; provides guidance to line of business leadership in clinical trends and development opportunities; provides oversight in the planning, implementation and coordination of health care audits and participates in quality review activities manages and oversees quality assurance activities, identifies and integrates best practices into health plan programs; serves as the subject matter expert on clinical quality management, program development, measurement criteria, and maintains awareness of industry standards and trends. Participates on quality committees and work streams; hires, trains, coaches, counsels, and evaluates performance of direct reports.

- **Practice Consultants and Health Promotions Consultants** are responsible for managing and coordinating comprehensive programs targeted at Health Promotion activities that enhance the value of managed care products and services. This includes the development of selected health-related policies and services, and design of health education materials. Primary duties may include, but are not limited to: assures compliance with contract requirements and ensures member and provider materials are State approved; coordinates the development and implementation of education targeting prevention and maintenance of physical, developmental, emotional, and addictive diseases; acts as a liaison to health care management services, for the coordination of joint activities; researches and recommends management strategies that can enhance ability to provide members and providers with cutting edge services and programs identifies and recommends activities and services that promote member compliance, participation, and retention; may also manage community events, member services (complaints, claims reimbursement), CAHPS survey, etc.; and hires, trains, coaches, counsels, and evaluates performance of direct reports.

MOC 2A.2: Clinical staff's roles and responsibilities, including oversight functions,

Clinical Team Healthcare Management Services (HMS)

The clinical team that supports the Special Needs Plan Model of Care has both regional and central (shared-services) staff. Many of the services such as prior authorization, behavioral health, initial outreach and completion of the health risk assessment, audit team, correspondence team, and clinical systems are located centrally. Oversight is provided by the Regional or the National Medical Director. Other services such as utilization management and case management are managed in the regions and report to the regional medical director.

Anthem may choose to delegate clinical services to a provider or vendor in order to supplement the program. A delegate must go through a pre-delegation assessment prior to performing services on Anthem's behalf. The clinical structure is communicated by Anthem and the delegate must follow the delegation agreement in order to comply with our Model of Care. Policies and procedures are reviewed and available during any audit activities. Delegates structure, organizational chart and other supporting position information is maintained by the delegate in their operational program descriptions and specific policies and procedures that outline how they will meet the Model of Care requirements. Delegates are allowed to have a clinical structure that supports the program they administer. Because many delegates are providers in a clinician based practice performing the holistic member facing clinical management,

the types of positions and the functions performed are different from our internal Anthem based team. For example, nurse practitioners may play an important role in a provider facing/clinical practice to see members in the offices, perform home visits, take after hour calls, assess and order services for those in a SNF. All functions are performed within the licensure requirements of the state/states in which they hold a clinical license. Another example is a provider group or other delegate may have a team that outreach and focus on disease management. The positions listed below are representative of the clinical positions within Anthem. Delegates are expected to structure their program based on services that are delegated and meet all of the requirements outlined by CMS and represented in the model of care.

- **Medical Directors** are responsible for the administration of medical services for company health plans including the overall medical policies of the business unit to ensure the appropriate and most cost effective medical care is received and for the day-to-day management of medical management staff. Primary duties may include, but are not limited to: interprets existing policies and develops new policies based on changes in the healthcare or medical arena; leads, develops, directs and implements clinical and non-clinical activities that impact health care quality cost and outcomes; identifies and develops opportunities for innovation to increase effectiveness and quality; serves as a resource and consultant to other areas of the company, may chair or serve on company committees, may be required to represent the company to external entities and/or serve on external committees, conduct peer clinical and/or appeal case reviews and peer to peer clinical reviews with attending physicians or other ordering providers to discuss review determinations, provides guidance for clinical operational aspects of the program; supports the medical management staff ensuring timely and consistent responses to members and providers. The Medical Director serves as a member of the ICT. As a member of the ICT, medical directors review clinical cases, provide clinical direction to the concurrent review nurses and case managers, and review cases that do not initially meet Medicare guidelines after the initial review. The medical directors are involved in concurrent review case rounds and case management rounds and they are a member of the interdisciplinary care team. They outreach to providers within the network and have peer to peer discussions on complex member cases and to work collaboratively with them to assist with the implementation of the treatment plan.

- **Vice President /Staff VP/Director Healthcare Management Services (HMS) or Integrated Care Management** is responsible for the operational components of the Healthcare Management Program, as well as oversight of utilization management functions and Case Management Programs. These positions are held by clinicians, generally registered nurses, who are responsible for ensuring the model of care elements are implemented at each health plan. While they sometimes attend the inpatient rounds or case management rounds they are not necessarily routine members of the interdisciplinary care team. They are voting members of the oversight committees and are responsible for reviewing reports and completing the program description and evaluation. Duties include: development and oversight of program operations across all markets with a focus on program development, program enhancements, managing interdependencies and risks, program status and evaluation, reporting, and program growth/expansion in both new and existing markets; and coordinates with leadership across health plan to ensure consistency with Medicare programs.

- **Managers in Medical Management: Manager of Case Management and Manager of Utilization Management (I and II);** in most areas these positions are separated by function. However, responsibilities remain similar with the day to day operations oversight for the UM or CM. Managers oversee the day-to-day operation of the Case and/ or Utilization Management Program.

These positions provides front line management working directly with the team that performs the utilization review or case management functions of the SNP MOC. The director or manager is responsible for providing day-to-day management. Responsibilities also include providing oversight to the model of care requirements in case or utilization management. The managers may serve as members of the ICT when appropriate. The Manager is responsible for performing or delegating responsibility for audits of processes, procedures, and model of care requirements. This is a key leadership role for leading the development, implementation and coordination of a comprehensive health care program that will assist HMS, medical management, and/or utilization management, resulting in improved health outcomes for members.

All of the above management team members are responsible for conducting audits or randomly observing the interdisciplinary care team meetings and ensure that follow up items is resolved.

- **Case Manager** is a nurse or licensed behavioral health clinician provides case management services, prior authorization clinical review, and model of care case management that includes assisting the members and their caregivers with care coordination. Registered nurses and licensed clinical social workers are hired in case manager positions. For behavioral health, staff responsible **only** for case management services, can also include clinicians with current active unrestricted license as an **RN, LCSW** (as applicable by state law and scope of practice), **LISW,** LMHC, LPC (as allowed by applicable state laws), LMFT, or Clinical Psychologist to practice as a health professional within the scope of licensure in applicable states or territory of the United States required. Case managers function as patient advocates and work with members and providers to design and implement an Individualized Care Plan (ICP) based on identified problems and goals. Case managers may be dedicated to specific programs or targeted populations. Case managers are responsible for completing the model of care health risk assessment analysis, stratifying the results, and developing the care plan working with the other members of the ICT, which includes the member and the primary care physician, and behavioral health specialist as appropriate. Responsible for performing care management within the scope of licensure for members with complex and chronic care needs by assessing, developing, implementing, coordinating, monitoring, and evaluating care plans designed to optimize member health care across the care continuum. The care managers are responsible to educate members and their caregivers on their conditions and self-management techniques. LSW may assist members with behavioral health concerns and coordinate the care as required with the behavioral health case management team. RN's may educate members on their medications or direct the member to a pharmacist for further educational needs. Duties may be performed telephonically or on-site such as at hospitals for discharge planning. Primary duties may include, but are not limited to: ensuring member access to services appropriate to their health needs.
  Case Managers have access to the Healthwise Knowledgebase through our internal case management system and SNP members have access through the member portal that includes educational materials about conditions and tools to assess risk and health status. The case manager may share this information with the members and their caregivers, send print educational materials, and assist them how to access the information directly.

- **Utilization Management Representatives (I and II)** are primarily responsible for processing authorizations for notifications and select precertification's' where clinical review is not required. Primary duties include, but are not limited to the following: Manages incoming calls, Processes faxed authorization requests into the UM system, Processes approval letters, Assists the Health plan

in Administrative functions such as: verbal notifications, voicemail follow-up, Data entry for post services claims work (Action grams), Sorting of faxes for Medicare faxed authorization requests, Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer requests and questions are handled appropriately

- **Medical Management Representative or Utilization Management Specialist:** is responsible for providing non-clinical support to the Medical Management and/or Operations areas. Primary duties may include, but are not limited to: gathers clinical information regarding case and determines appropriate area to refer or assign case (utilization management, case management, QI, Med Review); and provides information regarding network providers or general program information when requested, assists with complex cases, acts as liaison between Medical Management and/or Operations and internal departments, maintains and updates tracking databases, and prepares reports and documents all actions.

- **Nurse Medical Management/Utilization Manager** is responsible for collaborating with healthcare providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources. Duties include: ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out of network services, and appropriateness of treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs or community resources; works with medical directors in interpreting appropriateness of care and accurate claims payment. May also manage appeals for services denied; conducts pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts; facilitates member care transition through the healthcare continuum and refers treatment plans/plan of care to clinical reviewers as required and does not issue non-certifications

- **Manager Utilization Review-** is responsible for managing a team who is responsible for the daily operations of medical management activities which may include managing call centers, and/or planning, implementing and coordinating necessary health care services for members to ensure high quality, cost effective care. Primary duties may include, but are not limited to: Manages resource utilization to ensure appropriate delivery of care to members; monitors telephone queue to ensure adequate coverage while incorporating quality assurance measures. Provides assistance to team members with difficult and complicated cases. Coordinates service delivery to include member assessment of physical and psychological factors. Evaluates current processes of all support functions; determines and recommends changes for increased efficiencies and improved outcomes. Extracts and manipulates analytical data to present findings to relevant markets and stakeholders. Establishes relationships with advocacy groups; partners with Provider Relations to ensure provider satisfaction and resolution of issues. Assists in the education and implementation of program and service delivery area expansions. Manages reporting, monitors results, and provides direction on productivity improvement. Hires, trains, coaches, counsels, and evaluates performance of direct report

- **Licensed Utilization Reviewer III-** is responsible for working with healthcare providers to help ensure appropriate and consistent administration of plan benefits through collecting clinical information to preauthorize services, assess medical necessity, out of network services, and appropriateness of treatment setting and applying appropriate medical policies, clinical guidelines, plan benefits, and/or scripted algorithms within scope of licensure. Examples of such functions may include: review of claim edits, pre-noted inpatient admissions or, episodic outpatient therapy such as physical therapy that is not associated with a continuum of care, radiology review, or other such review processes that require an understanding of terminology and disease processes and the application of clinical guidelines that require the use of critical thinking/nursing judgment.

- **Utilization Management Representatives Early Intervention Team:** are responsible for the initial outreach to members when their case is due for either an initial or annual assessment. They work to introduce the member to the care management program and initiate the data collection for the health risk assessment. Outbound calls can be made via a predictive dialer system, which utilizes enrollment and HRA information to automatically load members who are due for an assessment. The UMRs primary duties may include, but are not limited to: data collection and entry of member health information into the health risk assessment. Customer service activities, such as providing member with information regarding their benefits and facilitating immediate Case Manager interaction for acute cases as needed. Monitoring queues and documenting data obtained from inbound mailed correspondence with in the clinical documentation system. All information collected by the UMR is shared with the RN Case Manager for evaluation and completion of the Health Risk Assessment

- **Transitions Coach ®** provides skill transfer and guidance to the patient/caregiver for effective care transitions, improved self-management skills and enhanced patient-practitioner communication. Duties will include teaching members how to manage their medications, red flags of their conditions, and how to communicate effectively with treatment providers.

- **The Health Coach ®** collaborates with patients/caregivers in four conceptual areas, or "pillars." Medication self-management: Patient is knowledgeable about medications and has a medication management system. Use of a patient-centered record: Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care across providers and settings. The PHR is managed by the patient/ caregiver. Primary Care and Specialist Follow Up: Patient schedules and completes follow-up visit with the primary care physician and/ or specialist physician and is prepared to be an active participant in these interactions. Knowledge of Red Flags: Patient is knowledgeable about indicators that suggest his or her condition is worsening and how to respond**.**

Any of the clinical positions, that have decision-making authority, may be involved with approving services (case managers, utilization managers, care coordinators). CMS coverage guidelines are utilized when available to ensure the medical appropriateness of those limited procedures on the pre certification list. If clinical guidelines/criteria are not available in the CMS manuals, or in local or national coverage determination guidelines Anthem has clinical policies and other resources such as: either Interqual or Milliman health guidelines are utilized. Coordination assistance is provided as appropriate for those services covered by Medicaid that are not available under Medicare of supplemental benefits. If any of

the services requiring pre-certification do not meet the CMS guidelines, the case is referred to the medical director for a final decision. More detailed job summaries are maintained in our manager resources within the human resource area.

Pharmacy

The clinical pharmacist, when requested by the case manager and based on the member assessment, participates in the ICT, participates in formal rounds and addresses any medication related questions related to the member. The clinical pharmacist is also responsible for various operational and clinical aspects of the pharmacy program including prior authorizations, SNP Model of Care, Medication Therapy Management (MTM) and Drug Utilization Review (DUR) programs.

The clinical pharmacist's role contributes to the management of the member's health status by reviewing the member's medications, educating members on their medications, evaluating a prior authorization request or assisting with barriers to care involving medications. The roles may be performed by in-house or contracted clinical pharmacists with appropriate job qualifications for the clinician's functional area. Each clinical pharmacist position has a job description that outlines the qualifications, education, and responsibilities. Clinical pharmacists operate under the direction of the Director of Clinical Pharmacy Services, who is responsible for verifying current pharmacy licensure and that SNP training modules have been completed.

- **The Staff Vice President of Clinical Pharmacy Services** is responsible for leading the development, implementation and evaluation of clinical interventions and cost of care management strategies for all customer business segments. Primary duties may include, but are not limited to: establishes and executes clinical intervention programs; evaluates and implements clinical quality and cost of care programs, manages clinical and economic rule sets used in the pharmacy care note communications; collaborates with the Care Management team to improve medication compliance and reduce hospital re-admissions; provides Request for Proposal (RFP) support and assists with business growth and client retention.

- **Director of Clinical Pharmacy Strategies** is responsible for evaluating, developing, and implementing clinical program components to optimize care management and product strategies and goals. Primary duties may include, but are not limited to: supports the sales/marketing process for new and existing clients through the delivery of program presentations and showcasing program value and outcomes to clients/prospects. Interfaces with clients, medical directors, physicians, and other healthcare professionals in the sales process and the ongoing development of provider collaboration strategies. Develops and implements clinical programs, enhancements, and products consistent with the product strategy. Collaborates with operations, IT, informatics, sales and marketing, and client services on program design and delivery. Manages the deployment of clinical data and serves as a clinical resource to operations management teams, informatics, and reporting teams in the development of evaluation models and reporting. Performs system-wide clinical analysis to identify and recommend disease management clinical strategies and goals to achieve/exceed program goals and targets (for new and existing clinical conditions). Hires, trains, coaches, counsels, and evaluates performance of direct reports

- **Clinical Pharmacist Senior** is responsible for developing and implementing pharmacy programs to promote quality and cost effective drug use. Primary duties may include, but are not limited to: provides clinical consulting services to client and implements clinical information and education programs; develops formularies; performs drug utilization analyses; and participates in and presents to Pharmacy and Therapeutics (P&T) committee meetings and management of client formulary.

- **Clinical Pharmacists** are responsible for managing the selection and utilization of pharmaceuticals and supports core clinical programs such as DUR, DIS and formulary management. Primary duties may include, but are not limited to: researches and synthesizes detailed clinical data related to pharmaceuticals; prepares and presents therapeutic class reviews and drug monograph information to the P & T Committee; serves as a clinical resource to other pharmacists on areas such as prospective, inpatient and retrospective DURs and provides dosage conversion and clinical support for therapeutic interventions; prepares information for network physicians.

- **Clinical Pharmacist Resident** is responsible for various operational or clinical aspects of the Anthem Pharmacy Solutions programs, including Prior Authorizations, MTM, Lock-in, and DUR programs. Primary duties may include, but are not limited to: performs daily clinical prior authorizations and coverage determinations for Medicaid and Medicare; completes work related to the P & T Committee including therapeutic class reviews, policy review, drug monographs, and formulary recommendations; completes a year-long project targeted at improving member care through proper medication management; participates in the pharmaceutical care management process through reviewing member profiles, recommending members for lock-in, case management or disease management; and responds to and resolves issues related to member/provider complaints, claims processing issues and appeals.

Credentialing Department

The Credentialing Department is responsible for ensuring that the Health Plan contracts with organizational providers that meet the requirements of an effective, quality credentialing program that meets or exceeds the state, federal and National Committee for Quality Assurance (NCQA) standards. The Credentialing program provides for oversight of the Credentialing committee activities; the Credentialing program is reviewed, revised and approved as needed, based on state, federal, and NCQA requirements and input from the Credentialing Committees, Health Plan Medical Directors and Chief Medical Officer.

- **Credentialing Manager** is responsible for leading all credentialing activities for a line of business, region of the company, standards set, and/or enterprise wide which are necessary for attaining and maintaining accreditation from various accrediting organizations, such as and NCQA. Primary duties may include, but are not limited to: interfaces with internal and external clients, quality committees, and departments in the review of credentialing data and in the implementation of appropriate interventions to effect improvement; manages the overall

credentialing accreditation processes and resources required to successfully lead the team; evaluates, interprets and summarizes credentialing standards and manages the process for accreditation activities identifies appropriate resources and accountabilities for project teams involved with accreditation conducts the ongoing evaluation and interpretation of accreditation standards to ensure compliance through reporting and measurement studies/ methodologies; serves as expert resource to credentialing committees and business owners across the organization; leads and provides oversight of credentialing studies/projects; facilitates project management and oversees work plans by establishing deliverables, accountabilities, and timelines for team members; and performs quantitative and qualitative analysis of credentialing related data and reports activities, improvements, and recommendations to the Credentialing Committee.

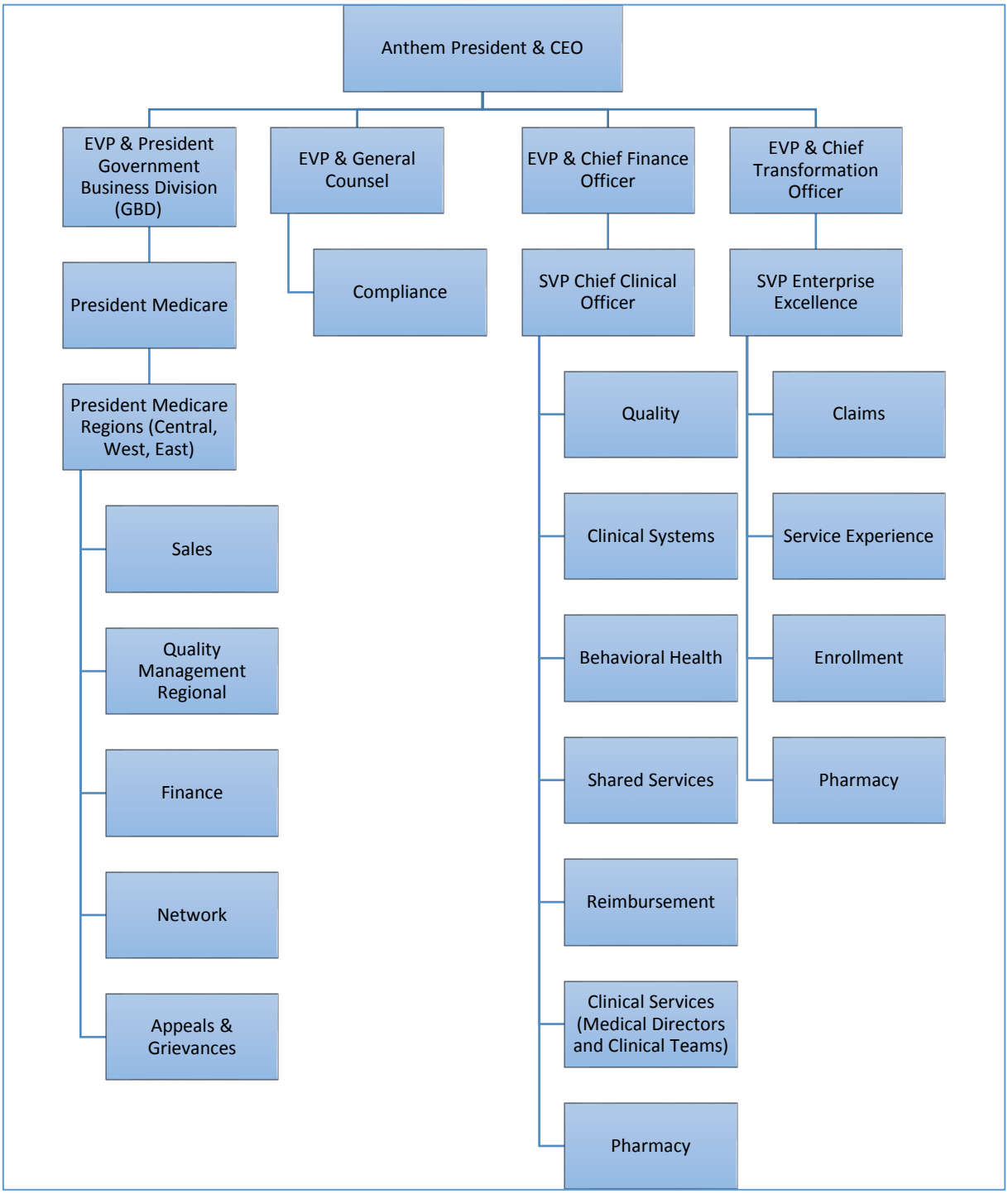
- **Credentialing Specialist** builds provider credentials file and makes file determinations regarding required credentialing criteria based on general guidelines, ensuring compliance with internal policies and external regulatory agencies. Primary duties may include, but are not limited to: receives provider applications and contacts providers for any additional supporting documentation or clarification; performs verification providers' credentials using primary and/or acceptable sources, applies general guidelines in determining whether provider meets criteria and documents deficiencies prepares correspondence to providers regarding status, assists in researching pended and probated applications and resolving discrepancies, refers non-approved providers or questionable situations to senior representative builds file documentation and as applicable, prepares file for Credentialing Committee review.

24-hour Nurse Help Line (NHL)

Members have access 24 hours a day, 7 days a week to our nurse helpline to speak directly with an appropriately licensed clinician. Based on information provided by the member, and approved guidelines and algorithms, the clinician will provide advice (e.g. management of a minor medical issue, help the member make an appointment with their provider, and when to seek care from their provider), to the member.

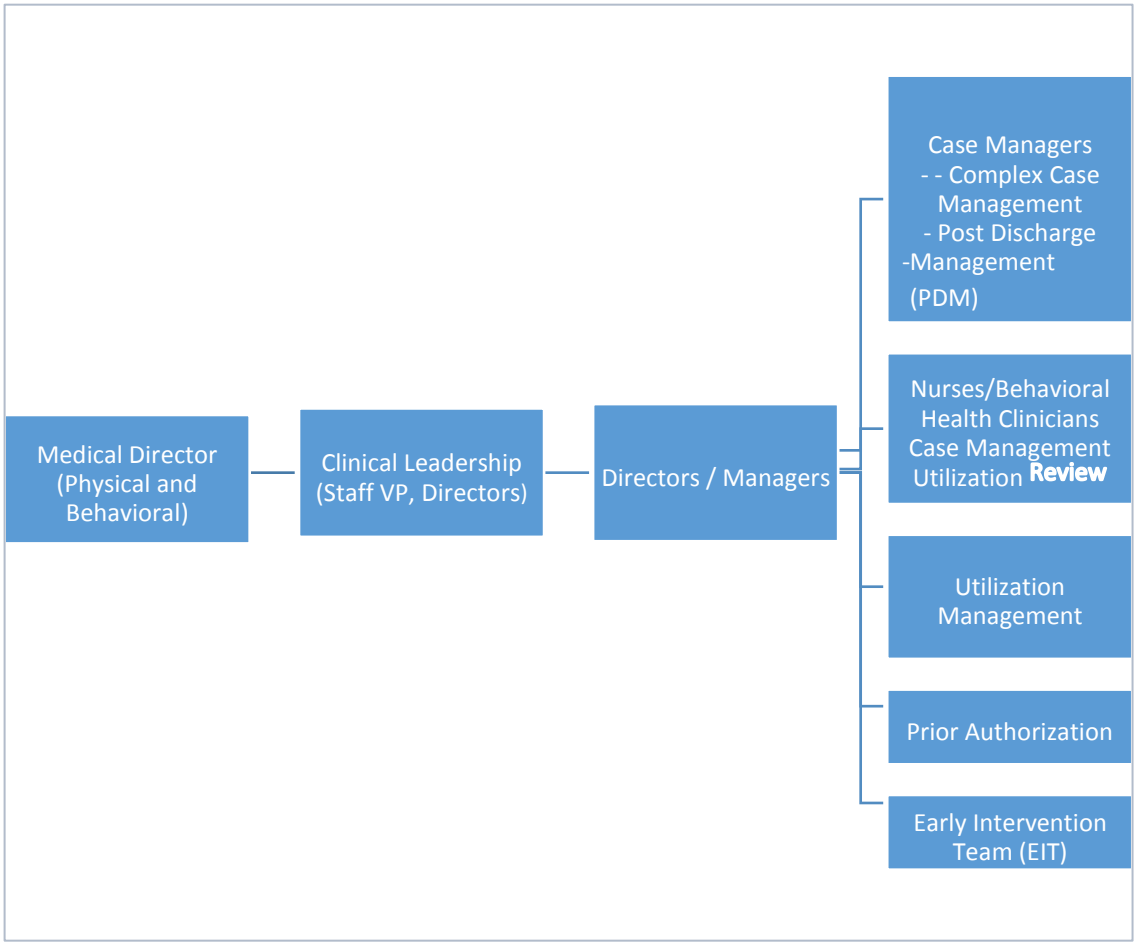
MOC 2 A.3 Describe how staff responsibilities coordinate with the job title

SNP Organizational Chart



The SNP organizational chart shows both administrative and clinical services, structure and accountability.

Health Care Management (Clinical Functions) Organizational Chart



The Health Care Management functional chart shows the functions that are under the clinical program.

The Medicare Division is supported by Regional and shared services or centralized teams including: behavioral health care management and prior authorization, outpatient pre-cert center (OPC), and the Early Intervention Team (EIT). We have Special Needs Plan (SNP) in each of our three regions West, Central and East. All of our medical management departments are governed by one set of program descriptions that describes management of our case management and utilization management functions. Our Model of Care core program is consistent across our plans. However, our leadership has the ability to establish processes or programs that are unique based on the needs of the population and the structure of our networks and plan design. Based on the membership analysis, we found the populations we serve in our SNP plans have very similar demographics and the most common clinical conditions are consistent. In addition, the social factors that complicate the management of this high risk population is very consistent regardless of the location.

The Chief Clinical Officer has accountability for all of the clinical programs including behavioral health, quality management and medical management. Oversight for both clinical and administrative functions is the responsibility of the management team in each of the shared services areas and the regional clinical

teams. The Medicare Advantage program operations is managed by our Regional Presidents who report to the President of Medicare Programs. Our clinical program oversight is provided by the VP Line of Business (LOB) Medical Directors, VP Clinical Shared and Specialized Services, and VP Behavioral Health. Each region has a Regional Medical Director that reports to the VP Medicare Clinical Operations. The leadership team consists of Medical Directors, Regional Clinical Directors and numerous managers and directors that have the responsibility to manage the day to day operations and provide oversight to the model of care clinical program. The clinical teams work together to develop the program, set policies and procedures, and to administer the program requirements.

All associates in clinical positions are required to have an active license, as required by the job description. Upon hire, education and licensure is verified through the recruiting process. Individual Managers are responsible for validating active license. If licenses are required in multiple states the Clinical Multi-State License Unit is responsible for tracking license renewal. Employees have the responsibility to renew the license prior to expiration and notify management with the information to allow for validation An employee who fails to renew and/or maintain active license in good standing are put on corrective action and are unable to work in the role. Failure to follow the licensure procedure may result in termination.

MOC 2A.4: Describe Contingency plans used to address ongoing continuity of critical staff functions

The leadership, in each area, is responsible for developing and maintaining contingency plans. Our Business Continuity Plan (BCP) is activated anytime there is a disruption in normal business functions. This formal plan covers minimal loss of function to a major disaster. In addition to the company BCP process, each department is responsible for maintaining appropriate staffing to perform business responsibilities. Each area has performance standards that are monitored and reported to evaluate how well an area is meeting the goals and what level of service is being provided. Examples of performance standards may be service related such as service level on the phone, abandonment rate, claim or fax backlog, or days to process. Other areas that are monitored include membership volume, complaints, or staff-turnover. While an annual program evaluation is performed in most areas the management team is responsible for monitoring performance continually and expected to take action based on the department results. The managers and department leads are responsible for activating any of the contingency plans that may be in place. If any of the clinical services are delegated to another entity, a business continuity process must be in place with any vendor or provider.

Examples of actions that are taken to maintain acceptable levels of operations include:

- Re-deploy resources from one area to another
- Hire temporary agency staff to cover responsibilities
- Advance recruiting of key positions if turn over or unexpected membership growth occurs
- Offer overtime or require mandatory overtime
- Suspend or limit time off requests
- Use of automated outreach or mail alternatives
- Vendor support to perform functions
- Program changes to systems allowing enhanced automation

- Activate the requirements when a disaster has been declared
- Proactively outreach to high risk members in case management to address impacts related to a potential disaster situation
- Excuse authorization requirements during disaster situations
- Allow early refill of medication
- Streamline processes

Pharmacy: Clinical pharmacists are trained cross functionally to ensure there will be no disruption in services offered to our SNP members and provided by the pharmacy team including ICT responsibilities, medication therapy management services, and authorization requests.

MOC 2A.5 & 6: Describe how the organization conducts initial and annual MOC training for its employed and contracted staff and describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training

Initial training for newly hired associates and annual refresher training is provided about the MOC for applicable employees, internal and contracted who are responsible for the management of the MOC. Employees identified for the required training, are those who participate in the ICT. Other employees, such as those who interact with members and providers, may be required to take the training as well.

Training may be provided in any of the following ways:

- Computer Based Training (CBT) internally through our Learning Management System site (internal training and tracking site for all CBT training modules)
- Printed material
- During staff meetings
- Power Point presentation

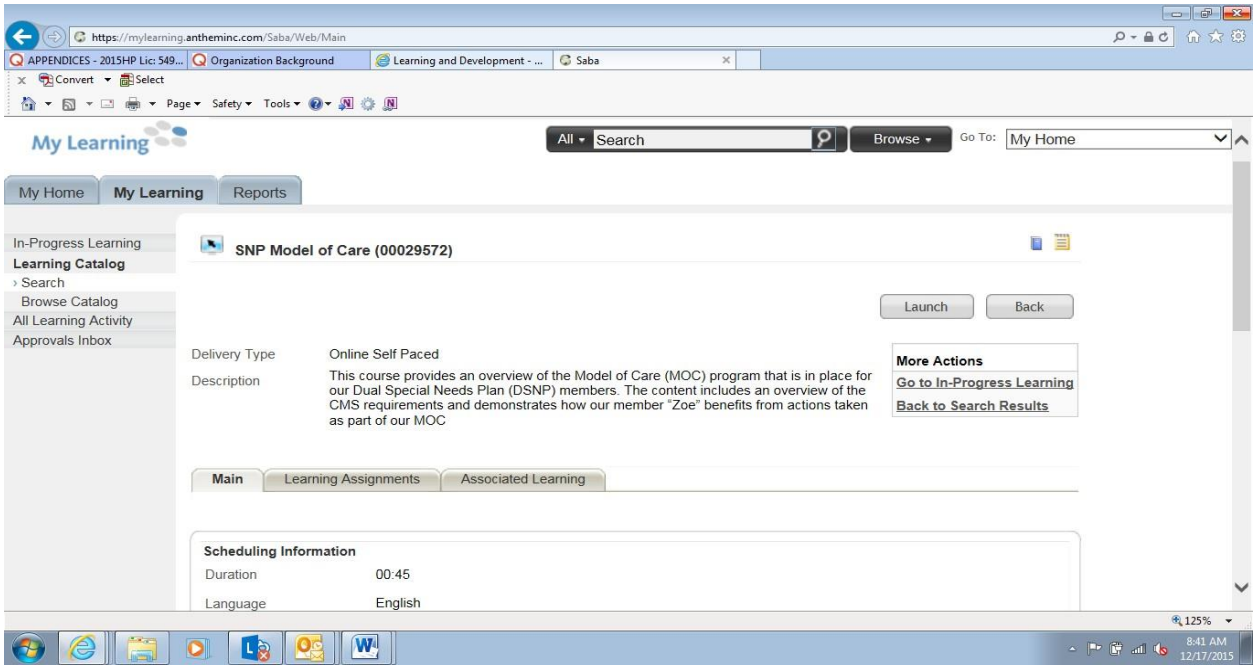
The training includes the following topics:

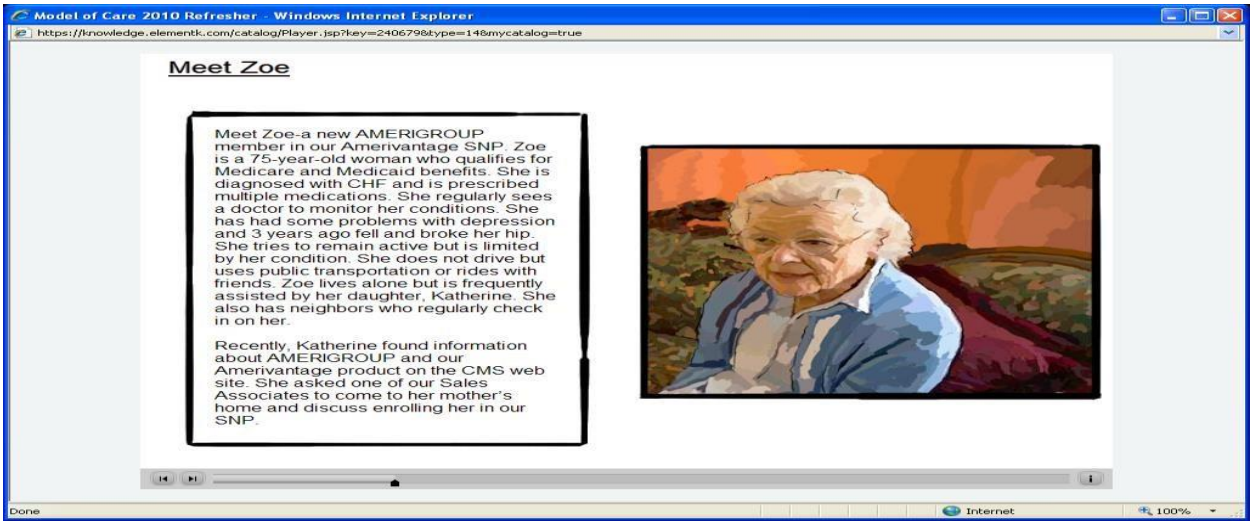
- Definition and background of the model of care
- Importance of the MOC for members considered most vulnerable
- Information on the training requirements
- Annual health risk assessment and what areas are assessed (medical, cognitive, behavioral and functional)
- Staff to support the model of care
- Development of a care plan based on the results of the HRA
- Information about the ICT and functions
- Communication process with the member and the provider
- Measuring performance and health outcomes
- Evaluating the effectiveness of the model of care

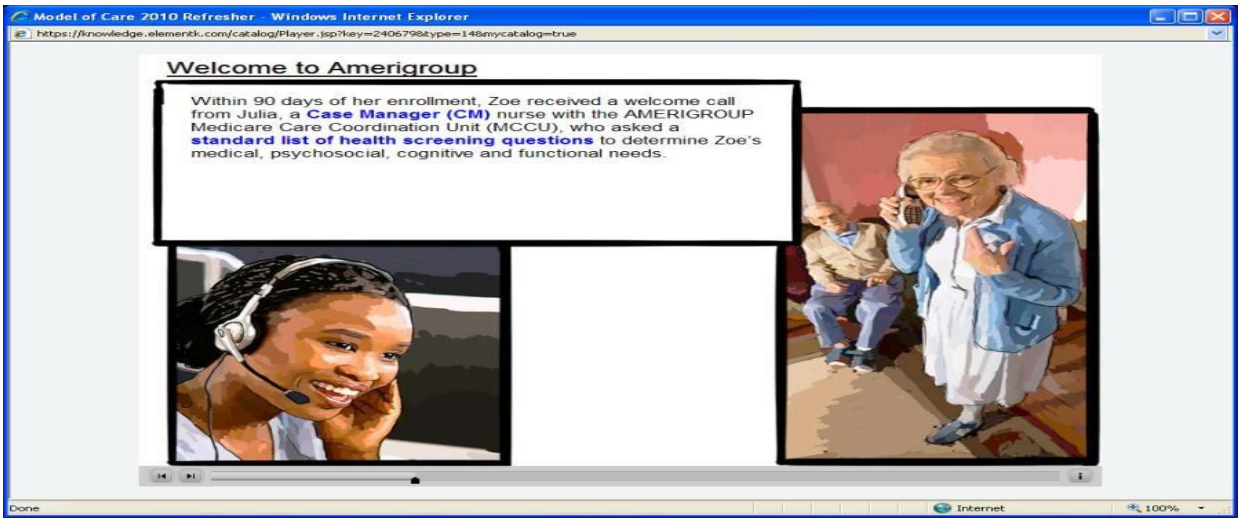
Annually, management with associates are members of the ICT, receive email notifications alerting them of their responsibility to have their associates who participate in the ICT, complete this required training. Associates may be pre-registered for the course via their management. When the associate logs into the

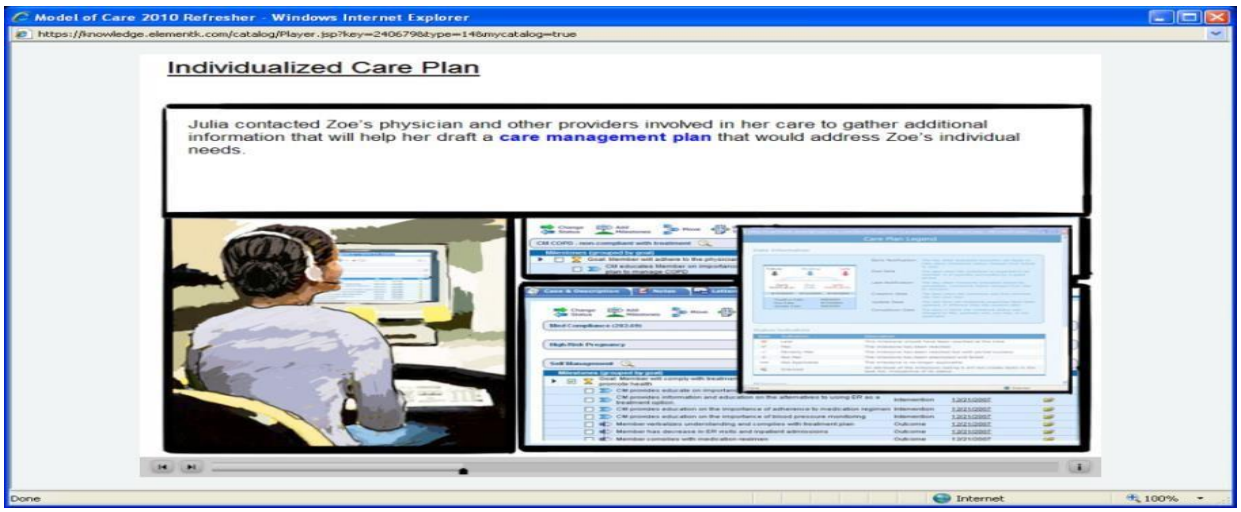
Learning Management System, the assigned MOC training course is listed on the associate's required learning list, if they are pre-registered. An interactive CBT module is the training approach. The training includes knowledge checks throughout the course to ensure comprehension. Tracking of the completion of the training occurs via the Learning Management System site. All training completed is tracked in each employee's history of completed training. The manager is responsible for ensuring employees complete the training and can monitor the training through the electronic training records.

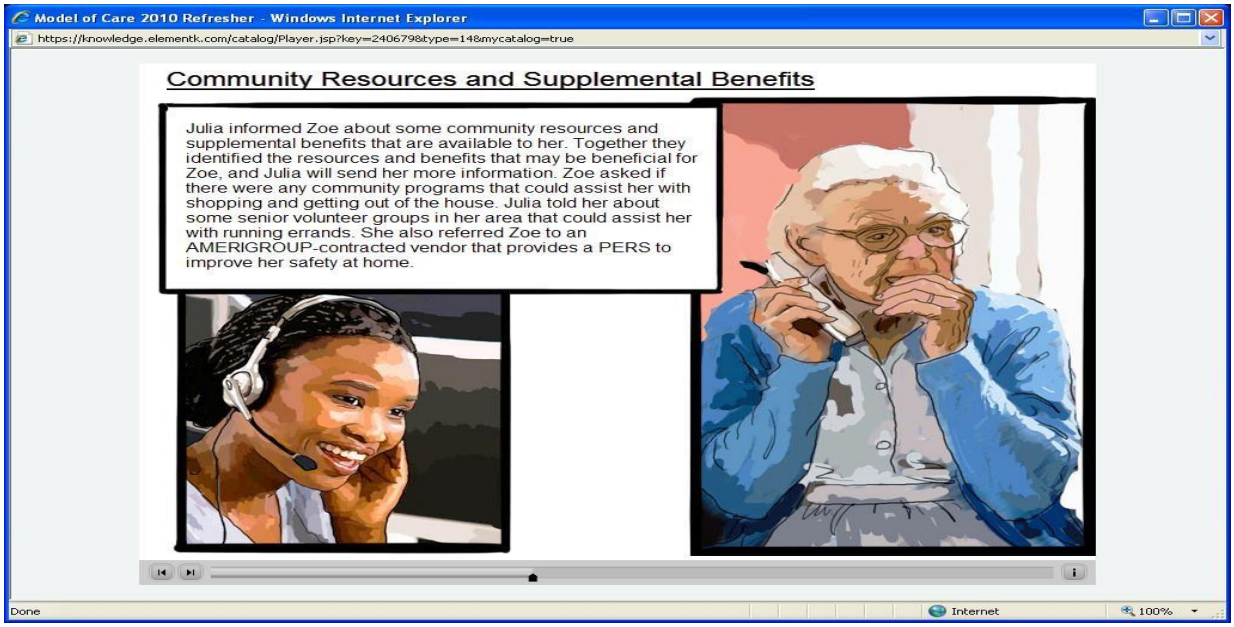
Below is a series of screen shots copied from the CBT to demonstrate the content and format of the training.

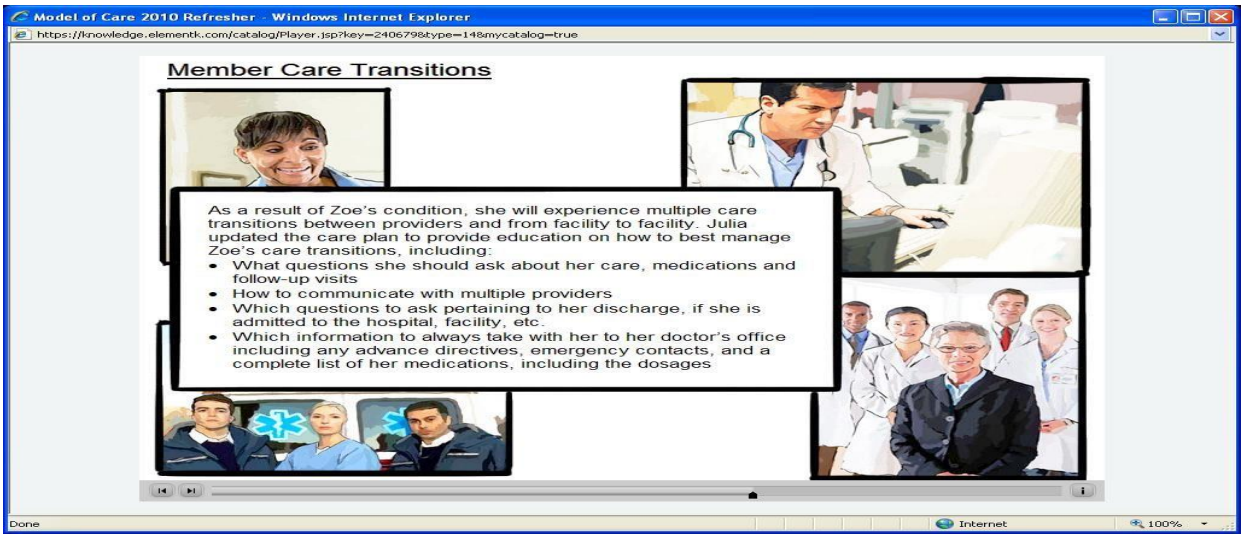





Model of Care 2010 Refresher - Windows Internet Explorer
https://knowledge.elementk.com/catalog/Player.jsp?key=2406798&type=148&mycatalog=true
Welcome to Amerigroup
Within 90 days of her enrollment, Zoe received a welcome call from Julia, a Case Manager (CM) nurse with the AMERIGROUP Medicare Care Coordination Unit (MCCU), who asked a standard list of health screening questions to determine Zoe's medical, psychosocial, cognitive and functional needs.
Done
Internet
100%


Model of Care 2010 Refresher - Windows Internet Explorer
https://knowledge.elementk.com/catalog/Player.jsp?key=2406798&type=148&mycatalog=true
Individualized Care Plan
Julia contacted Zoe's physician and other providers involved in her care to gather additional information that will help her draft a care management plan that would address Zoe's individual needs.
Done
Internet
100%


Model of Care 2010 Refresher - Windows Internet Explorer
https://knowledge.elementk.com/catalog/Player.jsp?key=2406798&type=148&mycatalog=true
Community Resources and Supplemental Benefits
Julia informed Zoe about some community resources and supplemental benefits that are available to her. Together they identified the resources and benefits that may be beneficial for Zoe, and Julia will send her more information. Zoe asked if there were any community programs that could assist her with shopping and getting out of the house. Julia told her about some senior volunteer groups in her area that could assist her with running errands. She also referred Zoe to an AMERIGROUP-contracted vendor that provides a PERS to improve her safety at home.
Done
Internet
100%



A list is generated from this system of every associate who has completed the training. In addition, each employee receives an electronic verification when the training is completed. Each employee's manager is responsible for monitoring and confirming the completion of the training and taking any action if they identify employees who are not compliant.

Management monitors their staff to ensure all who are required to take the training has completed it timely. The annual training is not optional and must be completed by the deadline, set by Compliance. Compliance sends multiple reminder notices to management prior to the training due date. Shortly after the training deadline has passed, Compliance obtains an attestation from managers indicating that all associates who meet the parameters have completed the training timely. The training is also included in the clinical team new hires agenda. We are able to generate a report to track employee training completion: A report is generated from the tracking system and has information such as: name, employee ID, department, registration date, completed date and manager contact information. Each manager is able to generate a team report to track this information

Training on the model of care is provided as part of the new associate curriculum for the clinical teams. Clinical staff is provided with more detailed training based on roles and responsibilities during new associate orientation as well as ongoing training is provided to all applicable associates to communicate changes or reinforce processes as needed. Training and education is process and offered a variety of ways including:

- Group training classes on systems, protocols and policies ○ Independent training through online technology
- Conferences to review and answer more detailed questions on protocols, processes, and best practices
- Shadow existing clinical staff
- Meeting 1-on-1 with their preceptor and manager to go over training status and assess their progress and knowledge, and develop an action plan for additional training as needed.

MOC 2A.7: Actions if training is not completed

Initial and annual training on model of care is mandatory. Compliance and the management team monitor the completion of the training. Minimal challenges exist due to the effective way tracking is performed. If a manager identifies associates who haven't completed training or if management doesn't attest timely, Compliance escalates to the next level of leadership for prompt attention. Management escalation continues until all required associates have completed the training. Leadership is engaged as needed to ensure training is completed timely.

Challenges that may occur with the training include missing the deadline assigned to complete the training. Actions that may occur if this training deadline is missed include: scheduling time during the work day to complete the training, assigning a new date for training to be completed, assessment of why the training has not been completed, and disciplinary action as part of our performance management process.

MOC 2B: Health Risk Assessment Tool (HRAT)

As demonstrated in our goals, we attempt to reach all members to complete the HRA and track our completion with the goal at 100% as required. We have processes in place to outreach in multiple ways. If we are unsuccessful in outreaching or obtaining a completed HRA, we develop a care plan using the information we have available and include some core elements applicable to the member. All members have a care plan and an ICT which is tracked in our case management system. We have additional goals set at 100% for our ICP and the ICT completion rates.

MOC 2B.1: How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary

A comprehensive HRAT is used to assess members across multiple domains including physical and mental health, and functional, cognitive and psychosocial status. All of our SNP members receive outreach in multiple ways to obtain a completed HRA. Each member has either a completed one on file in our case management system or documentation of the attempts to reach, or a refusal. This process is in place for new members and the initial HRA and annual for a reassessment. Our goals reflect the benchmark of 100%. Members have the right to refuse to participate in the HRA process. We continue to outreach in multiple ways even if a member is documented as UTC or refused. The comprehensive HRAT is an internally, developed tool that was created after reviewing other industry assessment tools and obtaining feedback and approval from internal physicians, nurses and other personnel. Various evidenced based tools were used in development of the HRAT including; the Folstein Mini Mental State Exam (MMSE), KATZ Basic Activities of Daily Living (ADL), Geriatric Depression Scale, the Health Outcome Survey, standard pain scale, and functional assessments.

The comprehensive HRAT consists of a series of questions that use branching logic to expand the questions based on the member's answer. For example, if a member states they have pain impacting their lives, a series of additional questions branch to further assess the level of pain or if cultural beliefs that may impact the delivery of healthcare, additional questions branch to all more details for the care team. If completion of the HRAT is delegated to a vendor or a provider, the core set of questions meeting the domain requirement are used however, additional questions or assessment tools may be used and the tool customized to meet the delegates program design.

Below are a few examples of questions from the HRAT, this is only a subset and not the full tool used. The example is not intended to demonstrate full compliance only show some of the questions that are asked. We use a variety of yes/no, multi select, and free text questions are used. We ask questions that address the following: medical, functional, cognitive, psychosocial and mental health. Delegates are required to meet the requirements of the domains but may add additional questions as applicable to the program and the system or medical record used by the vendor or provider practice.

Subset of Core HRA questions:

Do you have a living will or advanced directive in place? (Task: Recommend a guideline)	1-Yes 2- No
Do you have a person designated to make health care decisions for you if you are unable to make your wishes known , a health care proxy?	1-Yes 2-No
How many times have you been IP in the last 6 months/year?	0- None 1- One time 2- Two or more
I'm going to go through a short list of conditions with you and you can tell me if you have had any of these:	
Diabetes	1-Yes 2- No
Congestive Heart Failure	1-Yes 2- No
Chronic Lung Disease (COPD)	1-Yes 2- No
End Stage Renal Disease (ESRD)	1-Yes 2- No
How many different prescription medications do you take on a regular basis?	1 - None 2 - 1-2 3. 4-6 4. More than 6
Have you fallen within the last month? Within the last 6 months?	1- Yes 2- No
How often do you experience pain/are you currently having pain?	1- More than once a day 2- Once a day 3- Less than once a day 4- I do not have pain

How severe is your pain when you are having your worst pain? (Choose one answer from 1 to 10 with 10 being the worst)	1 2 3 4 5 6 7 8 9 10
Based on the responses and/or clinical history, Does the member appear to have any cognitive deficits or have problems with memory?	1- Yes 2- No
Feeling down, depressed/sad or hopeless	1- Not at all 2- Several Days 3- More than half the days 4- Nearly every day

For our C-SNP plans, additional questions are asked specific to the qualifying disease process. Below are a few examples of additional questions from our HRA. Our delegated providers or vendors may perform a full physical exam as part of the assessment process in addition to any HRA.

Lung:

How often do you experience shortness of breath?	1-Never 2- Rarely 3- Sometimes 4- Very Often 5- Always
Do you have an ongoing cough?	1- Never 2- Rarely 3- Sometimes 4- Very Often 5- Always
Do you smoke?	1- Yes 2- No
Does anyone in your household smoke?	1- Yes 2- No
Does your lung condition prevent you from getting a good night's sleep?	1- Never 2- Rarely 3- Sometimes 4- Very Often 5- Always

Cardiovascular and/or CHF:

Do you experience chest pain?	1- Yes - Rarely 2- Yes - Sometimes 3- Yes, Very Often 4- Always 5- No
Do you have swelling in your feet, ankles, or legs?	1- Yes - Rarely 2- Yes - Sometimes 3- Yes, Very Often 4- Always 5- No

Have you ever had a heart attack?	1- Yes, less than a year ago 2- Yes, 2-3 years ago 3- Yes, more than 3 years ago 4- No
Have you ever had heart surgeries (ex. Bypass, stents)?	1- Yes 2- No

Do you experience shortness of breath?	1- Never 2- Rarely 3- Sometimes 4- Very Often 5- Always
Do you get tired or short of breath when walking?	1- Never 2- Rarely 3- Sometimes 4- Very Often 5- Always
Do you experience abdominal pain or swelling?	1- Never 2- Rarely 3- Sometimes 4- Very Often 5- Always
Do you weigh yourself daily?	1 -Yes 2- No
(If no) Do you have access to a scale?	1- Yes 2- No
How much does your weight change in a week?	1- 1lb 2- 2 lbs 3- 3-4 lbs 4- More than 4lbs
Do you smoke?	1- Yes 2- No
How often have you seen your Cardiologist in the last year?	1- None 2- 1 time 3- 2 times 4- 3-4 times 5- More than 4 times

Diabetes:

Which type of medication do you take for your Diabetes?	1- Pills only 2- Insulin only 3- Both pills and insulin 4- Other medicine by shot 5- None
If you take insulin, how often do you take it?	1- 1 time a day 2- 2-3 times a day 3- More than 3 times a day 4- On an insulin pump
What was your last HgbA1C?	1- 6.5 or less 2- Between 6.6 and 7.5 3. 7.6 to 9.0 4- More than 9.0 5- Don't know

Do you have any of the following problems?	1- Cramping/pain in legs or buttocks after walking 2- Redness/swelling in legs 3- Pins/needles/burning to legs and/or feet 4- Lack of feeling in fingers or toes 5- Wounds that are not healing properly
How often do you have your feet checked?	1- 1 time a year 2- 2 times a year 3- Never 4- Don't know
How often do you have a dilated eye exam?	1- 1 time a year 2- Never 3- Don't know
How often do you have your urine checked?	1- 1 time a year 2- 2 times a year 3- Never 4- Don't know

Our goal is completion of the initial HRAT within the first 90 days of a member's enrollment for each new member. All of our existing members receive an annual reassessment prior to the anniversary of the last completed HRA. Reassessments may be completed when a significant change in status occurs, such as after a transition (based on risk level for readmission) or a change in the stratification level (based on our CI3 stratification tool) that qualifies a member to be evaluated for possible complex case management. For example, if a member transitions to an inpatient setting, if determined to be high risk for readmission, an assessment may be completed post discharge to minimize the risk of readmission. Additional assessment tools may be used based on the clinical or social background of the member. For example: disease specific or behavioral health assessments may supplement the HRAT, dependent upon the level of case management or program type the member qualifies. Based on the stratification of the member, which may occur after review by a clinician, from scoring methodology within the HRAT, or from other stratification tools, the full comprehensive assessment tool may be modified and a subset of questions from the comprehensive HRA may be used to assess the member and begin the care planning process. Additional information from Member 360 or other tools or system details (e.g. authorization history and/or claims data), is used to supplement the information obtained from the HRA to evaluate the needs of the member.

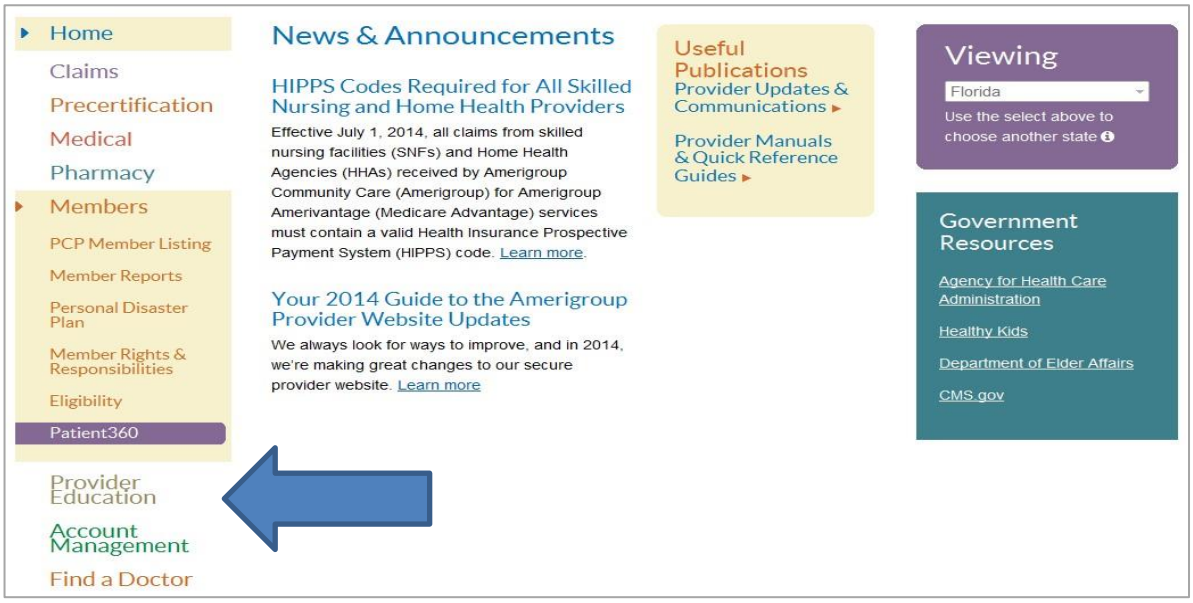
The data collected in the HRAT is the basis for beginning development of the individualized care plan (ICP), which is initiated immediately upon completion of the HRAT whenever feasible, but no later than 30 days after completion. The case management system houses the HRAT results as well as detailed clinical information on each member, including; medications (including history), authorizations, claims, and lab work results corresponding with certain trackers (HgbA1C). Care gaps are also available for the case manager's review and include gaps in appropriate treatment for specific conditions, such as diabetes and drug adherence information. The results of any of the previous assessments are available for a side by-side comparison. This comparison allows the case manager to identify any changes that may have occurred since the last time the assessment was performed. The HRAT is used to not only identify any immediate needs a member has after joining the Health Plan or any changes since the last assessment but as a screening tool for referral to other programs and benefits. The member may be identified as a potential candidate for complex medical or behavioral case management programs. The results of the

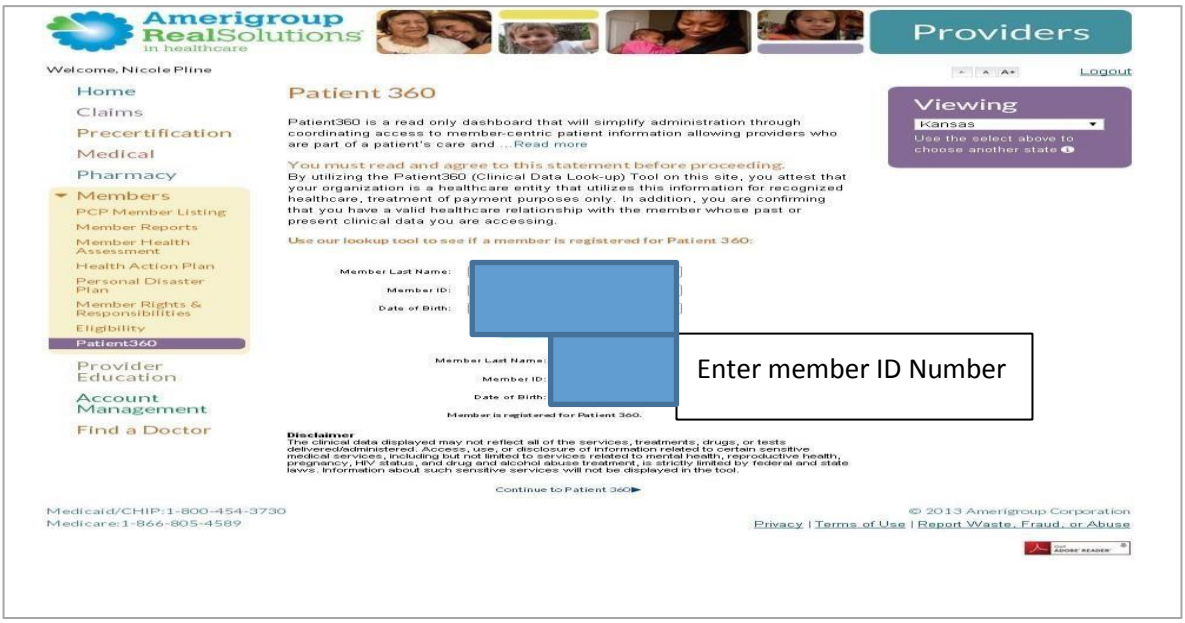
HRA are also used to identify the member's program and community resource needs. If a delegate is responsible for completing the HRA and performing the care planning process, the provider or vendor is responsible for communicating results as required in guidelines to the members of the ICT which would be supported in the delegate's policies and procedures. As described later in the MOC, providers have access to Patient360 (P360) which has similar information that internal associates have access to manage the care of the members.

The members of the ICT work together to develop the ICP, manage transitions, address gaps in care, and determine the most appropriate care path for each member. Based on the delegation agreement, we may have a partnership in place with the provider where Anthem may perform certain processes and share information, collaborate and coordinate with the delegate.

MOC 2B.2: How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information

Each member has an ICT. Once the ICP is completed, the case manager obtains and documents member agreement with the ICP. This acceptance is received verbally as the CM works with the member. The ICP is available through Member360 (M360) or Patient360 (P360) as described below. Upon request, copies of the ICP are also available via electronic or paper copy (email, fax, mail) including to providers and case managers from participating external programs. The copies will be shared following HIPAA requirements. If this process is delegated, the delegate must manage this process and have policies and procedures to describe how the information is disseminated to the ICT.
The longitudinal member record is housed in M360, our internal repository for the HRA, ICP, ICT notes and actions, notes from member discussions, transitions information, pharmacy data, claims and authorizations , care gaps, risk stratification results, correspondence and other pertinent clinical information Our case managers have access to M360 via a link in our case management system. Within M360 is the dashboard, which provides an easily accessible view of the information that has been pulled from various other internal systems. Patient360 (P360), is available to members and providers via the Member and Provider Web portals, respectively. Members have access to their HRA results and their ICP, while providers, that are part of the ICT, have access to review the entire longitudinal health record. Below are examples of training materials displaying some of the information and screens demonstrating the provider access within P360:





Patient360 has six tabs of data for each member record. A screen shot of each tab and a key describing the items within that tab are listed below in the order shown in the tool. Members and their providers use these tabs to navigate the tool and find specific medical information. Some of the screens may have different appearances based on the brand information or the structure of the pages within the individual portals.

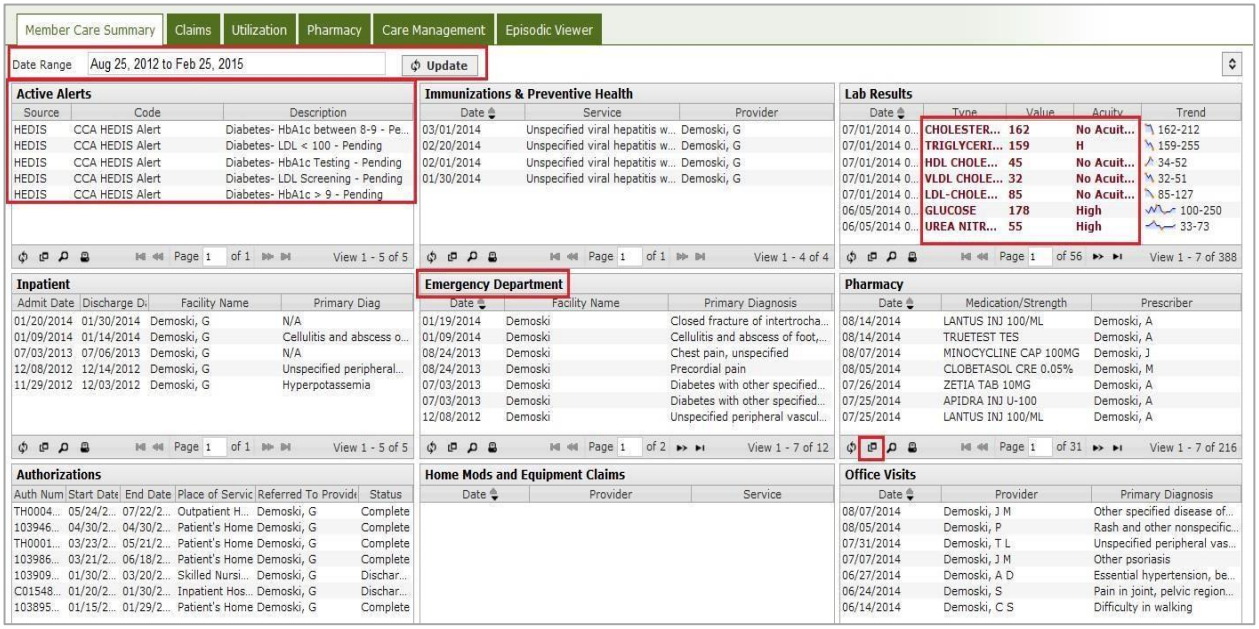
Patient banner

At the very top of the tool is the patient banner, which displays all of the demographic information we have on file for that member.

Traffic Lights are used to quickly determine key information about a member: green signifies an OK status, while red requires provider attention.

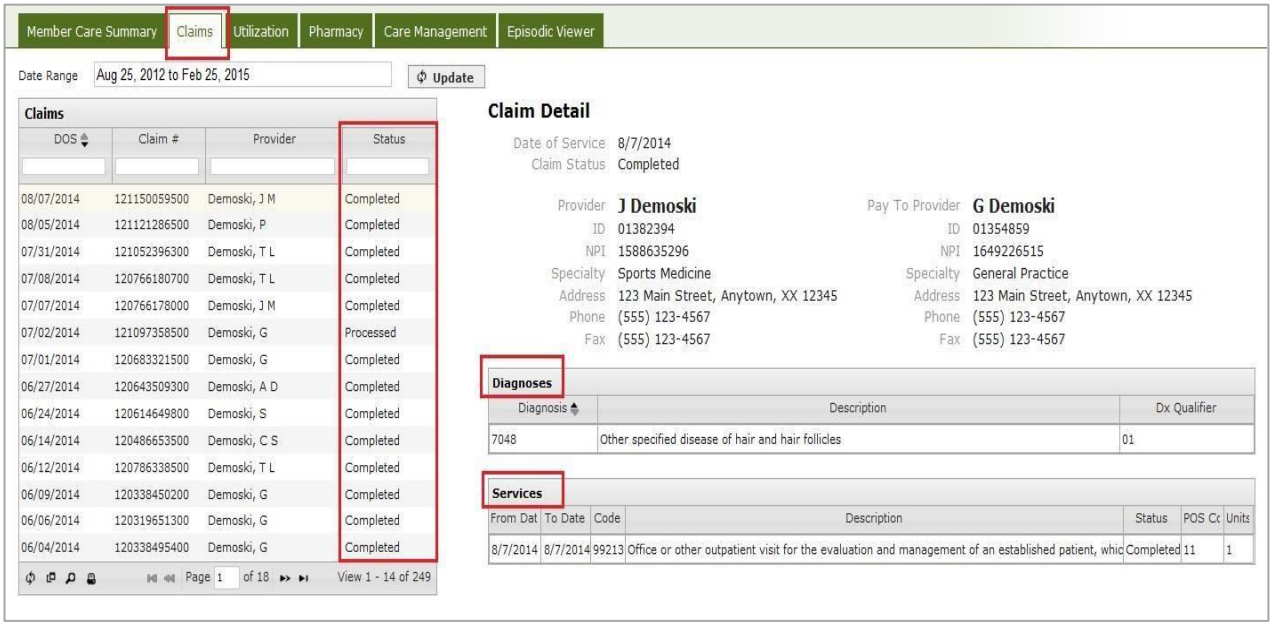
Member Care Summary tab

The first tab in P360 is the Member Care Summary. This page summarizes important aspects of the member's care; including active alerts for HEDIS care gaps, immunization and lab records, ER visits and inpatient stay summaries, and a history of office visits.



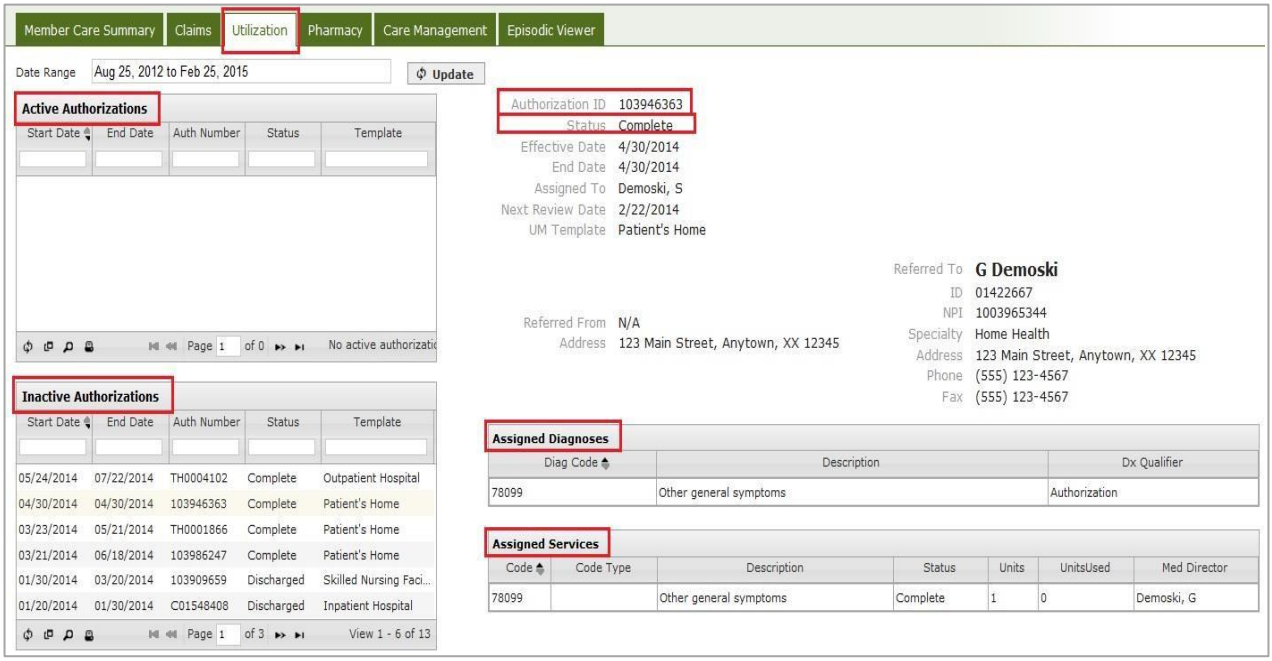
Claims Tab

The next tab shows claims details for up to two years, including claim status, assigned diagnoses and services rendered. Sensitive claim data is not displayed which includes claims related to behavioral health diagnoses, HIV status, abortion history, etc.



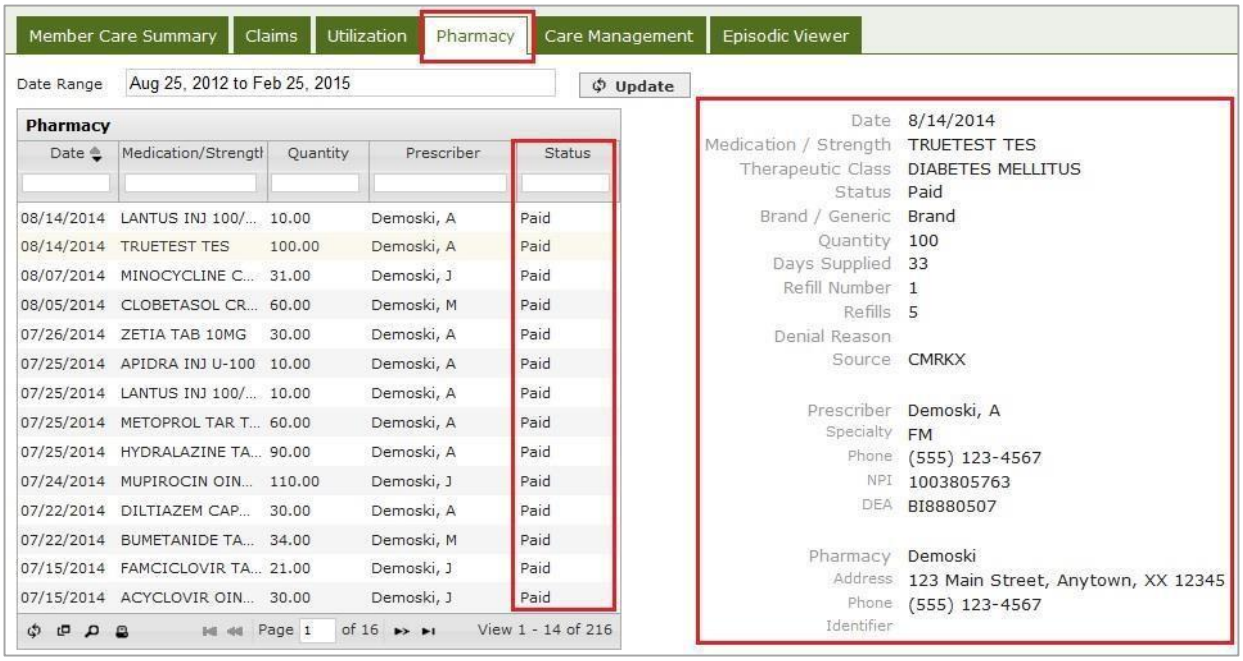
Utilization tab

The Utilization tab provides details about active and inactive authorizations on file for the member for up to two years.



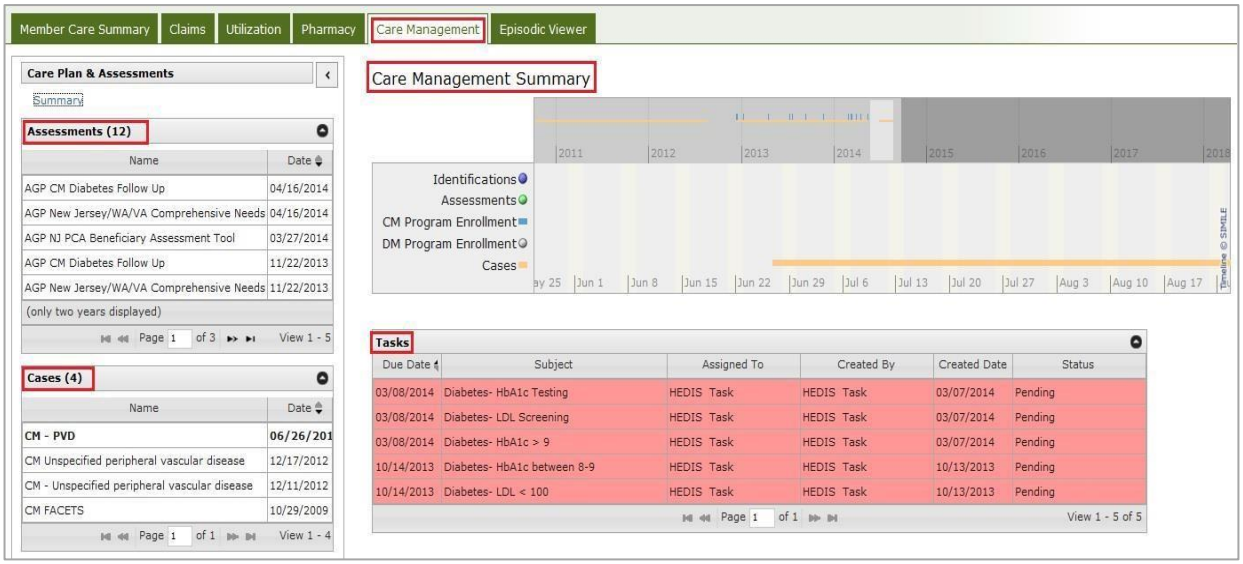
Pharmacy tab

The Pharmacy tab includes all the pharmacy information associated with claims we have received. Sensitive information is not displayed.



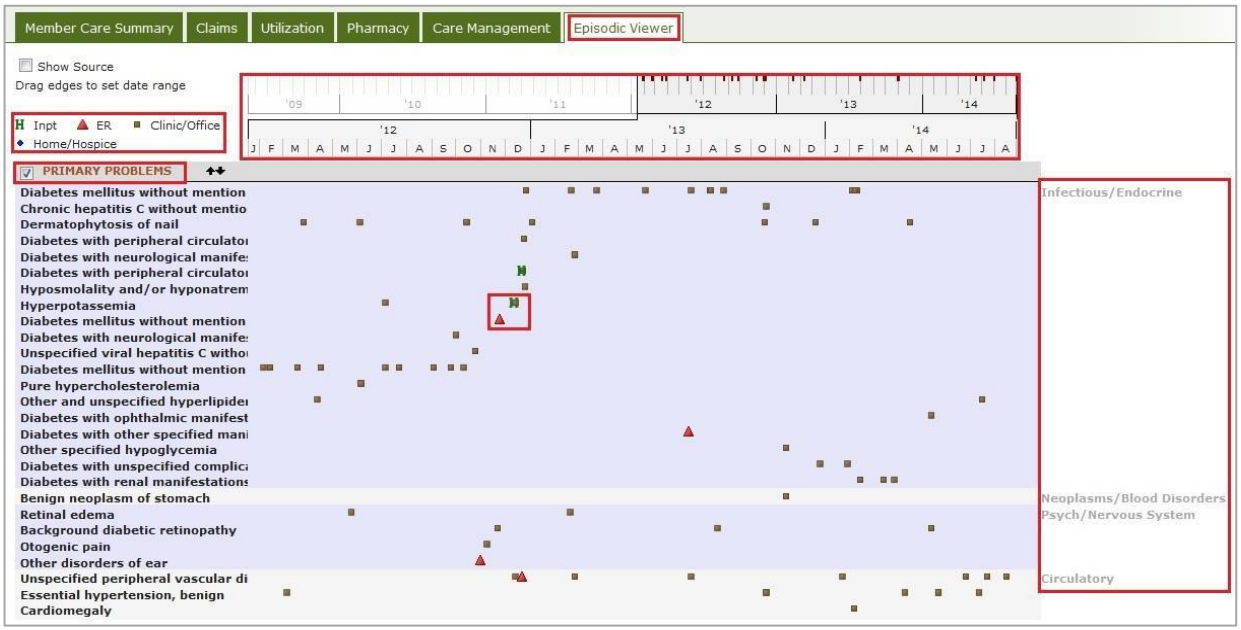
Care Management tab

All care management activities are shown here, including assessments, care plan goals and initiatives.



Episodic Viewer tab

The final tab graphically shows the member's medical history over time. This is an excellent tool for management of transitions and for coordination of care between disciplines.



Upon request, the member or provider can request paper or electronic copies of the HRA results and the ICP which are printed directly out of the case management system and sent to the requester following HIPAA requirements.

MOC 2B.3: How the organization conducts the initial HRAT and annual reassessment for each beneficiary

The goal is completion of the HRA within 90 days of the member's enrollment in the health plan and within 364 days from the initial assessment. The primary methodology for outreach to the members to complete the HRA is by telephone. Multiple attempts are made to reach all members by telephone. If contact is not made during the first attempt, calls are placed on different days and during different time periods to improve the reach rate. The initial outreach process is managed by using a predictive dialer in addition to a possible manual direct dial process. The predictive dialer is an automated call solution that makes the phone call attempts and when the call is connected, the system transfers the call to a live agent to proceed with completing the health risk assessment. The processes related to the predictive dialer are compliant with all of the Federal Communication Commission (FCC) Telephone Consumer Protection Act (TCPA). Processes are in place, through the predictive dialer, to pull in updated phone numbers as the system is updated when the next attempt is made to reach the member. After a minimum of three attempts by phone, we try to reach the member by mail. The additional outreach may be made by either sending a postcard to the member's address indicating we are trying to reach them and request they contact us at the number provided on the postcard or send a paper version of the HRA to the member asking them to complete and return the HRA. Upon receipt of a completed HRA by mail, the results are entered directly into the case management system for the clinician to use as part of the review process. The clinician then attempts to reach the member by telephone to review the results of the mailed HRA and begin the care planning process. If outreach is not successful after receiving the completed HRA, a

care plan is created based on the results of the HRA. Additional alternatives for administration and/or distribution of the HRA in may include any of the following: mail, the member portal, interactive voice response, in the new member welcome packet, during initial sales enrollment process, member services, in-person visits, vendors, or utilizing home care providers.

The HRA may be completed by any of the following: RN, social worker, behavioral health team member, Nurse Practitioner, non-clinical outreach, member services, or utilization management representative. Because of a high incidence of behavioral health diagnoses among our population and considering the needs of our members with long term care needs/benefits, some of our case managers are also social workers, or have other behavioral health credentials. Data collection initiated by nonclinicians is reviewed by a nurse or other appropriately trained clinician who reviews the HRA responses with the member to validate any triggers and question any responses indicative of a potential problem. Additional clinical information available in the system is reviewed during this analysis process.

Once the HRAT is completed, the licensed/credentialed health care professional performs an analysis of the HRAT results. The case management system allows the review of the results and a comparison can be assessed side-by-side. This allows the nurse, or social worker, or other team member, stratify the needs of the member based on the answers and information provided during the assessment process. If all attempts fail to result in positive contact, the member's record in the case management system is flagged as unable to reach. Within the case management system, automated processes are in place to generate and document the HRA mailing and automate the entry of the returned paper HRA results. Additional attempts are made during the year to contact members who remain unable to reach including when a member uses the ER and has outreach, is identified for screening for complex case management or has an inpatient admission and is considered high risk for readmission.

Once all outreach have been made and the contact with the member has been unsuccessful we have a process in place to create a care plan for the member as further outlined in the ICP section of the MOC process. Valuable information is available to the care team as demonstrated below in explanations about our M360 and P360 portals. We continue to outreach to the member at designated intervals if we have been unable to reach them. At a minimum of every 6 months if a member remains in an unable to reach designation, he or she will be placed back on our dialer list and the process described above will be repeated. This is in addition to other outreach processes when the member may be identified as a candidate for other programs such as post discharge or complex case management or post discharge if the member is considered high risk for a readmission. If contact is made for other programs, the process includes reviewing the history to determine if the member is in an UTC or refused status for the MOC HRA. If this is found, the case manager interacting with the member will complete the HRA, ICP and ICT or coordinate with our Early Intervention Team (EIT) to complete all required processes. Weekly, monthly, and quarterly reports are monitored to evaluate the HRA completion rate, reach rate, volume of unable to reach, and refusal rate. As part of the annual program evaluation the comprehensive tool is evaluated to confirm that it continues to be applicable to the population and edits to the HRAT, if necessary are made.

Delegates that have accountability to complete this process must at a minimum meet the core requirements and have systems that support the required processes. Outreach may be completed using

additional processes or may be completed in any order that may not align exactly to our internal program description. Delegated oversight is responsible for evaluating each delegate and the compliance with the processes as well as verifying policies and procedures are in place outlining how the requirements are met.

MOC 2B.4: The detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the HRA results

Multiple data elements are reviewed to stratify and analyze results to build the ICP that include: risks, care gaps, barriers to care, care coordination needs, referral needs, functional deficits, behavioral health needs, and other actionable items. The case manager is responsible to discuss the evaluation and care plan with the member or caregiver, focusing on potential clinical and social needs. Where indicated outreach is also made to the appropriate treating providers to obtain a holistic view and appropriate stratification level.

Each month, the entire member population is evaluated and potential candidates for case management are prioritized by identifying members with the highest expected need for services. In additional to manual stratification processes other measures may be used to stratify the complexity of our membership or to identify if members may qualify for programs. Delegates may use our internal established processes or may have their own defined processes. Our internal monthly stratification process is a systematic process using proprietary software to stratify membership and risk rank to identify potential candidates with the highest expected need for services. Our continuous case finding (CCF) process monitors each member's health status, as it incorporates a sophisticated predictive modeling system that continuously synthesizes member data, such as diagnoses, hospitalizations and ER encounters. This information is reported back to the case management team for appropriate action as necessary. Referrals from both internal and external sources for possible enrollment into our case management program are accepted and evaluated using internal criteria.

Our locally developed CCF process and tool is a proprietary predictive modeling system that drives the case management program by allowing us to stratify members into four levels of case management intensity. The Chronic Illness Intensity Index (CI3), our predictive model, compares the complexity of the conditions of all members in our diverse population. CI3 is the primary component of our proprietary predictive modeling system, which synthesizes member data, such as diagnoses, hospitalizations, pharmacy data, ER encounters, expenditures and demographics, to develop individualized risk profiles. This allows us to stratify all members appropriately, thus identifying the sickest and most complex members needing intensive case management, who can be expected to benefit most from the case management interventions. This system allows us to deploy integrated outreach services in a prioritized fashion.

Among our sickest and most complex members who require intensive or complex case management, we employ a second predictive model. This predictive model, the Likelihood of Inpatient Admission (LIPA), ranks members based on their chance of having an unplanned admitted to the hospital in the next 60 days using utilization data, demographic factors and diagnostic data. This allows the Health teams to focus

resources on members with the highest immediate risk among their Group 3 and 4 members. We use the LIPA score to prioritize member outreach by an interdisciplinary team of care managers. The CI3 score indicates the overall illness burden of a member, and the LIPA score indicates the member's likelihood to be admitted to the hospital in the next 60 days. During inpatient acute and behavioral health admissions we evaluate members to determine a high risk of readmission to enroll in our post discharge management program monitor the readmission score (RAS) that predicts the likelihood of a readmission occurring within 30 days post discharge. This score helps the case managers to target those highest risks for readmission as part of the post discharge care outreach program.

The HRA results and other risk scores resulting from CI3 stratification and LIPA scoring are used to help focus case management resources on meeting the needs of higher risk members utilizing a mix of standardized and individualized approaches to care.

The CI3 stratification is available to the ICT and communicated verbally during the ICT meeting and made available through the P360 system. The stratification results are displayed in the banner under risk score. The results of the HRA are also available to the ICT. The case manager communicates the needs as identified based on the results and other history directly to the ICT and with the member and/or caregiver during the care planning process. The detailed description of what is available to the provider is described above. The member has a modified view but does have the results of the HRA and the case manager discusses by telephone possible areas of need based on the results.

As part of the annual program evaluation process, the HRA is reviewed to determine the effectiveness of the tool and to determine if any changes need to be made, during the year, based on any of the following:

- Reporting requirements
- Change in demographics
- Changes in model of care standards
- Program changes resulting in new processes
- Modifications of questions (additions and deletions)

Medication Review

A dedicated clinical pharmacist has responsibility for coordinating medical therapy management services. The pharmacist, leading a team of clinical pharmacists, receives requests from the case manager (nurse) or nurse practitioner who participates in a member's ICT for a medication review based on defined criteria or triggers identified during initial assessment/reassessment or transition. Outreach to members and providers is included as part of this review process. Some of the triggers for pharmacist review include a high volume of medications, additional medication therapy needed, multiple medications in the

same category, and a prescription for high-risk medications that could lead to adverse events such as falls. The clinical pharmacist participates in the ICT based on members' individual needs identified during completion of the member's assessment/reassessment or by request from an ICT member. The clinical pharmacist is also responsible for various operational or clinical aspects of the pharmacy program including prior authorizations, Medicare MOC, MTMP initiatives and DUR programs.

MOC 2C: Individualized Care Plan (ICP)

MOC 2C.1: Essential components of the ICP

The ICP is developed using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines (CPG) that may be used during the care planning process. The ICP includes prioritized goals (long and short term) that consider the member's self-management goals, personal healthcare preferences, and desired level of involvement in the case management plan. The ICP also includes services designed to meet the member's needs, and the role of the member's caregiver as necessary. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase the member's investment in their successful completion of the ICP. Goals include target dates for completion and are included in the ICP within the case management system.

When a member's goals are not met, the case manager assesses the possible reasons with the member and as appropriate, other members of the ICT. The case manager reviews the ICP with the member/caregiver to update the goals and barriers to meeting goals, in order to remain current with the member's life-stage and current health status.

If there are identified barriers to achieving goals, the ICP is revised to include actions designed to remove the barriers. The case manager may schedule a call with key members of the ICT to help revise goals or may schedule a case conference to address any complex care needs.

Updates to the ICP are communicated in the same manner as the initial ICP (primarily electronically), with copies provided to the member and other ICT members when needed.

Delegates may establish additional processes or may have unique systems that create the ICP which may be a clinical treatment plan. Policies and procedures are required by each delegate to document how the requirement is met and how the information is communicated to the member.

MOC 2C.2 & 3: The process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change and the personnel responsible for development of the ICP, including how the beneficiary and/or caregiver(s) are involved.

Case managers (Physical or Behavioral Health) are responsible for developing the initial ICP working with the members of the ICT, which includes the member and the PCP, as determined by the CM. The

case manager is responsible for documenting the ICP within the case management system. The member and/or caregiver consent to be in the case management program and additional consent (verifying understanding and agreement) is also obtained for the ICP. The member may also choose to opt out of any case management services during their HRA or the ICP processes.

A case manager may be a registered nurse, licensed behavioral health clinician, or licensed clinical social worker (who works with members who have a mental illness or substance use diagnosis). A minimum of three years of clinically-related experience is required.

In collaboration with the member and/or caregiver and other ICT members, the case manager creates the ICP and reviews the actions with the member. When the member cannot be contacted to collaborate in the ICP creation, the case manager will create the ICP based on information available within our case management system, targeting high priority items of preventive care and managing transitions. The copy of the care plan is available for the member through the member portal.

Periodic outreach attempts are continued through the predictive dialer system or mail. In addition, the member continues to be stratified through our case management process and additional outreach will occur.

Assessment information, including feedback from members, family/caregivers, and, in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include, but are not limited to:

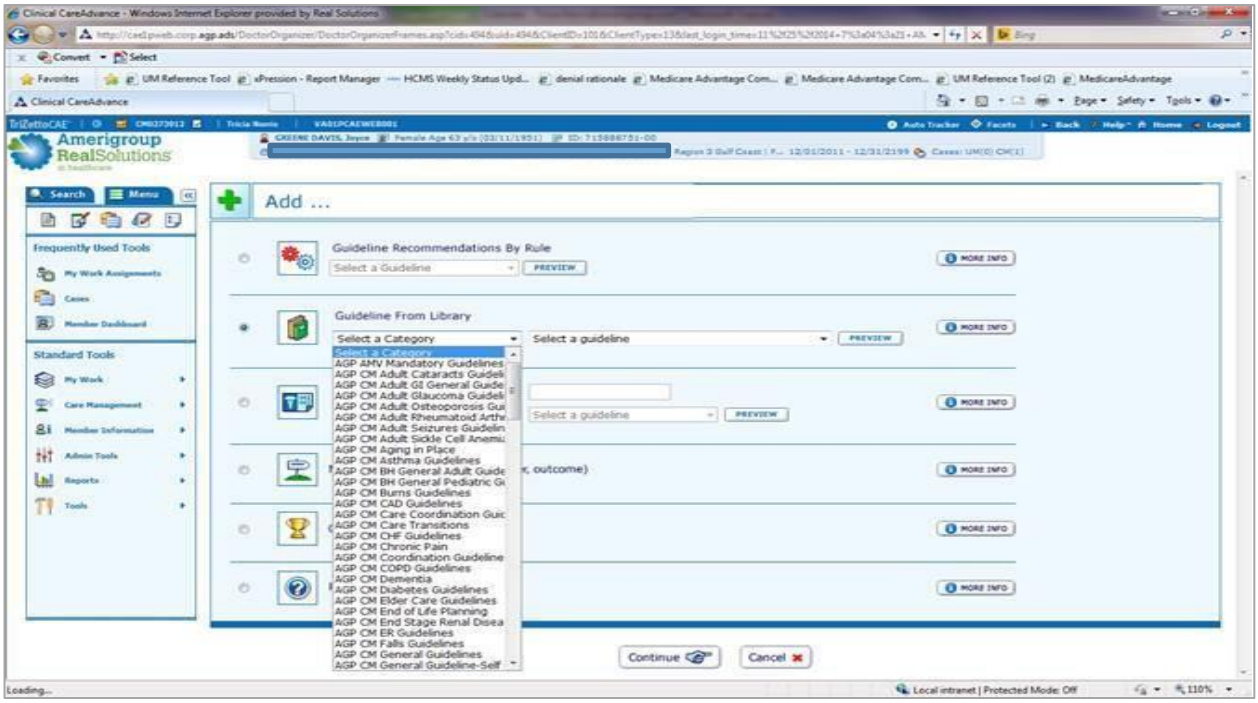
- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Co-morbid conditions
- Medical/psychological/functional complications
- Health education deficits, including preventive services
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers, or potential barriers, to meeting goals or complying with the case management plan

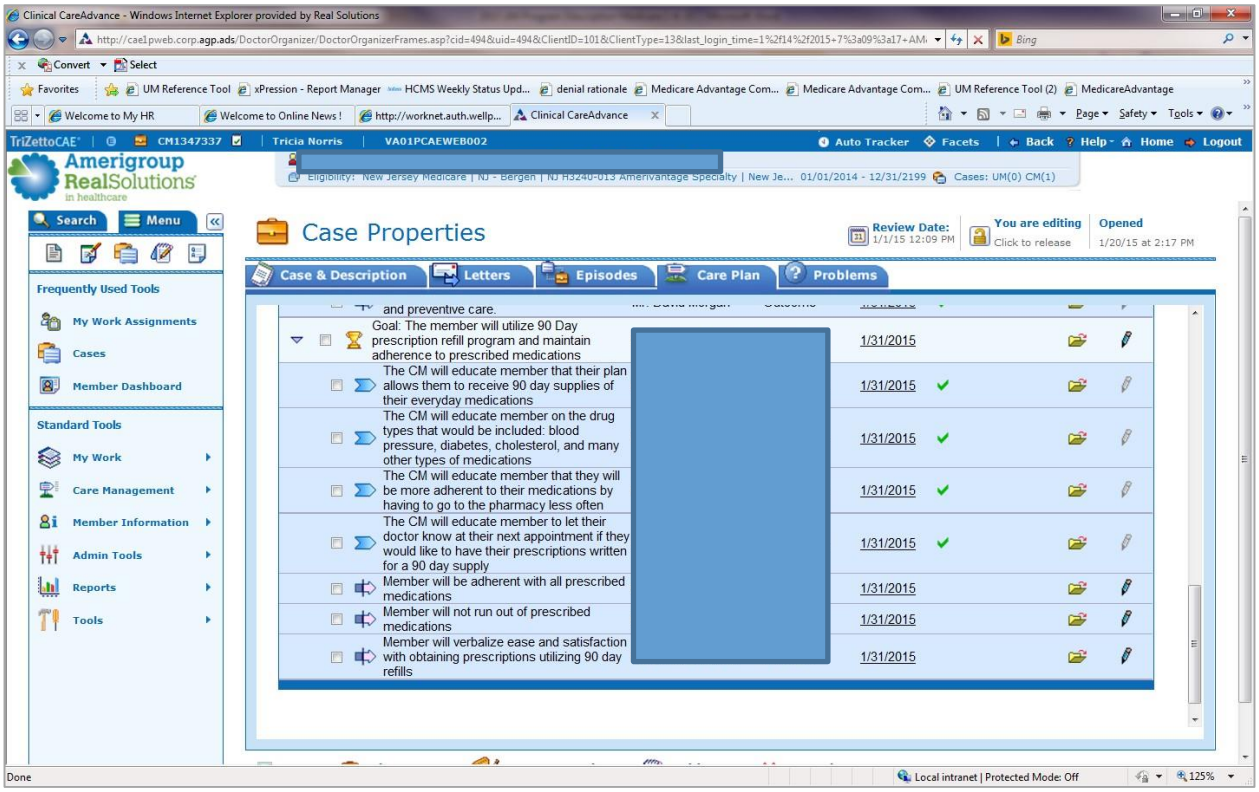
After the problem list is developed, the case manager works with the member, caregiver, healthcare providers, and other members of the ICT to develop interventions which support achievement of the health goals. The case manager determines the frequency of interaction, to review the care plan, based on the member's complexity and stratification level; documents this in the notes and sets a task in the case management system to schedule the next follow-up with the member. The ICP is reviewed at a minimum annually, whenever the member experiences a change in condition or status, or when ICP goals are achieved or require revision.

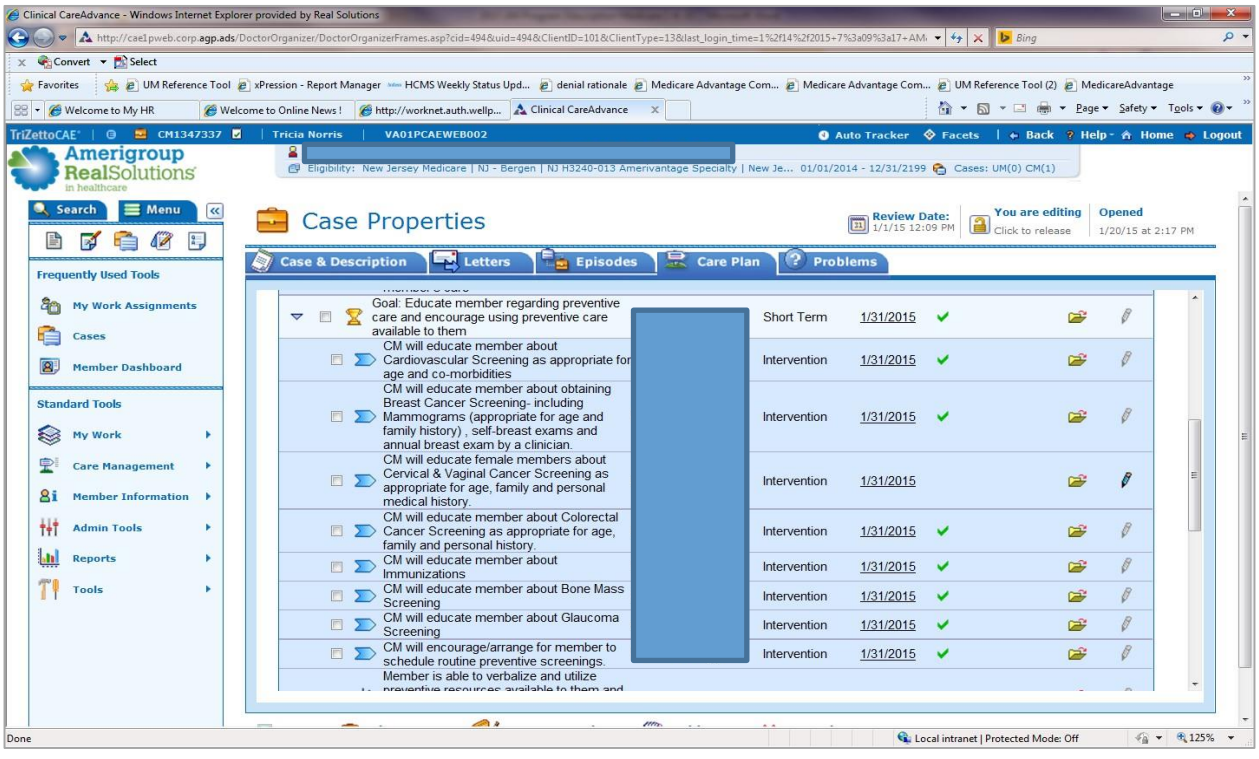
The range of potential interventions is lengthy, but most fall into one or more of the following general categories:

- Health education
- Interpretation of benefits
- Community resource referrals
- Facilitating referrals to other health organizations
- Post-discharge service authorizations and member outreach (e.g. DME, home health services and coordination of physician appointments)
- Service coordination
- Medication reconciliation review
- Assistance in developing a self-management plan
- Community-based services (e.g. home or hospital visits)
- Provider-based Intensive Case Management (Behavioral Health)
- Special needs program interventions
- Ongoing assessment of barriers to meeting goals or complying with the case management plan and interventions to address those barriers
- Referral to other physical and behavioral CM programs

To assist in the development of the care plan, the case management system provides certain recommended guidelines or interventions based on the answers provided in the HRA. Diagnosis-based standard care plan templates are available and can be customized based on the member needs. Some of the standard available and relevant care plans are: diabetes, transitions, preventive care, CVA, dementia, ESRD, fall risk, maintaining independence in the home, incontinence, CHF, and chronic pain (see examples below). This is just a sample of the available care plans, the list is lengthy and allows the case manager to customize the ICP based on the needs of the member.







Engagement techniques, such as those derived from Motivational Interviewing techniques (Miller and

Rollnick, 2012) are part of the training program for case managers. These techniques help the Case Manager to assess and influence member motivation and readiness to change and, once the case management plan is formulated, may increase the likelihood that members will accept responsibility for making changes in health behaviors.

ICP Guidelines Development and Updates: To ensure care planning guidelines address the needs of the special needs population, the global care guidelines are used to determine the level of review required based on the severity of the member and unmet needs. The goals of the Global ICT guidelines are:

- Streamline the ICT review process allowing more intensive reviews/rounds on members with unmet needs or higher complexity Establish protocols for the team to use as the ICT review when the member is stratified to be low complexity and has minimal needs or the needs are resolved during the initial review process by the case manager
- Streamline the review process by providing a set of standard interventions based on low complexity and minimal needs as identified by the clinician (Case Manager) after reviewing the HRA results and the history.

The global guidelines are applied to the member interactions and incorporated into the ICP by the case manager.

MOC 2C.4: How the ICP is documented, updated and where it is maintained

All ICP related documentation is maintained in the case management system and is, accessible to members and ICT team members, including providers through M360 and P360. As with the HRA, the ICP is available, upon request, to members/ caregivers, and ICT members, including external ICT members, electronically or hard copy (by email, fax or mail) n accordance with HIPAA requirements.

Depending on the documentation guidelines of certain targeted programs, care plan interventions may also be documented in the assessment section and/or the progress notes. Members receiving Medicaid services such as MLTSS may also have a Medicaid record with protocols and processes put in place to meet the regulatory and care needs of that program. All of the case managers utilize the same system, have access to both the Medicare and Medicaid records and are responsible for monitoring the care plan and documenting interventions when interacting with the member.

The longitudinal member record is housed in M360, our internal repository for the HRA, ICP, ICT notes and actions, notes from member discussions, transitions information, pharmacy data, claims and authorizations , care gaps, risk stratification results, correspondence and other pertinent clinical information. .As previously stated, our case managers have access to M360 via a link in our care management system. Within M360 is the dashboard, which provides an easily accessible view of the information that has been pulled from various other internal systems. Patient360 (P360), is available to members and providers via the Member and Provider Web portals. Members have access to their HRA results and their ICP, while providers, that are part of the ICT, have access to review the entire longitudinal health record.

The Case Management process is a continuous process of delivering and monitoring interventions designed to meet the ICP goals as well we ongoing assessment of progress toward achieving those goals.

The ICP is an evolving document that may be re-evaluated and updated based on the member's level of progress. As part of the monitoring process, the Case Manager:

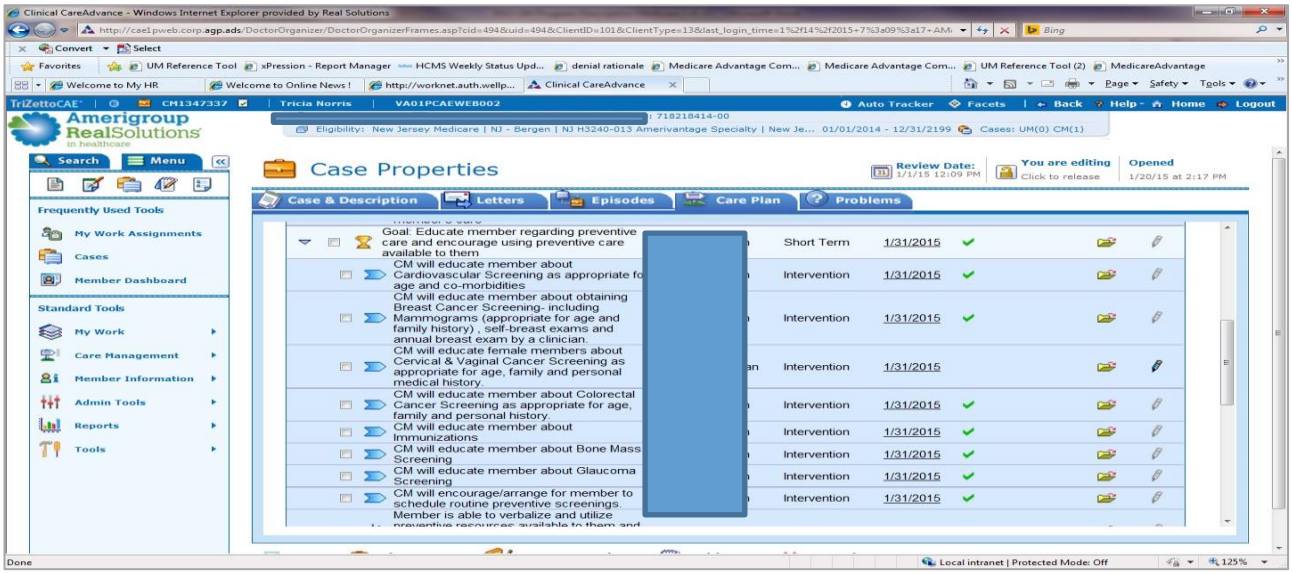
- Maintains communication and collaboration with the member and family/care givers (as appropriate) in order to monitor the member's health status and progress toward meeting treatment plan goals.
- Maintains communication and collaboration, as appropriate, with the member's PCP, other treating providers, and other members of the ICT to assess progress in meeting the ICP goals. Providers are advised of any significant updates to the ICP.
- Monitors the evolution of the ICP and the member's progress in relation to relevant clinical guidelines and makes adjustments as necessary.
- Monitors changes in the member's health status and progress in meeting ICP goals, and assesses to identify barriers to meeting goals or complying with the plan.
- Follows-up at the next scheduled contact to determine if members act on referrals.

MOC 2C.5: How updates and modifications to the ICP are communicated to the beneficiary and other stakeholders

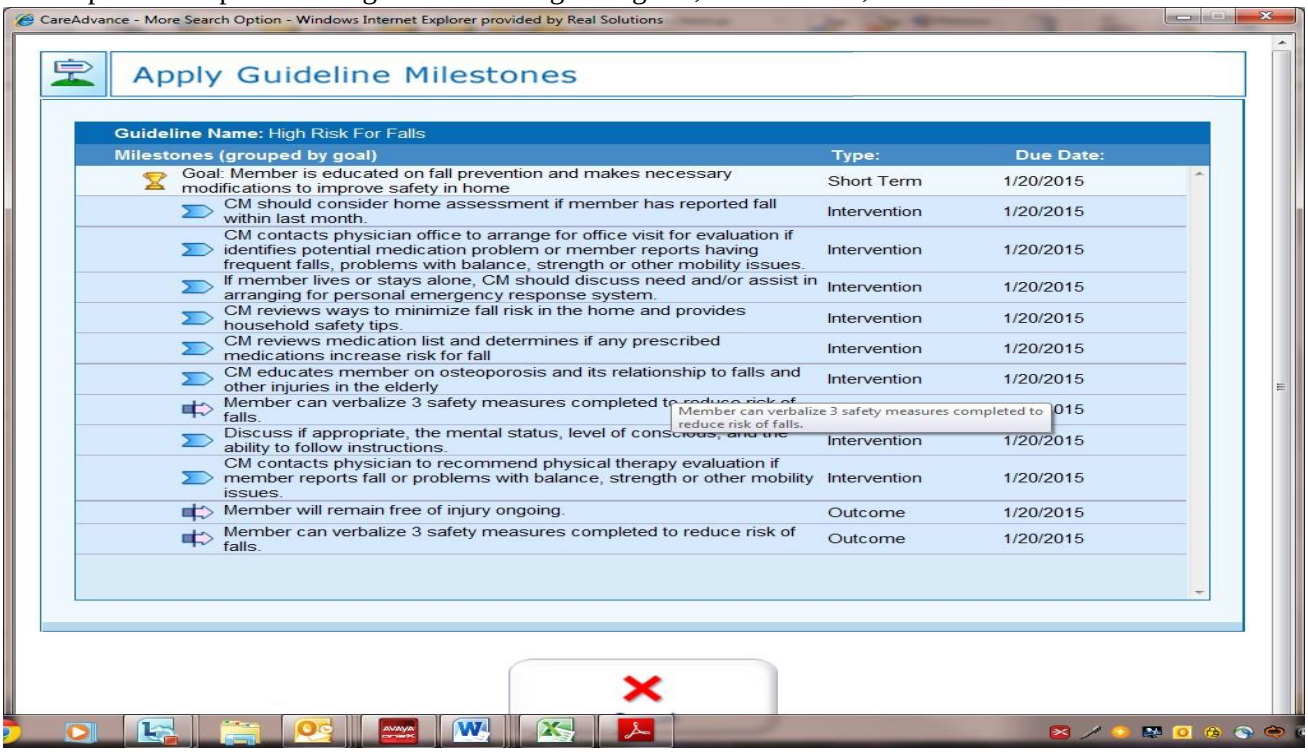
The case manager maintains the ICP within the case management system and communicates the updates as needed, verbally, hard copy or electronically to any or all members of the ICT. Changes in the member's health status will impact the ICP and thus will be updated to align with these identified changes. As previously stated, P360, available through the member and provider portals, contains the current ICP. During conversations with the member or providers, the case manager reinforces the availability of the materials available on the portals. Sample ICP screenshots are provided below to demonstrate the ability to update the ICP.

At a minimum, the care plan is reviewed and updated annually. A care plan that has been implemented for a member is updated but maintained in an open status to allow the ability to see historic information. In the annual provider training, available on the provider portal, includes messaging on the readily accessible member information through the provider portal, including but not limited to; HRA results, care plan and other information to assist them in the care coordination process.

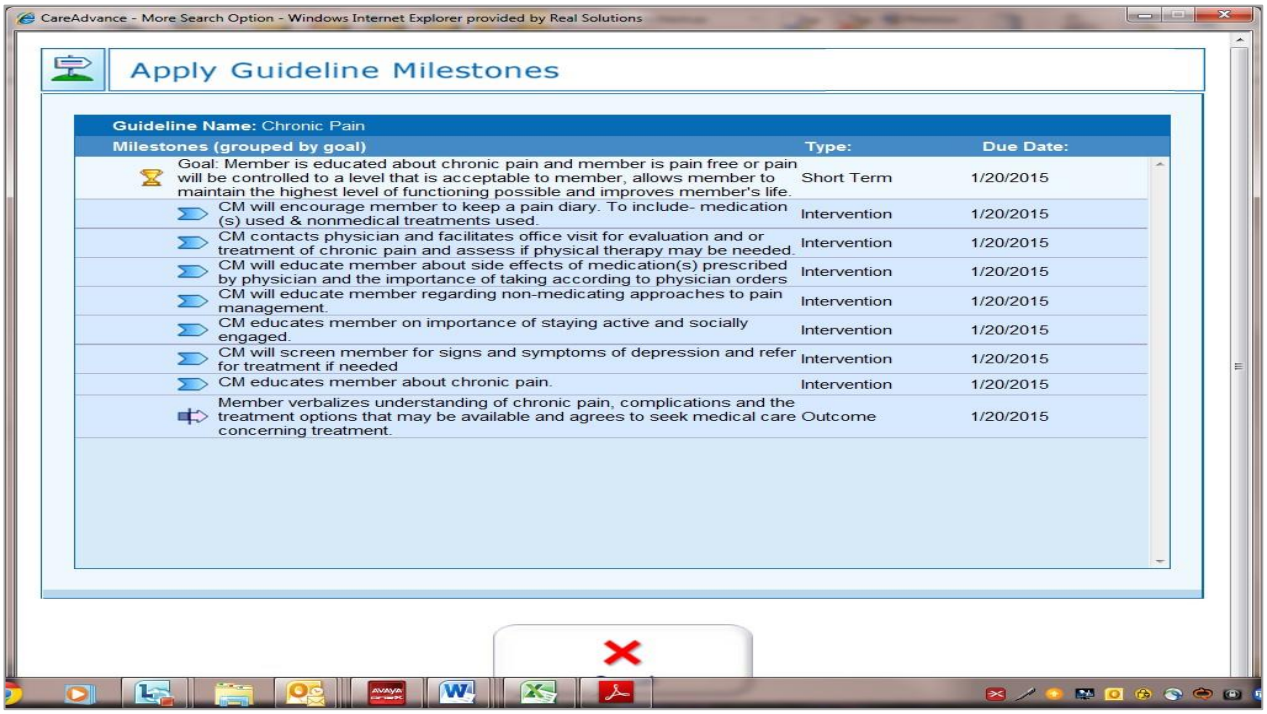
Example from a member ICP



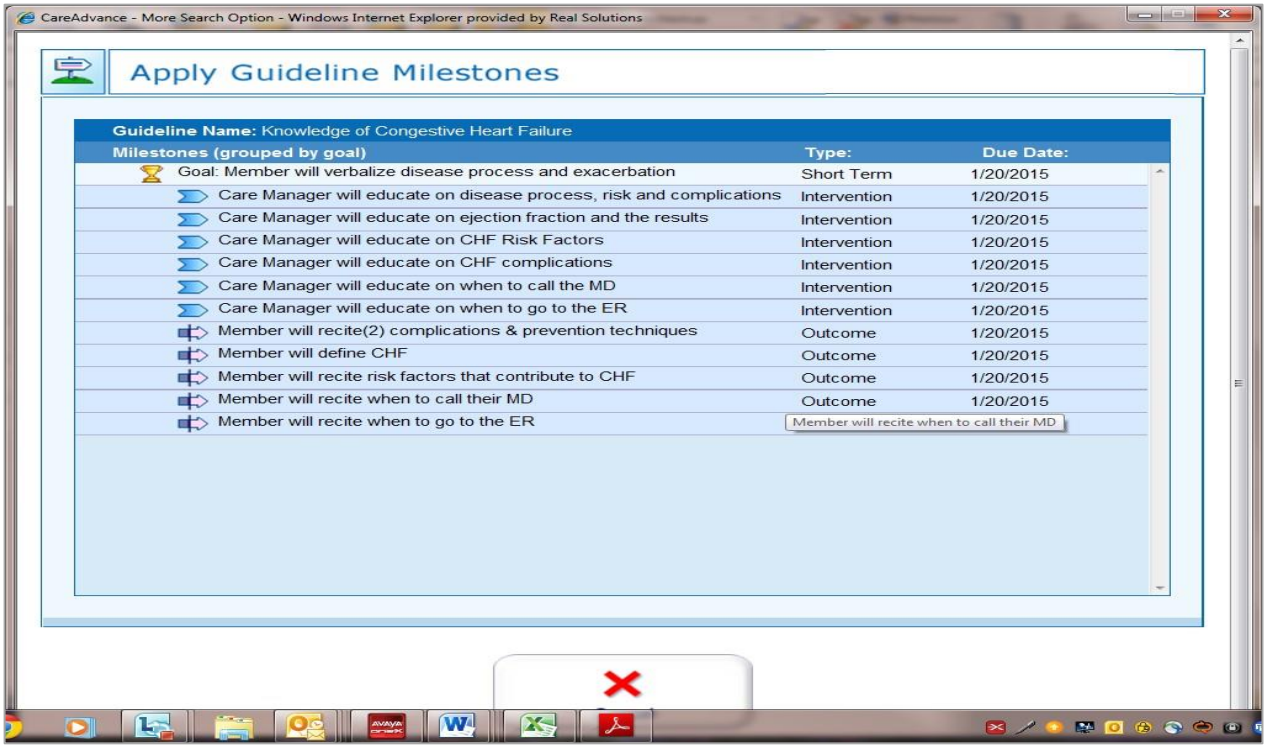
Example of care plan showing short term/long term goals, interventions, and outcomes



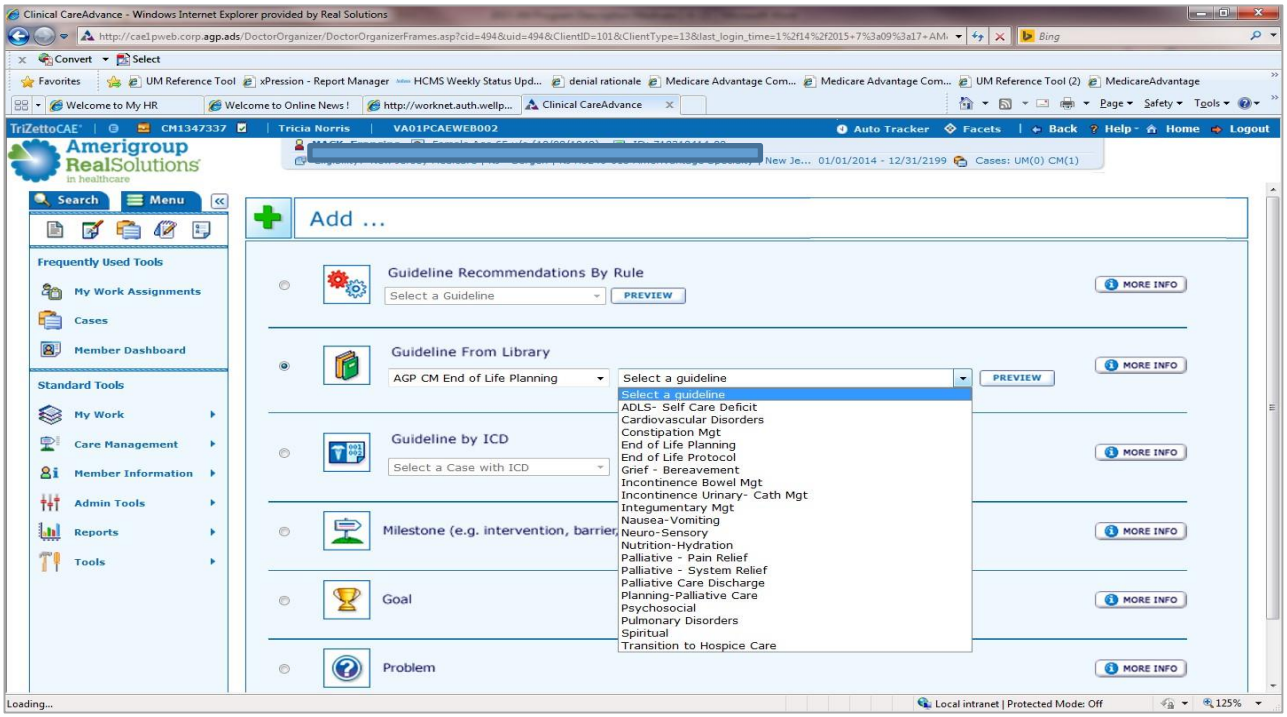
Chronic Pain Guidelines



Knowledge deficit in diagnosis of CHF Guidelines



ESRD



MOC 2D: Interdisciplinary Care Team (ICT)

MOC 2D.1-3: How the organization determines the composition of ICT membership and how the roles and responsibilities of the ICT members (including beneficiaries and/or caregiver(s) contribute to the development and implementation of an effective interdisciplinary care process and how ICT members contribute to improving the health status of SNP beneficiaries.

The ICT, a multidisciplinary team, may include any of the following based on the complexity and needs of the member: medical representative including physician, behavioral health (mental health/substance use) representative, pharmacist, social services representative and other practitioners as determined by the member's needs, medical conditions, support system, caregiver needs, HRA results, and other criteria. The PCP, or the provider identified by the member to manage their care, is always considered a member of the team, since they are responsible for coordinating the member's medical care. The case manager works closely with the identified provider via phone, fax, and/or in person during the care planning process as necessary, to assist the member and their provider with care coordination. The member or the member's caregiver is part of the ICT.

The ICT meetings may take place telephonically, electronically or in person. Meetings are scheduled at a time convenient to the member/caregiver. When the member requests to attend the telephonic ICT, the case manager contacts the members, as well as providing copies of materials as needed. However, the case manager typically represents the member/ caregiver during the meeting. The case manager, may

also meet with the member in the home, physician's office or in a facility depending on the structure of the program.

Prior to the first ICT meeting, the consent to participate is obtained, HRA completed and initial ICP started. Based on the results of the HRA and the member's claims and authorization history, the case manager develops the problem list. The member is encouraged to set some of their own goals and identify any needs including those cultural beliefs that may impact their ability to achieve the results. The ICP is created with the member to address the member's specific needs, (e.g. preventive testing/screening, medication information, condition specific education, and specialized programs to fill gaps in care such as the post discharge or case management program). The case manager uses evidenced based guidelines from the Healthwise Knowledgebase database, claims data, and care plan elements to monitor outcome completion. The ICP is used as the centralized tracking document to monitor completed and open goals/ outcomes. It is the case manager's responsibility to maintain an accurate ICP. During the course of the member's engagement in the program, the ICP is updated and revised, based on member needs, including adding and deleting goals and outcomes. The ICP is available to all members of the ICT via the case management system and/ or M360 and P360.

At a minimum, there is an annual presentation and/ or review/update of the ICP that may take place telephonically or electronically. Additional rounds may be scheduled when the case manager determines the ICP requires review and updates dependent upon a significant change in the member's condition. ICT meetings or assessments may occur during inpatient or skilled nursing facility admissions during the discharge planning process. Members of the team may come together or have discussions to facilitate a transition to another level of care. Meeting notes are documented in the progress notes within the case management or utilization management systems. Members or network providers are informed verbally of meeting dates, times and methods for participation if there is a desire for attendance at the rounds. Most frequently the ICT rounds are managed internally and any feedback from network providers gathered during the care planning process is communicated on the provider or member's behalf.

The clinical pharmacist participates in the ICT rounds, as necessary, to provide medication related recommendations. Established on defined criteria or triggers addressing medication indication, effectiveness, safety and member's adherence to prescribed medications, the case manager will request a clinical pharmacist's consultation for a medication review. The clinical pharmacist prepares a medication summary and recommendation letter that is sent to the member's PCP as well as maintained within the case management system. Additional follow up is completed as needed when additional pharmacist intervention is required.

Behavioral health (BH) case managers participate in weekly rounds with the medical team. In addition, they are available to consult on any identified behavioral health treatment needs Dependent upon the ICP, the BH case manager will collaborate with the medical case manager, or the BH may assume primary responsibility when the BH needs are primary importance.

Inpatient concurrent reviews include multiple ICT members including: Medical Directors, CM and UM Clinical Managers, UM & CM Nurses dependent upon specific case, Social worker/discharge planner

representing the facility, attending physician if available otherwise facility representative will present physician notes from the inpatient record and other disciplines as needed.

Reports are available to identify that a case has been presented at least annually to the ICT. This report is monitored monthly, at a minimum, to verify compliance. This report can be generated at any time to monitor progress and are reviewed as part of the program evaluation. Notes from the discharge and complex case review rounds are documented in the notes section of either the UM or CM systems but depending on the program design may be documented on an internal secure site.

All delegates are required to have policies and procedures to outline the process followed and reporting is monitored to verify meetings have occurred. Delegates are expected to verify the processes in place to meet the core requirements but many are in a unique position to meet directly with the member during an office visit or assessment process. Documentation may be in a medical record that would be produced during any audit or during delegation oversight activities to demonstrate compliance with the requirements.

MOC 2D.4: How the SNP's communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange

The ICT meets in several different ways including discharge and high risk rounds, individual discussion, and designated meetings with providers or other disciplines.
As the leader of the ICT, the case manager is responsible for initiating and maintaining communication with ICT members and for documenting ICT member participation in the case management system. ICT rounds typically have a recurrent meeting schedule maintained within *Outlook* and communicated to all participants. If an ad hoc or urgent case discussion is required, the case manager will schedule off cycle meetings for internal ICT members. If there is a need or a request for an external stakeholder such as a provider, member, care giver or other external participant, to attend the ICT, the CM will notify the participant, through phone calls, emails and if necessary, mailings,.

Upon completion of the ICT meeting, the case manager is required to enter a progress note into the case management system's Electronic Health Record (EHR). The case manager documents; the attendees' present, attendees' feedback, actions or recommendations, and any follow up requirements. As previously stated, the ICP and notes are readily available to members and providers. By having access to this level of data, the members of the ICT work together to develop the patient centered ICP, manage transitions, address gaps in care, and determine the most appropriate care path for each member. Also, as previously stated, upon request, copies are available via mail, fax, or electronically per HIPAA requirements.

Because the PCP or attending physician is such an important member of the ICT there may be a need for ongoing communication by the case manager with the provider that does not require a presentation to the entire team. The case manager is the point of contact for the member and provider while the member is engaged in complex case management. The case manager contacts the member to continue working towards meeting ICP goals at defined intervals. During these interactions, if new needs are identified the

case manager will reach out to the providers to resolve issues. Updates are made to the care plan, when applicable. The case manager, assigned to the member, is responsible for preparing the case for presentation at rounds and verbally giving a report to the team members incorporating results of the HRA, applicable clinical information, recommendations from other team members such as network providers, PCP, home health agencies, pharmacists or social services are provided during the rounds. Documentation of the ICT team meetings, issues identified and actions planned or executed are documented in the case management system. The case manager is responsible for documenting the results and ensuring any follow up takes place.

Members who have hearing impairments, language barriers and/or cognitive deficits receive the intensity and type of assistance required to participate in the ICT and ICP development. The case manager is responsible for arranging translation services including sign language, member's preferred language, TTY technology all that are available via the health plan, in order to verbally review the ICP with the member / authorized representative. When a care giver, family member, or other person is the designated representative for the member, the case manager works directly with that point of contact to gather information and develop the care plan. Translation services are available using a language or translation line. Some internal case management teams hire bilingual case managers to assist those members that have language barriers.

MOC 2E: Care Transition Protocols

Assisting with the management of transitions is an important part of our case management program. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided at many touch points and through educational materials. A team approach is necessary to assist the member with a successful transition.

MOC 2E.1: How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries

Transitional care management includes a comprehensive set of protocols that include logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both receiving and sending health care information during the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider partner in ongoing health care management with goal of providing access to high quality, cost-effective medical care. The PCP or the designated provider, including a specialist, has the responsibility f to coordinate care for the members, while the members of the ICT, especially the care manager collaborate with the PCP/ identified provider, to help ascertain important health information is shared between care settings. We have multiple processes in place to assist the member with these transitions or to interact with the providers. Protocols attempt to establish a smooth process that results in transitions that have the least amount of disruption and provide an environment of positive member outcomes.

Prior Authorization Process and Utilization Review: The goal of prior authorization is to assure that members are treated in the most appropriate, least restrictive and most cost effective setting, as determined by the severity of the illness and/or the intensity of the services needed to contribute to an improved health status relative to the specific condition. Evidenced based guidelines are used to review and determine the appropriateness of the care being requested. The ICT has access to the member's history, as published in our clinical systems.

When a member is admitted to an inpatient facility the utilization review team is responsible for reviewing the admission against the evidenced based guidelines to determine the most appropriate level of care and immediately initiate discharge planning to assist in facilitating the transition to the next appropriate level of care. This team works closely with the facility discharge planning and social work team, the attending provider, the case management team and the Medical Directors to assist in the execution of the plan of care. An evaluation occurs during the transition planning to determine if there is a need for more complex case management or enrollment into any of our external or internal clinical programs is needed. Designated rounds are held to discuss complex discharge needs and care planning. These ICT rounds include members of the internal care team and feedback is obtained from external providers and others responsible for the care of the member.

Case Management services are available at a level determined appropriate to address the specific needs of the member based on the program definition and includes any of the following programs: vendor programs, early intervention assessment and care coordination, physical and and/or behavioral complex case management, and post discharge care management. The early intervention team is responsible for completion of the HRA and annual reassessment and facilitating transition management with the member and provider. The case manager assists the member with any existing transitions as well as provides education on how to manage transitions between providers and during admissions and discharges. The relationship with the primary care provider is reinforced with the member since he/she is the primary point of contact to assist with transitions. In addition, the member is informed the health plan's member services department as another area that can assist with transitions. When a member is enrolled in complex case management, the case manager assists with transitions and coordination with the provider offices. This includes transitions between providers, outpatient or inpatient services, ER visit, and between health care facilities, or return home. Through our internal post discharge program, members identified at risk for a readmission, are contacted post discharge by a case manager or transition coach, to enroll them in our short term (30 day) post discharge care program. The components of the post discharge care program may include any of the following (based on the member risk level):assessment of any triggers for readmission, identification of red flags related to the condition, health education and promotion of self-management skills, medication reconciliation and ensuring follow-up care is provided. If the member is involved in the transition program where we have partnered with some of our acute care facilities the interaction with the member includes a visit prior to discharge. The goals of our transition coaches is to build member skills and provide tools to support self-care and focus on the member's goal. Additional actions include a home visit and three (3) phone calls during the 30 days post discharge. Some other transition management actions that case management may provide to the member include any of the following:

- Identify that a planned transition is going to happen

- Collaborate with health care professionals involved in the care of the patient; ensure the patient's providers are notified when applicable or provide information to the provider of care concerning the primary care provider contact information
- Work with the patient to ensure he or she is coordinating care with the primary care provider
- Support the patient and/or care giver through the transition by communicating and assisting with needs, including community resources
- Modify the care plan based on the care provided during the transition or needs created as a result of the transition
- Assess the member for any new health or social risks
- Assist the patient with coordinating referrals and follow up care
- Ask the member if any new medications were prescribed and obtained
- Make referrals to other programs such as Complex Case Management (CCM), Long Term Services and Supports (LTSS) or other vendor programs

Support during Inpatient Confinements:

Our utilization review team follows a member during a hospitalization and assists with any transition to another level of care. The discharge planning begins at admission when the utilization review nurse coordinates with the facility discharge planner, the case management team, or the receiving facility (if transferred) to help facilitate a smooth transition. Information about the patient's history on authorizations or other services that have been provided and/or available to the member including any benefits that may be available, or benefit limits that may create the need for an alteration in discharge planning. Communication is the cornerstone in both coordinating and facilitating the next level of care.

MOC 2E.2: The personnel responsible for coordinating the care transition process

Members are asked to select a PCP when enrolling in a D-SNP plan and may request a change to their selected PCP at any time. The PCP is the member's central point of contact for medical care. The PCP is responsible for referring members to appropriate network provides, obtaining precertification and managing transitions. If the plan structure does not require a PCP selection, the member is asked during the assessment process to identify the provider they use to coordinate care which may be a specialist managing the primary medical condition. The term PCP used in this section will represent the main provider of care which may be the assigned PCP or the primary provider of care. The member is always encouraged to have a primary care provider regardless of the plan design.

The Case manager is available to assist the PCP in managing transitions in care. As required, the case manager may collaborate with other members of the ICT to assist with care coordination. The Case Manager is available to assist with the coordination of care, including but not limited to helping the member schedule follow up visits, following up to ascertain the visit was completed, assisting in coordination with appropriate community resources, and assisting with transportation needs. The membership of the team varies based on the complexity of the member's needs, member preferences, and type of transition. The member and/or caregiver are kept informed during all steps of the transition, as

necessary. Members of the ICT have access to the entire member's health information to reference during the care coordination via Member/Patient360 application. Communication between ICT members, including physician to physician is included for tracking. Members enrolled in case management services may directly access their case manager to assist with coordination of care including making appointments. The member services department is also accessible to the member and will assist in making appointments. Coordination with Medicaid services includes coordination with Medicaid case managers/service coordinators and providers of long term services and supports (LTSS) to further close care gaps. In the annual provider training on model of care, access to the provider portal is reinforced and the role of providers in managing transitions is reviewed. Information on how to contact the case manager or make referrals for services or to request assistance with care coordination.

We assist members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent how our case managers work with our providers and members during enrollment in a case management program to coordinate care and assist in the management of transitions:

The customer service department is an integral member of the care transition team and is most likely the first internal point of contact for the member when outreach is made. The phone number listed on the member identification card connects the member to one of our representatives specially trained to manage our dual population. The representative has the ability to provide information on benefits, assist with providing information concerning network providers and connect the member to other resources internal and external. In new member materials, transition information is provided to all new members which includes a check list to assist with provider communication and transition management and reinforces the customer service department is available to assist with transition. This form is also available through the case management department.

MOC 2E.3 & 4: How the organization transfers elements of the beneficiary's ICP between health care settings when the beneficiary experiences an applicable transition in care and how beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.

Providers are expected to communicate the medical treatment plan to the member and/or care giver and to the receiving person or level of care through verbal discussions, written or Electronic Medical Record (EMR) (care plan, discharge plan, medical orders) to provide the required health information to prevent gaps in care. The providers should be sharing information related to tests results, medical notes, medication records and treatment plans when his or her patient experiences a transition. For provider groups that maintain EMRs and are part of a hospital or provider network, this sharing of information is provided electronically. Other ways of sharing information may be through verbal or paper copies of applicable information.

Internally, our care management program assists in this process by providing information to the members and the providers through our Patient360 program. Patient360 is a longitudinal member record that is available to members and providers via the Member and Provider Web portal. The provider application provides access to the HRA results, risk stratification results, ICT notes and actions, ICP, pharmacy data,

transition information, care gaps, certain claim and authorization data, correspondence, and other pertinent clinical and care information. Through Patient360 the provider is notified of transitions the member experiences including any inpatient admission at the point we are notified and transitions from inpatient to other settings including home, skilled nursing facility, and long term acute care facilities. Members have access to the HRA results and the care plan.

As previously stated, upon request, paper or electronic copies of any documents related to the member's health care, including but not limited to: HRA results and ICP.

Multiple programs are in place within our care management program to coordinate care, provide supportive care and collaborate with providers and members assisting in the management of transitions. The following actions are taken at a global level and provided to all members concerning managing transitions. Information is available on the member portal, through member newsletters, and communicated in the required annual distribution of member materials. This information includes the point of contact available to assist during transitions and educational information on how to communicate during transitions with the providers involved.
All of our programs include actions that address transitional care. A centralized member services department is available, as the initial point of contact for members, to assist with general questions and coordination of services.

Delegated providers or vendors are required to have transition processes in place and meet the intent of the requirements as outlined in the model of care.

MOC 2E.5: How beneficiary and/or caregiver(s) will be educated about the beneficiary's health status to foster appropriate self-management activities.

The providers treating the member are responsible for providing information about the conditions and the treatment options as well as changes in their condition. Internally, when a member is in our case management program, the case manager incorporates self- management activities into the care plan. During care planning, information about the member's health status, such as determination on recent falls, functional limitations including ability to complete activities of daily living, schedule of provider visits for follow up care, onset of new conditions and/or behavioral health issues, and preventive care gaps are all considered and assessed. When identifying a problem list, self-management activities such as understanding and obtaining preventive care, need for educational classes or providing educational material, chronic condition management, and need for follow up care are all examples of tools for self-management. Our case management system makes Healthwise Knowledgebase clinical information available to the clinical teams for use when providing educational information. This ensures we are providing consistent information and evidence-based guidelines. Our case managers may also discuss self-management activities with the member or caregiver and/or send member specific educational information by mail, based on diagnosis. The Case Manager will educate members or caregivers on the signs and symptoms to watch for and suggestions for follow up. For example, the discussion with a member in heart failure may include; recommendations of daily weights, documentation of weights, and notification their practitioner when their weight increases by 3 pounds in 1 day. All of the education and member/caregiver acknowledgment of understanding is documented in the case management system in

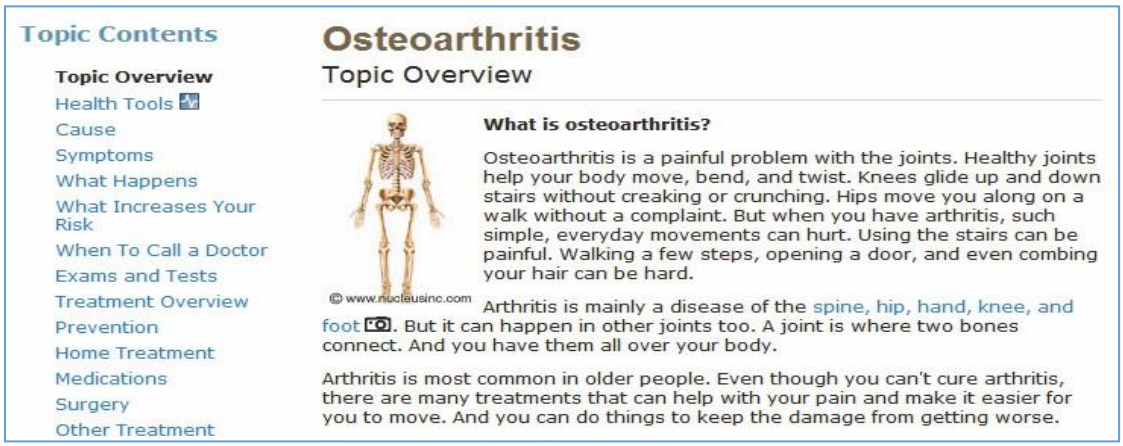
the member's care plan and/or progress notes. In addition, the Case Manager can mail printed material to the member/caregiver and schedule follow up calls.

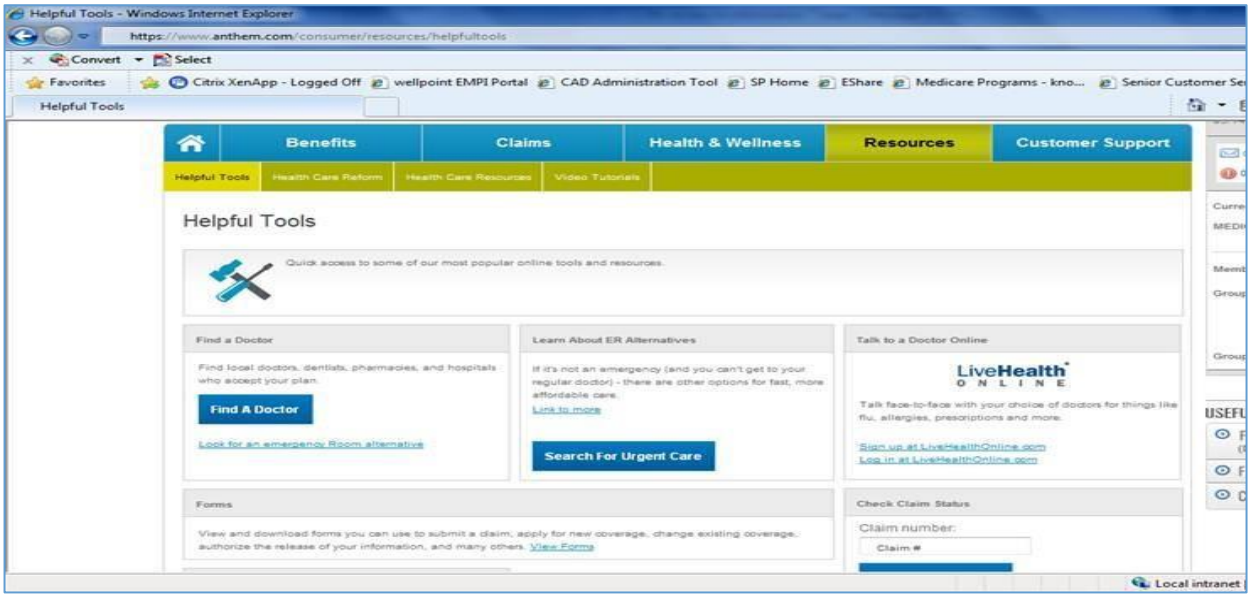
As a supplemental resource tool, members have online access, through the member portal to the Healthwise Knowledgebase. The Healthwise Knowledgebase includes condition related educational material and tools to evaluate risks and health status. These programs provide access to general health and wellness information and tools to assist the members in managing their health status and outcomes. While the information may be displayed differently, depending on which program is available, there is a wealth of information and tools provided to our members. Each of the sections on the knowledgebase are arranged to provide not only medical information but self-help tools. In addition, members have access to a 24/7 Nurse Help Line which provides medical advice to direct members to the most appropriate level of care, provide self-management activities, and disease-specific education.

Below are some examples of the information available through Healthwise Knowledgebase for our members and clinical teams:

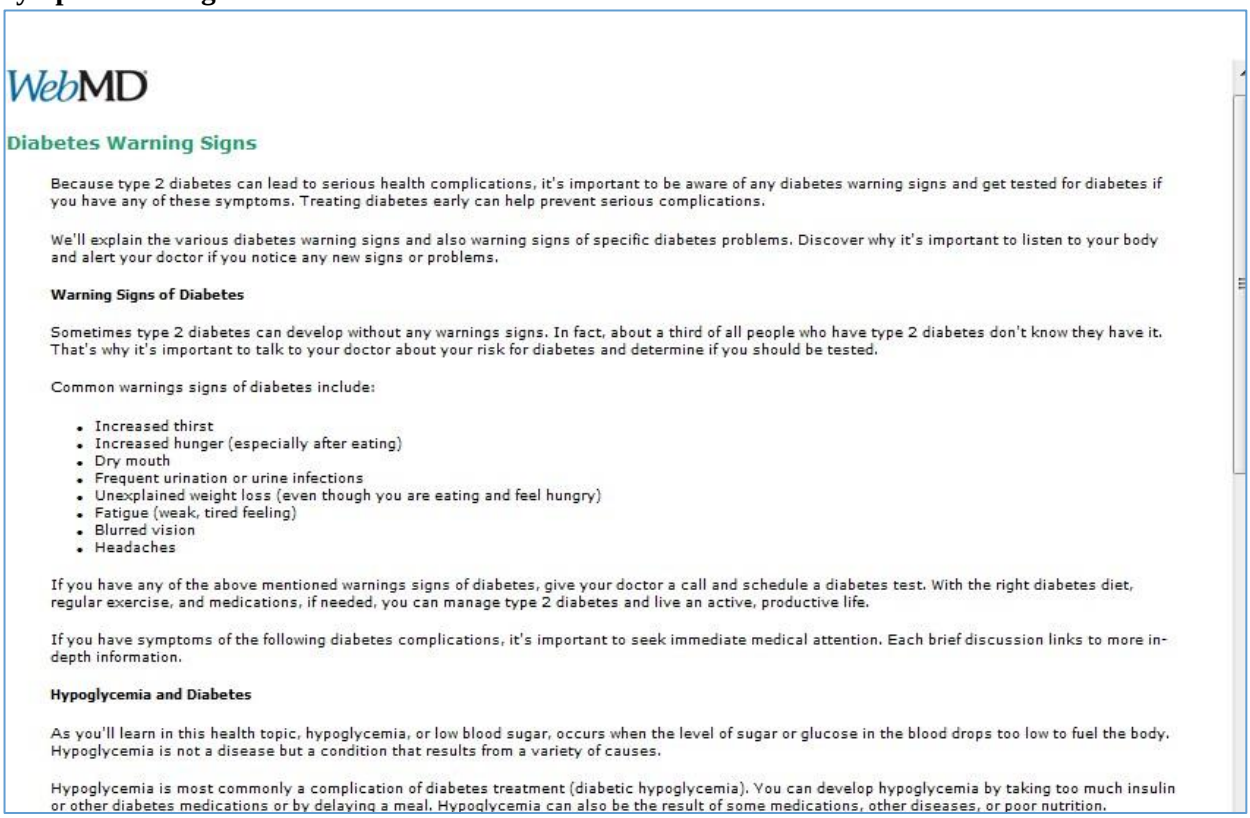
Disease specific information

:





Symptom Management:



WebMD

Diabetes Warning Signs

Because type 2 diabetes can lead to serious health complications, it's important to be aware of any diabetes warning signs and get tested for diabetes if you have any of these symptoms. Treating diabetes early can help prevent serious complications.

We'll explain the various diabetes warning signs and also warning signs of specific diabetes problems. Discover why it's important to listen to your body and alert your doctor if you notice any new signs or problems.

Warning Signs of Diabetes

Sometimes type 2 diabetes can develop without any warnings signs. In fact, about a third of all people who have type 2 diabetes don't know they have it. That's why it's important to talk to your doctor about your risk for diabetes and determine if you should be tested.

Common warnings signs of diabetes include:

- Increased thirst
- Increased hunger (especially after eating)
- Dry mouth
- Frequent urination or urine infections
- Unexplained weight loss (even though you are eating and feel hungry)
- Fatigue (weak, tired feeling)
- Blurred vision
- Headaches

If you have any of the above mentioned warnings signs of diabetes, give your doctor a call and schedule a diabetes test. With the right diabetes diet, regular exercise, and medications, if needed, you can manage type 2 diabetes and live an active, productive life.

If you have symptoms of the following diabetes complications, it's important to seek immediate medical attention. Each brief discussion links to more in-depth information.

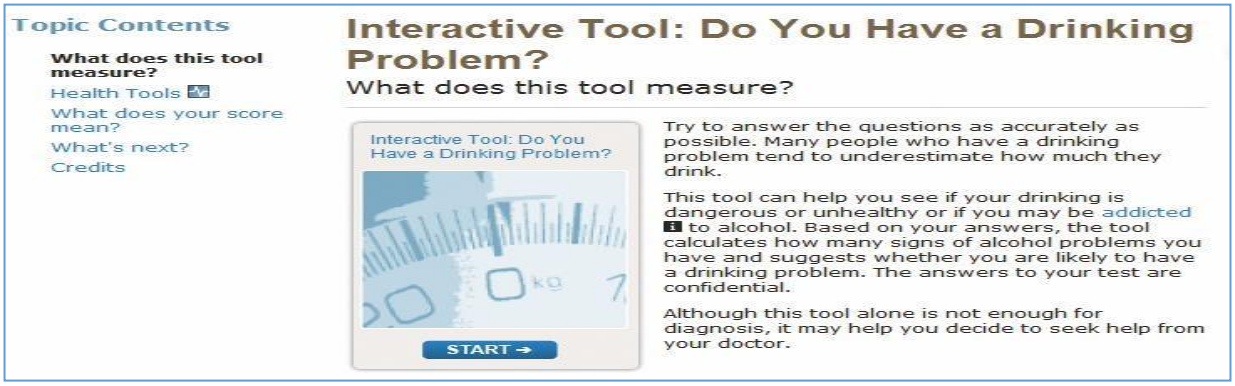
Hypoglycemia and Diabetes

As you'll learn in this health topic, hypoglycemia, or low blood sugar, occurs when the level of sugar or glucose in the blood drops too low to fuel the body. Hypoglycemia is not a disease but a condition that results from a variety of causes.

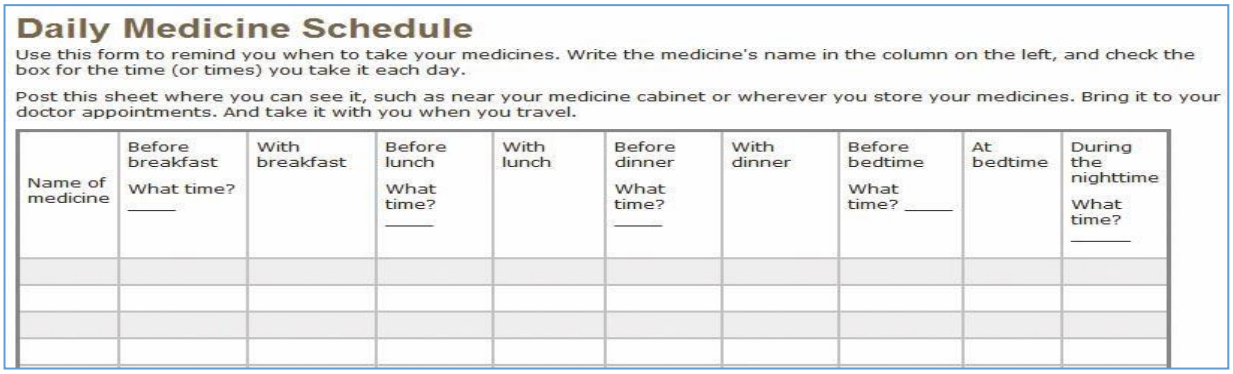
Hypoglycemia is most commonly a complication of diabetes treatment (diabetic hypoglycemia). You can develop hypoglycemia by taking too much insulin or other diabetes medications or by delaying a meal. Hypoglycemia can also be the result of some medications, other diseases, or poor nutrition.

Interactive Tools:

The topic areas include health and fitness & lifestyle checkups



Checklists and Self-Help Tools:
Checklists, diaries, charts, plans, and self-test forms can be filled out online and printed. These tools are designed to help members keep track of their health.



MOC 2E.6: How the beneficiary and/or caregiver(s) are informed about the point of contact throughout the transition process.

The member's/caregiver's point of contact throughout the transition process is the PCP and/or case manager. The case manager works closely with all members of the ICT, especially the PCP as appropriate, and informs the member/caregiver of each ICT member's roles and responsibilities. At any point in the transition process, the member or caregiver may contact the case manager or customer service for assistance. When a member is initially contacted by the case manager, directions are provided about how to outreach if issues are identified. The PCP relationship is verified and the member is instructed to coordinate care through the primary care provider. In the annual member materials the role of the PCP is communicated and the process to coordinate referrals with the PCP. Other health plan associates that may help members throughout various care transitions include:

Member/Customer services staff are available to assist with health plan related questions and/or to transfer the member or caregiver to the correct department (for example utilization management, case management)

Transitional/Post Discharge Care Team supports members in the following ways**:**

- Outreach to members post discharge to minimize the readmission risks
- Identify precipitating factors that led to the admission and address
- Management of medication and reconciliation including education on new prescriptions ordered post discharge
- Follow-up care post discharge including assistance in making the appointment and discussion about importance of coordinating care through the primary care physician
- Red flag management: Education on condition specific factors that may lead to an admission, areas that may signal a change in the member's condition, and when the member should contact the provider.
- Educate member about self-management strategies and chronic medical conditions Provide the member with the points of contact to assist with transition management Assist members in identifying their barriers to care and resolving those barriers.

Early Intervention Team supports members in the following ways:

- Outreach to new members within first 90 days after enrollment and annually for existing members to complete the HRA
- Provide care coordination activities as a result of the HRA and review of utilization data
- Collaborate with the ICT to address needs
- Develop ICP addressing barriers to care, arranging community services, coordinate care needs
- Establish self-management plans
- Provide the member with the points of contact to assist with transition management

MOC 3: Provider Network

MOC 3A: Specialized Expertise

MOC 3A.1: How providers with specialized expertise correspond to the target population identified in MOC 1.

Our provider network consists solely of contracted providers who provide direct patient care services. The majority of our providers are contracted for Medicaid and Medicare. The health plan does not employ providers that deliver care directly to our members. Our provider networks are built and maintained, at a minimum, to meet CMS access standards and the requirements of our membership. Our networks are refined to more strategically target providers that support the health care needs of our population, including our member with special needs. Our providers represent the culturally diverse

backgrounds of our SNP members and are located in our members' communities. The highest-ranking conditions in our population are: diabetes, cardiac, and pulmonary.

Our network of providers includes specialties trained to manage these conditions as well as the special needs of this population. Our provider types include but are not limited to:

- Geriatricians, physical medicine physicians and physiatrists
- Behavioral health (mental health and substance use) providers and facilities
- Cardiologists
- Endocrinologist
- Pulmonologists
- Nephrologists

The provider network also includes facilities and other resources as required including:

- Diabetic educators
- Physician Extenders (Nurse Practitioners and Physician Assistants)
- Dialysis centers
- Home Health Agencies
- Transportation Services
- Durable Medical Equipment companies
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinic (RHC)
- Social workers and nursing professionals available through home health agencies
- Skilled nursing facilities
- Ancillary providers and facilities
- Telemonitoring Vendors

MOC 3A.2 & 3: How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses and how the SNP documents, updates, and maintains accurate provider information

Our health plan maintains credentialing, monitoring and re-credentialing procedures that meet state and federal regulations and National Committee for Quality Assurance (NCQA) standards. There is a monthly process to monitor all credentialed and non-credentialed providers that have an active provider number. This monthly check is against the OIG LEIE (Office of Inspector General, List of Excluded Individuals and Entities), GSA SAM (General Services Administration System for Award Management exclusion records from EPLS), and FEP (Federal Employees Program) Debarment Report. Action is required to be initiated within three business days of confirming there is a match.

We verify the following information as part of our credentialing and re-credentialing process:

- Board certification (preferred) or completion of an approved residency or internship
- Acceptable education and training (initial only)

- Absence of unexplained work gaps of six months or more within the five years prior to application
- Hospital admitting privileges in good standing as applicable
- Current, unrestricted license to practice in the state
- Current Drug Enforcement Administration (DEA) number or Controlled Dangerous
- Substance (CDS) certificate if applicable for the provider type
- Proof of adequate malpractice insurance
- Acceptable malpractice history
- Absence of sanctions by Medicare and Medicaid, and state licensure boards
- Not listed on the sanction, exclusion or debarred provider listings (OIG LEIE, SAM or the state agency Terminated/Exclusion listing

We require that all practitioners and facilities are re-credentialed within 36 months of the previous credentialing decision to identify any changes in a practitioner's licensure, sanctions, certification, clinical privileges, competence or health status that may affect the practitioner's ability to serve our members. The process also includes an assessment of the provider's performance as part of our network

We continually screen our existing providers and monitor our network for Medicare, Medicaid, and state licensure sanctions. Providers are also required as defined in their Provider Agreement to notify us within 30 days or as defined in their contract of any material change in the information including privileges, licensure, and ability to perform professional duties or change in OIG Sanction or GSA debarment status. This regular scrutiny protects us and our state partners from sanctioned providers, supports us in maintaining national certification requirements and enhances our risk management capabilities.

Monthly there is random quality audit of completed files within our credentialing department. The auditor reviews each file in accordance with our policy and any NCQA or other regulatory requirements to ensure compliance with the process. A number of elements are verified and action is taken to correct any deficiencies noted.

Information about the provider network is communicated through an online provider and hospital directory, through a hard-copy provider directory and can be communicated by the Member Services department. We have procedures in place to ensure this information is current and up-to-date. Routine management oversight of credentialing staff includes:

- Supervision of staff's credentialing data review and assessment process to ensure credentialing data meets predetermined criteria.
- Supervision of staff's Board Certification verification process to ensure accuracy.
- Supervision to ensure accurate credentialing data storage and maintenance in credentialing database.
- Regular audits of delegated groups are performed to include oversight of the data collection and verification of issues related to education, training, certification and specialty for those entities to which this has been delegated.
- Designated Credentialing database Reports and Credentialing audits are presented and reported to the National Credentialing Committee.

- Audits by Credentialing Staff of Provider Data Base are performed on at least an annual basis.

All of the internal policies that describe how we perform our credentialing process are reviewed and approved annually.
The following policies and procedures have detailed information on the credentialing and re-credentialing process: Credentialing and Re-credentialing Requirements for Organizational Providers (Facilities and Ancillary providers), Credentialing and Re-credentialing for Licensed Independent Practitioners, Delegated Credentialing, Government Sanction Notification and Ongoing Sanctions Monitoring; Credentialing Monthly File Quality Control Process

MOC 3A.4: How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services

The PCP is responsible for coordinating the member's medical service needs and members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine and preventive care and behavioral health care), which may be accessed directly. The member is educated on the importance to coordinate care through his or her PCP and obtain referrals for routine medical services to better manage and monitor transitions in care, assure clinical services are appropriate and timely and coordinate care. Providers can reach our case management department by calling the number on the member's identification card to speak to a representative. Provider or member services would transfer the provider into the case management area. Using a central phone number is the most optimal way to ensure the provider is linked to the right area to assist in the management of our members.

Provider communication to the ICT is facilitated by the member's case manager. The case manager is responsible for:

- Providing the member's PCP, other treating providers (and ancillary providers when relevant to the member's specialized care needs), copies of the member's HRAT or informing providers who have access to Patient360 of the availability of a completed HRAT.
- Obtaining the providers' treatment plans and other relevant clinical documentation for use in developing the initial ICP and for reference during the ICT meetings.
- Scheduling the ICT meeting, through conference calls or other means, and notifying PCPs and other treating providers of the planned ICT meeting or calls. Calls may occur as conference calls or individual calls when necessary to accommodate provider schedules.
- Facilitating discussion of the member's specialized health care services needs with relevant providers and helping to arrange access to the recommended specialized services.
- Revising the ICP to ensure it reflects the specialized services agreed to by the member and other members of the ICT.

- Notifying members of the ICT of a completed ICP available in Patient360 or distributing the completed ICP electronically or through other means to the member's PCP and other treating providers (and ancillary providers) as appropriate.

Members of the care team monitor receipt of specialized services for timeliness and effectiveness and maintains contact with the member's PCP and other treating providers as needed to support coordination of care. Any concerns related to access, timeliness or other quality issues that cannot be resolved directly with the provider are brought to the medical director for consultation and resolution.

MOC 3B: Use of Clinical Practice Guidelines and Care Transition Protocols

MOC 3B.1: Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP's target population

The Health Plan reviews, adopts, and revises CPG relevant to the needs of its membership to:

- Assist practitioners and enrollees in making decisions about acute, chronic, and behavioral health care services;
- Ensure that Anthem's condition, perinatal and high risk population management program incorporate current, evidence based CPGs from recognized sources; and
- Meet NCQA, regulatory and/or contractual requirements

CPGs provide Plan practitioners with "best practice" evidence-based resources and form a basis for Plan efforts to monitor the delivery of health care processes and outcomes.

CPGs accept clinical evidence from a variety of nationally-recognized source organizations, including, but not limited to:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American College of Obstetrics and Gynecologists
- American Diabetes Association
- American Heart Association
- American Psychiatric Association
- Centers for Disease Control and Prevention
- Global Initiative for Chronic Obstructive Lung Disease
- National Heart, Lung and Blood Institute
- National Institutes of Mental Health
- Substance and Mental Health Services Administration (SAMSHA) National Kidney Foundation, Inc.
- American College of Cardiology Foundation
- Eighth Joint National Committee (JNC 8)
- Substance Abuse Mental Health Services Administration

- National Alliance for Tobacco Cessation
- Infectious Diseases Society of America (IDSA)
- American Association For the Study of Liver Disease (AASLD)
- U.S. Preventive Services Task Force (USPTF)

Evidenced-based guidelines, criteria and protocols are the basis for case management assessments, goals and recommendations. During discussions with the PCP and ICT, guidelines and protocols are shared as part of the ICP. As a member of the ICT, our medical directors review clinical cases, provide clinical direction to the concurrent review nurses and case managers, and review cases that do not initially meet Medicare guidelines after the initial review. The medical directors are involved in concurrent review case rounds and case management rounds and they are a member of the interdisciplinary care team. They outreach to providers within the network and have peer to peer discussions on complex member cases and to work collaboratively with them to assist with the implementation of the treatment plan. This helps ensure evidence-based guidelines, protocols and criteria are applied, as appropriate, and serve as a resource for network PCPs.

The CPGs are updated at least biennially (every two years) or when changes are made to national guidelines.

The procedures for developing, updating, adopting and disseminating CPG are applicable across all lines of business in order to ensure a consistent set of guidelines for the provider community. In addition, CPGs are applied consistently across all types of members based on the applicable parameters. In development and review of the CPGs the Office of Medical Policy and Technology Assessment (OMPTA) Guidelines Coordinator manages the guidelines process described below:

- For medical guidelines Anthem utilizes a dedicated corporate-level Clinical Practice and Preventive Health Guidelines (CPG/PHG) Workgroup composed of medical directors, disease management program owners and clinical program development managers, for the process.
- For behavioral health guidelines Anthem utilizes the Behavioral Health National Clinical Advisory sub-Committee (BH-NCAC), consisting of Anthem BH Medical Directors, BH clinical and operations staff and BH Network providers, among others.
- The clinical practice guidelines are reviewed at least every two years or when new evidence is available.
- The CPG/PHG Workgroup and BH-NCAC reviews suggestions for any new guidelines.
- The CPGs use evidence-based research from recognized sources. If such guidelines are unavailable or inappropriate, board certified practitioners from appropriate specialties are involved in developing clinical guidelines.

Recommendations on new and revised guidelines are finalized and presented to the following committees for their review and approval for use:

- Commercial: The Enterprise Commercial/Marketplace Quality Committee (ECQC)
- Medicare and MMP: The Medicare Medical Advisory Committee (MMAC)
- Medicaid: The Quality Improvement Committee (QIC)

The presentation of the CPGs is documented in the committee meeting minutes. Guidelines that require additional research or clarification are taken back to the appropriate Workgroup or Committee for further review.

After review, adoption and approval by all governing committees, the OMPTA guidelines coordinator:

- Submits a request to have CPGs links or information posted and/or updated to each brand/plan's internet site and the Clinical Health Policy intranet site;
- Works with appropriate Accreditation or Communications team to update the provider newsletters, postcards and/or manuals of the availability of the guidelines;
- Gathers any feedback on the CPGs and refers back to the CPG/PHG Workgroup or BH-NCAC for consideration.

Adopted (new or revised) guidelines are posted for internal use to ***pulse*** Anthem's Network site.

If guidelines are adopted from national organizations or societies, disclaimers developed by Legal must be included on the website or hardcopy pages with the national organization or society's link. An example of a disclaimer is as follows:

> *The CPGs are based upon guidelines developed by nationally recognized sources such as the American Diabetes Association, American Congress of Obstetricians and Gynecologists, National Heart Lung and Blood Institute, and others. These organizations produce evidence-based guidelines using medical literature, professional standards, and/or expert opinions. CPGs are not a substitute for the professional judgment of physicians or other health professionals. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited. CPGs are made available to network providers for all lines of business (unless otherwise noted), through committee meetings, provider websites, newsletters and other communications as informational resources for providers and members, to assist in evidence based clinical practice, setting member goals for health improvement, and other clinical purposes. CPGs are not used by the plan for medical necessity review.*

The health plan develops Medical Policies and UM Guidelines (Medical Policies) for this purpose. The practice guidelines do not supersede the member's health benefit plan or Certificate and Schedule of Benefits. With respect to the issue of coverage, each member should review his/her health benefit plan or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment.

To establish a link to an Anthem site from an external organization, the Guidelines Coordinator will check the site's "terms of use," "legal," or similar section of the organization's site and contact the organization if permission is needed.

Information about the availability of the guidelines is included in the Provider Manuals, provider newsletters and bulletins and through committees. The guidelines are also posted on plan web sites. Performance against relevant guidelines is measured per NCQA standards and state contract requirements, as applicable.

For those plans/products going through an NCQA survey for the first time, Anthem annually measures performance against at least two important aspects of the following practice guidelines:

- A clinical practice guideline for an acute or chronic medical condition
- A second clinical practice guideline for an acute or chronic medical condition
- A clinical practice guideline for a behavioral health condition
- A second clinical practice guideline for a behavioral health condition that addresses children and adolescents.
- A preventive health guideline
- A second preventive health guideline

MOC 3B.2 & 3: Identifying challenges where the use of clinical practice guidelines and nationally recognized protocols appropriate to each SNPs target population and providing details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT, and acted upon by the ICT.

Oversight of members with complex health care needs, including members with comorbidities, can present significant challenges for treating providers. Dually eligible SNP members include members who often presented with multiple co-morbidities and who have few resources and significant socio-economic needs. CPGs may include standards for adherence to specific protocols that a treating provider's patient finds difficult to adhere to as a result of their co-morbid challenges. In addition, CPGs that address each of a member's comorbidities may in combination present clinical contraindications. An example of contraindication may be when recommended drug regimens can result in adverse drug interactions.

The Health Plan may identify a need to modify CPGs and protocols to address a subset of members who have specific comorbidities or face specific challenges adhering to a protocol. Evidenced based guidelines are not intended to be applied rigidly without taking the individual needs of the member including any contraindications to the established guidelines. The individual member history, symptoms, treatment options and other applicable information is considered when reviewing the request. Individual exceptions to evidenced based guidelines or CPG are decided primarily by the treating provider based on the appropriate treatment protocols available to the physicians or practitioners condoned and approved by the governing bodies and associations. Examples of these associations include American College of Obstetrics and Gynecology, American Diabetes Association, and American Medical Association.

Revised protocols and/or CPGs are distributed to the CPG/PHG Workgroup for review and approval. The workgroup will supply any evidenced-based recommendations on the protocol or guideline as well as proof of approval to the Medical Policy Department which will incorporate suggested change. A summary grid with new protocols or guidelines, including CPG/PHG Workgroup recommendations, is circulated to the Enterprise Clinical Quality Committee (ECQC) for final review and approval.

After review and approval by all governing committees the Office of Medical Policy and Technology Assessment (OMPTA) guidelines coordinator submits a request to have CPGs link or information posted and/or updated to the plans internet site and the Clinical Health Policy intranet site; works with appropriate Accreditation or Communication team to update the provider newsletters, postcards and/or

manuals of the availability of the guideline. Guidelines are also posted for internal use to *Pulse* Anthem's Network site.

Treating providers are responsible for introducing revised protocols or CPGs during ICT meetings when relevant to the member's needs. Interventions based on the revised protocol or CPGs are included in the member's ICP by the case manager. The case manager assists the treating provider and member with implementation of these interventions as needed, for example arranging in-home telemonitoring and access to preventive services. The updated ICP is provided to members of the IDT through Member360 or Patient360 or through hard copy.

Certain elective prospective procedures require an authorization prior to care being rendered. The goal of prior authorization is to assure that members are treated in the most appropriate, least restrictive and most cost effective setting that is compatible with medical necessity as determined by the severity of the illness and/or the intensity of the services needed to contribute to an improved health status relative to the specific condition. Evidenced based guidelines are used to review and determine the appropriateness of the care being requested. Appropriate clinicians are responsible for reviewing and applying these guidelines based on information obtained from the requesting provider. The clinical team has access to the member's history as published in our clinical systems. This included claims data, utilization data, previous authorizations, lab, pharmacy, and care provided by multiple providers. If the request for services does not meet the evidenced based guideline the Medical Director will review the request and when necessary has a discussion or peer to peer review with the requesting provider to discuss the individual needs of the member. This provides the treating provider to request exceptions to the evidenced based or clinical practice guideline. The Medical Director will document in the utilization system notes on the case the conversation with the provider and why an exception was made.

MOC 3B.4: Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

Protocols are communicated to the provider network through newsletters and published in the Provider Manual. The protocols include managing transitions in care, to ascertain continuity of care between providers participating in the member's health care needs is maintained.

The PCP has the responsibility for coordinating care for the members. It is a team effort with other members of the ICT involved in managing the care. Based on the complexity of the SNP members, multiple providers may be engaged in order to adequately treat and/or resolve the needs. Our internal clinical teams collaborate with the PCP and other ICT members to facilitate a smooth transition between health care settings. The protocols assist the ICT for effective communication between the disciplines caring for the member. Once the PCP refers to a network specialist the specialist assumes the role of coordinating care while keeping the PCP informed. Provider access to electronic medical records, are available through many organizations for collaboration in continuity of care including reducing duplicate testing, preventing prescribing same class medications, and managing the care. P360 may help to supplement information by providing the pharmacy information as well as the longitudinal record information on emergency room visits and consultants caring for the member.

MOC 3C: MOC Training for the Provider Network

MOC 3C.1: Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis

MOC initial training and annual refresher training may be provided to our contracted providers in any of the following ways; new provider orientation, via mail in the provider newsletter, on an external provider training web site, which includes a computerized based training module and in the Provider Manual. Additionally, some larger provider groups may receive annual MOC training during joint operating committee meetings.

The case manager or the local Provider Solutions representatives (if determined necessary based on a member' care team or if requested) will offer training for providers who cannot access the online training or need assistance with the model of care refresher training.

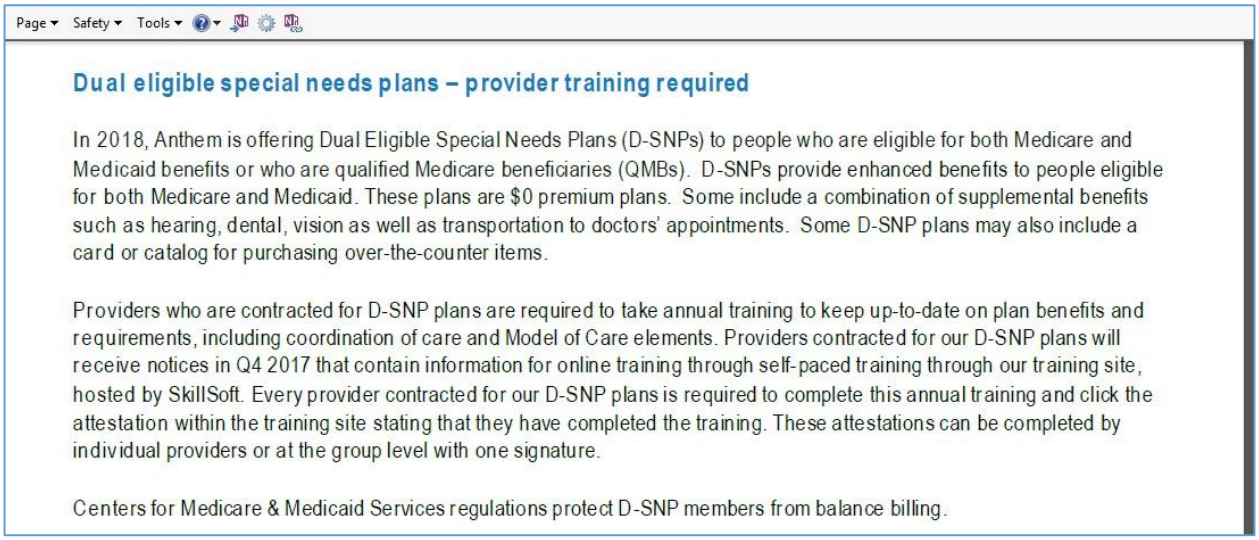
Training is provided in any of the following ways:

- Training overview materials provided on an external provider training website
- Telephonic/WebEx review or in person review of Power Point Presentation
- Medicare Advantage Provider Manual

The training includes the following topics:

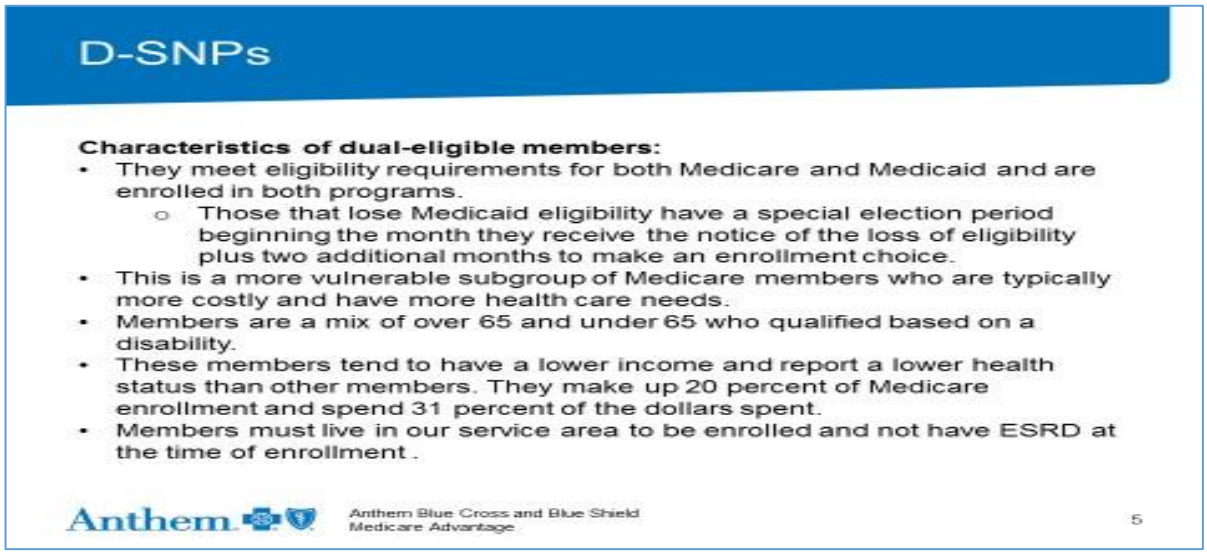
- Definition of the MOC and why it was developed
- Annual training requirement
- Annual HRA including assessment domains (medical, cognitive, behavioral and functional)
- Staff who support the MOC
- Development of a treatment plan based on the results of the HRA
- Information about the ICT and functions
- Communication processes
- Measuring performance and health outcomes
- Evaluating the effectiveness of the MOC
- How providers can work with the internal team to benefit our members
- Orientation to the website for additional training
- Accessibility and of the member specific documents e.g. HRA and Care Plan,

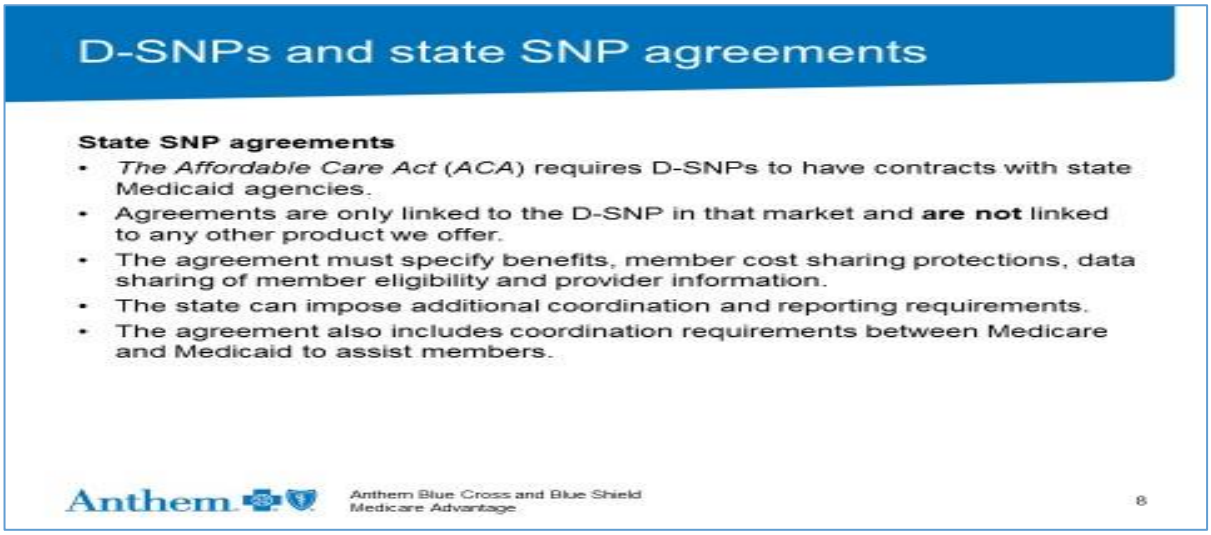
Example of the provider newsletter with training on the model of care:



Efforts are made so that newly contracted network providers are orientated within 30 days of their contract effective date and as requested thereafter. Training and orientations are augmented with provider communications and onsite staff visits from local Provider Solutions representatives. Provider orientations are the responsibility of the Health Plan Provider Solutions representatives. The plan uses a Participating Provider report to identify newly contracted providers.
The Provider Solutions representatives may either conduct in-person orientations (large forums to accommodate groups/IPAs/multi specialties affiliated with a hospital, one-on-one and small group sessions) and online training sessions through our external provider training site.

The provider orientation includes PowerPoint slides, as described above. Below is an excerpt of the Provider MOC Training slide deck:





If a non-contracted provider is seeing a member routinely, and is determined by the case manager to be a contributing member to the ICT, the Medical Management staff will direct these providers to the provider portal that includes MOC training content for self-paced training. Once complete, providers will complete an attestation which can be tracked by us. Out-of-network providers who require additional information about the Health Plan including the MOC may contact a Provider Solutions representative by phone for assistance.

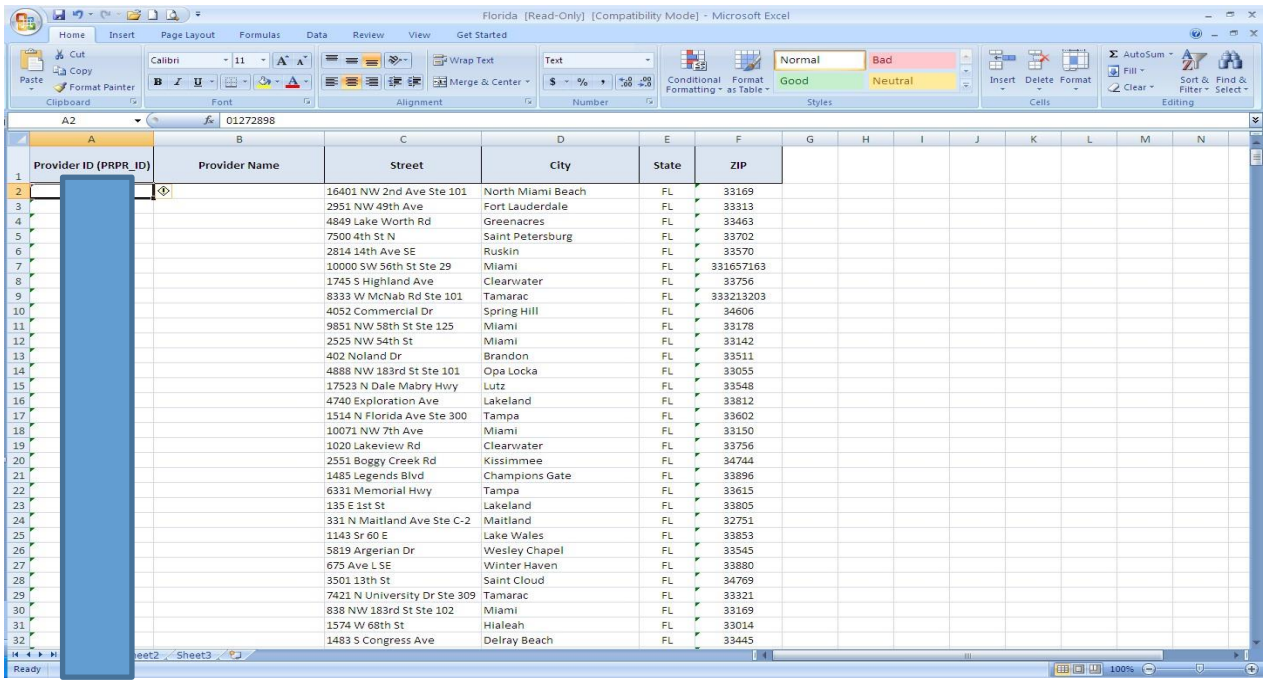
MOC 3C.2: Documenting evidence that the organization makes available and offers training on the MOC to network providers

All providers are required to sign an attestation which acknowledges that they have completed the required MOC training. Attestations are included as part of the PowerPoint presentation for in-person or online training sessions. These attestations are then saved in a central location as well as being included in the provider's file.

All training activities that occur on the external provider training site will also generate and store attestations.

A mailing list documents distribution of newsletters to verify training was delivered to contracted providers identified as potential ICT members. The newsletter is distributed to all providers.
The Health Plan conducts an annual provider survey, which includes a question specific to the MOC training, asking for the provider's verification as to whether or not they received enough information. Based on the responses to the question, modifications to the model of care training may be made.

Example of documenting training distributed to providers:



Provider ID (PRPR_ID)	Provider Name	Street	City	State	ZIP
		16401 NW 2nd Ave Ste 101	North Miami Beach	FL	33169
		2951 NW 49th Ave	Fort Lauderdale	FL	33313
		4849 Lake Worth Rd	Greenacres	FL	33463
		7500 4th St N	Saint Petersburg	FL	33702
		2814 14th Ave SE	Ruskin	FL	33570
		10000 SW 56th St Ste 29	Miami	FL	331657163
		1745 S Highland Ave	Clearwater	FL	33756
		8333 W McNab Rd Ste 101	Tamarac	FL	333213203
		4052 Commercial Dr	Spring Hill	FL	34606
		9851 NW 58th St Ste 125	Miami	FL	33178
		2525 NW 54th St	Miami	FL	33142
		402 Noland Dr	Brandon	FL	33511
		4888 NW 183rd St Ste 101	Opa Locka	FL	33055
		17523 N Dale Mabry Hwy	Lutz	FL	33548
		4740 Exploration Ave	Lakeland	FL	33812
		1514 N Florida Ave Ste 300	Tampa	FL	33602
		10071 NW 7th Ave	Miami	FL	33150
		1020 Lakeview Rd	Clearwater	FL	33756
		2551 Boggy Creek Rd	Kissimmee	FL	34744
		1485 Legends Blvd	Champions Gate	FL	33896
		6331 Memorial Hwy	Tampa	FL	33615
		135 E 1st St	Lakeland	FL	33805
		331 N Maitland Ave Ste C-2	Maitland	FL	32751
		1143 Sr 60 E	Lake Wales	FL	33853
		5819 Argerian Dr	Wesley Chapel	FL	33545
		675 Ave L SE	Winter Haven	FL	33880
		3501 13th St	Saint Cloud	FL	34769
		7421 N University Dr Ste 309	Tamarac	FL	33321
		838 NW 183rd St Ste 102	Miami	FL	33169
		1574 W 68th St	Hialeah	FL	33014
		1483 S Congress Ave	Delray Beach	FL	33445

Network Management collaborates with Care Management, Innovations Leads, Product Management Leads, and Compliance to maintain current training content. The team annually reviews and updates the training material as necessary.

Provider Services representatives determine the best options for coordinating and the delivering the training for providers. They oversee all activities related to provider communications and educational materials for the department. While the provider newsletter is sent to all contracted providers, Provider Solutions also mails information to critical providers (PCPs, specialists (Cardiology, Pulmonary, Endocrinology, Psychiatry, Nephrology, Neurology, etc.) to ensure they are aware that SNP MOC training is available and required annually. Provider Solutions representatives are responsible for strategic concept and development, research, writing, editing, and revision of content for provider communications. In addition, Provider Solutions representatives deliver training through electronic selfpaced courses, WebEx trainings and orientations, and verify completion through attestations.

MOC 3C.3 & 4: Explaining challenges associated with the completion of MOC training for network providers and describing how SNP providers maintain continuity of care using the care transition protocols outlines in MOC 2, Element E

Our experience in training providers on the model of care demonstrates that the array of methods, described previously, best addresses the challenges we have encountered. For example, providers are typically busy and need to complete training when they have time. Some providers complain they are required to take similar training for every payer that they are contracted. Some providers prefer to complete online training, while others may request one-on-one training or take advantage of a training session offered during a standing meeting, such as a hospital provider group meeting. Some providers who practice in rural areas need computer-based options. This includes WebEx with conferencing for

sessions where providers need to have access to Health Plan representatives to answer questions (especially during initial training). We offer one-on-one assistance from our local Provider Solutions representatives, who can provide help by phone or onsite at the provider's office. This option enables us to meet any specialized need for assistance with training a provider may have.

To ensure that providers are aware that they must complete SNP MOC training annually, provider newsletters will contain a reminder for all providers to complete training in a mid-year edition. All completed orientation activities are logged and saved in a central location available to the Provider Solutions Team and reporting can be run to determine who has or has not completed their training.

MOC 4: MOC Quality Measurement and Performance Improvement

MOC 4A: MOC Quality Performance Improvement Plan

MOC 4A.1: Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.

Anthem is dedicated to and cultivate a culture of continuous quality improvement throughout our organization. As part of that commitment, Anthem has established an effective quality management program and evaluation structure with the goal to deliver high-quality healthcare services and benefits, with an emphasis on achieving maximum health outcomes for our members.

The scope of the Quality Management Program is comprehensive, systematic, and continuous, encompassing the full spectrum of medical, pharmaceutical, and behavioral health care, services and programs for our Medicare Advantage (MA) & SNP.

The QI program is designed to integrate all functional areas in decisions that affect the quality and safety of care and services provided to members. The program provides for the ongoing review of the entire scope of care assuring that all demographic groups, races, ethnicities, special needs populations, care settings and types of services are addressed. The QI Program has the organizational infrastructure necessary to provide effective monitoring, reporting and analysis, and to act on opportunities to improve clinical care and services. In order to meet the Quality Management program goals interdepartmental collaborations are very important. The Quality department works very closely with Medical Management, Behavioral Health, and Pharmacy departments.
The following program components are inherent to the promotion of quality medical, physical and behavioral health care delivery and service:

- Accessibility of Services
- Availability of Practitioners
- Continuity and Coordination of Care
- Patient Safety
- Clinical Practice Guidelines

- CAHPS
- HOS
- HEDIS
- Quality Improvement Projects (QIP)
- Chronic Care Improvement Program (CCIP)
- Clinical Quality
- Over/ Under Utilization
- Complaints, Grievances, and Appeals
- Credentialing/Recredentialing
- Medical Record Audit/ Physician Quality
- Provider Satisfaction
- Provider Engagement

Through our annual evaluation process, Anthem performs an analysis of our SNP demographics to identify any changes to ensure we continue to meet the needs of our members and address the challenges that exist due to the unique characteristics of the SNP population. We use multiple sets of data to perform our analysis including, but not limited to, member surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Health Outcomes Survey (HOS); demographic analyses and multiple HEDIS, medication adherence and other gaps in care data.

Anthem works to address not only medical and psychological issues and conditions but the social and environmental situations that impact our members. The social and environmental issues, if not identified and managed, can create limitations and barriers that impact the ability of our members to effectively manage their medical conditions and achieve optimal health outcomes.

Through our quality improvement plan and ongoing monitoring approach, we evaluate data on a monthly, quarterly, semi-annual or annual basis. The plan is regularly reviewed to reflect updated metrics, action plans, and status of interventions that are implemented to continuously drive improvements in our MOC and quality initiatives. On a quarterly, semi-annual or annual basis, progress reports are provided to our applicable quality and monitoring committees that oversee the quality program and deliverables.

MOC 4A.2: Describes specific data sources and performance & outcome measures used to continuously analyze, evaluate & report MOC quality performance

A sophisticated data system is maintained to store and analyze quality-related data. Reports and progress tracking tools are derived from those data to identify quality gaps and high risk members for intervention as well as tracking progress with quality indicators. Multiple warehouses store data from numerous sources to address CMS reporting requirements. These sources include but are not limited to claims from transaction systems, vendor data from pharmacy, dental, vision, lab, state FFS and member historical data. The data warehouses are updated and backed up nightly to ensure accurate and current information is available. Each type of data in the warehouse are formatted uniformly (e.g. state vision data from multiple vendors are uniformly formatted in one table and pharmacy data for all Medicare Markets and is

formatted and stored in one location with appropriate identification by data source). Such standardization ensures the ability to extract data quickly to produce required reports.

Anthem maintains a rigorous monitoring system of source data before the data are moved into the EDW. The data is validated and transformed into digestible formats for quality reporting. Once results are generated, we conduct our monthly benchmark and research process to ensure we have accurate and complete results.

Our population assessment data warehouse is a dynamic data system that shows member data related to gaps in care, race, ethnicity, language, age and gender, as well as other socio-demographics and can be analyzed at the state and county levels

Data is collected on a routine (monthly, quarterly or annually) and ad hoc basis from internal and external sources to systematically and objectively monitor, analyze, evaluate, and report health outcomes and indices of quality.

The QM data measure reporting system is supplemented by other systems/ departments such as: Utilization Management, Provider Service Organization, Participating Providers, Health Promotions, Credentialing, Medicare Complaints and Grievances (MCAG), Dedicated Service Unit (DSU), Pharmacy, Sales and Marketing, Case Management, Clinical Compliance and Audit, Compliance, and STARS. Opportunities are pursued to integrate and/or develop appropriate enterprise-level processes and programs to support collaboration between the business units and provide support to the plans.

Process and outcome measures collected on our SNP population are monitored through various teams. The Care Management team reviews utilization management reports including: admissions per thousand, ER visits per thousand, follow-up visit with a professional practitioner within 30 days post medical hospitalization, over and under-utilization, network access and availability reports, case management reports and various measurements via care transitions including: documentation of attempt to reach member to complete the initial and annual HRA (documentation when members refuses or unable to reach), creation, implementation, and evaluations of the care plan.

The provider network team monitors network access and availability reports.

The Care Management teams also review the monthly stratification of the membership using our CI3 and LIPA processes to assess the distribution of members among risk groupings and to identify the most frequent diagnoses among our membership. This stratification allows for SNP members to rise to the priority for Care management intervention when multiple comorbidities are present and the need for intervention is evidenced as well as at its point to be most impactful. The stratification of membership also allows for the evaluation of adequacy of our provider network, benefits and special programs. The assessment may identify a need for additional providers of a specific specialty, changes in supplemental benefits and the modification of existing specialized programs or development of new programs.

The Behavioral Health Team reviews follow up visits with a professional practitioner within 30 days post mental health hospitalization in addition to other utilization reports.

The MCAG committee reviews complaint, grievance and appeal data.

The Quality Management team reviews HEDIS, CAHPS, and HOS reports to assess the adequacy of our MOC and to confirm the specialized needs of our members are met, including those of our most vulnerable members. Monthly review and analysis of multiple reports including; gaps in care performance, health outcomes, member and provider satisfaction surveys, and claims are completed.

MOC 4A.3: Describes how its leadership, management groups, other SNP personnel & stakeholders are involved with the internal quality performance process

Senior Executive Leadership

The Regional Vice President Medical Director (RVPMD) is the senior physician executive responsible for the QI program. The Vice President of Corporate Clinical Quality Management is the senior quality leader responsible for execution and outcomes of the QI program. Responsibilities of these leaders includes procuring adequate resources for QI program implementation, serving on the governing body, aligning the goals/objectives of the QI program with the business objectives, and setting QM priorities in conjunction with the Corporate Medicare and Regional Medical Directors. The Corporate Quality Management Committee reviews and approves the QM Regional Program Description, Work Plan and QM Program Evaluation.

The Company's RVPMD provides overall direction and support to the QI program and is responsible for oversight of the clinical quality improvement operations including:

- Responsibility for the care delivered by contracted providers as well as the care coordination and utilization management activities of the company.
- Ensures that evidence based practice is incorporated into the SNP MOC, medical guidelines, and utilization management activities
- Leads the analysis of utilization data to identify areas of over and underutilization and develop corrective action plans
- Is responsible for providing clinical guidance and oversight regarding the development, implementation, and evaluation of QIPs and CCIPs
- Provides clinical guidance to ensure the coordination of Medicare, Medicaid, and community services to meet the identified needs of individual members.
- Reviews as appropriate data submitted for Part C and Part D CMS reporting Reviews departmental policies and procedures.

Corporate Quality Management

The Corporate Quality Management Department supports the Quality Management Program in several areas, including:

- HEDIS Technical Project Management, including coordination with HEDIS certified software vendor and certified HEDIS compliance auditors state agency submission; data analysis and reporting; coordination of improvement activities across health plans; and communication of best practices;

- Project Management of the Member Satisfaction Survey, CAHPS, HOS; analysis and report production; and assistance with satisfaction improvement activities across health plans;
- Project Management of the Provider Satisfaction Survey; analysis and report production;
- Coordination with the health plan in annual delegation oversight audit findings and improvement actions required;
- Assistance in preparation for both state of External Quality Review Organization (EQRO) audits and Federal Centers for Medicare and Medicaid audits
- Providing oversight of the CCIP and QIP Programs and ensuring quarterly compliance and annual reporting to CMS and states where applicable.
- Development of standardized policy and procedures for health plans based on goals and objectives
- Assists in the development of programs and interventions to meet the needs of frail and vulnerable members

Regional Quality Management

The Regional Quality Management Department supports the Corporate Medicare Quality Management Program in several areas, including:

- HEDIS , CAHPS and HOS analysis and satisfaction improvement activities across health plans
- Medicare Member Grievance and Appeal Process oversight which includes monitoring and trending of appeals and complaints
- Review and investigation of Medicare related Quality of Care issues
- Development of health plan specific policies and procedures based on goals and objectives
- Develop programs and interventions to meet the needs of frail and vulnerable members
- Establishing indicators for monitoring and evaluating the full spectrum of care and service provided to members for quality, safety, appropriateness, continuous improvement and satisfaction
- Compliance with regulatory organizations
- Integrating utilization information and quality issues by the Medicaid and Medicare utilization management teams into the quality management process
- Coordinating/performing medical record reviews and data collection
- Providing Network Performance & Planning department with quality information to be used as part of the recredentialing process
- Coordinating the quality assessment peer review process including participating in the development of remedial action plans for providers as indicated
- Participating in interdepartmental quality improvement teams
- Designing and implementing interventions to resolve identified quality issues and improve process, clinical, and financial outcomes
- Educating providers and associates about the QI Program and HEDIS Health Outcomes
- Developing and Updating Performance Improvement Projects (PIP); CCIPs and QIPs, Quality Improvement Activities (QIA), and other state and federal agency defined studies

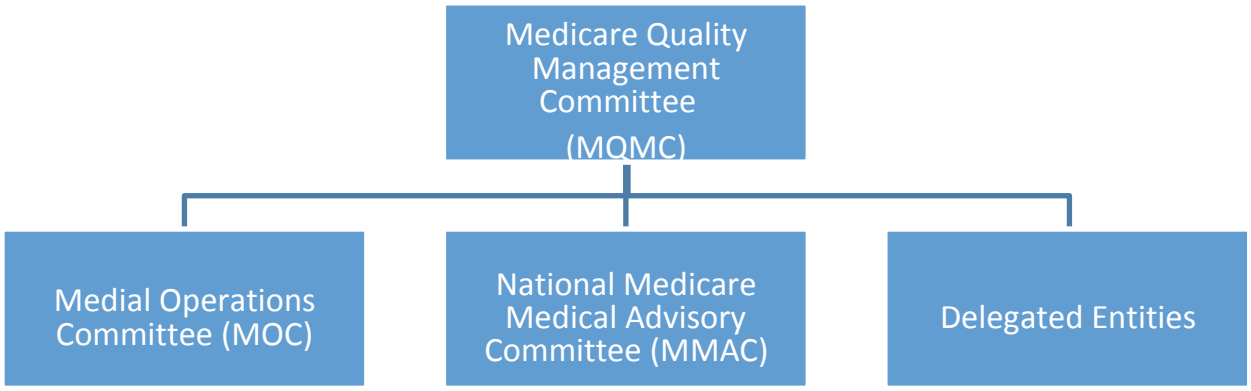
Corporate Medicare Quality Management Committee (C-MQMC)

Purpose:
The purpose of the Corporate Medicare Quality Management Committee (C-MQMC) is to provide a forum for members of the committee to review, coordinate, and direct the Medicare Quality Improvement Program. This enables interdepartmental leadership and oversight of key quality improvement activities and processes, including Medicare specific policies and procedures. This work supports improved quality of care and services, and improved member health outcomes.

Responsibilities:

- Review and approve Quality Management (QM) Trilogy Documents: Program Description, Work Plan, and Annual QI Evaluation
- Review standardized reports (at least annually) reflecting progress towards goals, actions taken, improvements
- Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service Quality Improvement Projects (QIP) and Chronic Care Improvement Programs (CCIP)
- Review, monitor and evaluate program compliance against Anthem, Inc., State, Federal and CMS standards
- Oversight of the overall effectiveness of the Special Need Plan (SNP) Model of Care (MOC) goals
- Oversight and overall effectiveness of the MMP MOC goals
- Review overall regional and corporate quality program effectiveness including, but not limited to, member and provider satisfaction, quality of care, and accessibility and availability of care and services
- Oversight of entities delegated for clinical services

The quality committee structure is shown below. The Medical Operations Committee, the National Medicare Medical Advisory Committee and delegated entities report into the Medicare Quality Management Committee on at least a semi-annual basis. Reporting elements may include, but are not limited to, Model of Care goals, program descriptions, work plans and evaluations, quality indices and program outcomes, accomplishments, challenges, improvement initiatives and other updates as necessary.



Medical Operations Committee

The Medical Operations Committee reports to the Corporate MQMC.
Medical Operations Committee reviews and/or approves policies and procedures and utilization management policies, and operationalizes approved Medical Policies and Clinical UM Guidelines for use across the GBD to ensure consistency. Additionally, MOC reviews appropriate UM, DM, and CM Program documents dependent upon market and product. MOC membership includes Enterprise and Regional/Plan Medical Director and HCM clinical leadership.

MOC responsibilities include:

- Review and/or approval of documents related to disease management programs, utilization management, behavioral health, and case management policies and procedures;
- Review of UM Policies and Procedures that are in place to meet NCQA UM Standards;
- Review of Medical Policy and Technology Assessment Committee MPTAC approved medical necessity policies/criteria/Clinical UM Guidelines for operationalization;
- Review of DM specific clinical practice guidelines that have been approved by Quality Improvement Committee;
- Review Model of Care documents
- Review of Inter-rater Reliability Program Report
- HCM Regulatory Policy/Procedure Review and Approval;
- Review of State specific medical necessity criteria

National Medicare Medical Advisory Committee (MMAC) – Reports to the Corporate MQMC
The purpose of the National Medicare Medical Advisory Committee (MMAC) is to assess programs provided to our Medicare, SNP and MMP membership. The goal is to review the levels and quality of care provided to members, as well as recommend, evaluate, and monitor minimum standards of care for members; to review/evaluate program materials and provide recommendations for program improvement and enhanced provider communication and engagement.

The MMAC reports to the Medicare Quality Management Committee (C-MQMC). It includes Anthem, Inc. network physicians and core members from the regions and including, MMP QMC. The MMAC assists with monitoring and evaluation of the Medicare Quality Management program via input from physicians external to the organization.

Responsibilities:

- Approve the adoption of CPGs to facilitate the delivery of quality care and appropriate resource utilization
- Review and approve for adoption the clinical study design and results including CCIP and QIP Programs
- Provide applicable advice and input on HEDIS, gaps in care initiatives, and STARS measures to facilitate provider engagement
- Provide peer review as external practicing physicians for any provider related level 3 or above quality of care issues found that require peer to peer discussion

- Develop and approve action plans/recommendations regarding clinical quality improvement studies, as appropriate
- Review and provide feedback regarding new technologies

Corporate Pharmacy and Therapeutics Committee

Purpose: The purpose of the P&T Committee is to review various federal legend drugs, insulin products, and related supplies, and to develop and approve guidance and clinical recommendations for the therapeutic use of drugs, insulin, products, and related supplies that are covered by the Delegating Entities' pharmacy & medical benefits. In furtherance of this purpose, the P&T shall:

Responsibilities:

- Research and evaluate the therapeutic use of pharmaceuticals.
- Clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition.
- Recommend clinical designations and appropriate clinical criteria to assist with the placement of products on formularies by the VAC subject to benefit design and government mandates.
- Identify trends, clinically significant factors and nationally recognized standards regarding accepted utilization of prescription medications.
- Fulfill the CMS-specified functions for Medicare Part D purposes.
- Interface with other IngenioRx initiative owners concerned with drug use, selection, efficacy, and safety as appropriate.
- Provide ongoing review and monitoring of the safety, effectiveness, and quality of care of drugs contained within the IngenioRx or Delegated Entities' formularies and pharmacy & medical benefits management programs.
- Review and approve drug utilization review and drug utilization evaluation programs.
- Review and approve prior authorization clinical criteria.
- Review and approve effective drug utilization control programs and initiatives.
- Review and approve drug quantity supply limits.
- Review and approve policies and procedures for the development of IngenioRx formularies.
- Annual review of IngenioRx and Delegated Entities' formularies.

Value Assessment Committee (VAC):

The purpose and function of the VAC is to determine the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "tier" or tiering"). The VAC may not make any tier or tiering decisions with respect to a drug or class of drugs without that drug or class of drugs being reviewed and clinically evaluated by the IngenioRx Pharmacy & Therapeutics Committee ("P&T") in accordance with its charter.

Medical Policy and Technology Committee (MPTAC)

The Medical Policy and Technology Assessment Committee (MPTAC) serves as the official medical/clinical policy-making body of Anthem in development of clinical standards or review and adoption of nationally recognized standards, to support evidence-based coverage policies. MPTAC approved Medical Policies and Clinical UM Guidelines are presented to the Medical Operations

Committee (MOC) for adoption to ensure consistency and a standardized process across the Medicaid Business Unit. MPTAC responsibilities include evaluation and recommendation of revisions to existing utilization management (UM) decision-making guidelines adoption of new criteria for standardized UM decision-making, and the assessment of new medical procedures and technologies and new applications of existing medical technologies for incorporation into Parent Company Medical Policy and Clinical Guidelines.

MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Behavioral Healthcare professionals are also represented in the MPTAC decision making process. Voting membership includes:

- External physicians in clinical practices and participating in networks;
- External physicians in academic practices and participating in networks;
- Internal medical directors.
- Input from the medical community is solicited and utilized in developing and updating policies.

MOC 4A.4: Describes how SNP-specific measureable goals & health outcomes objectives are integrated in the overall performance improvement plan, as described in 4B

The identified health outcomes goals of the MOC are part of the overall monitoring conducted in the Quality department. These goals are integrated into the Regional Quality Improvement Work Plans which are comprehensive tracking documents supporting the Regional Quality Departments. All MOC goals are tracked interdepartmentally and presented to the C- MQMC quarterly, bi-annually and annual basis. The Quality Management Department has monthly meetings to review health outcomes, patient safety information and to develop interventions for continuous quality improvement.

The QI Work Plan, appended to the QI Program Description, reflects specific activities/ projects initiated and the performance measures evaluated/monitored throughout the year based on program priorities and improvement opportunities realized in the prior. A QI Work Plan is developed annually at regional levels. The work plan is a dynamic document and is updated as needed to reflect changes in processes, priorities and/or activities throughout the year. The C-MQMC reviews and approves the regional QI Work Plan annually.

The Regional QI Work Plan addresses the following:

- Inclusive of all departments, units and organization-wide activities including clinical, service, physician and member experience activities. Including but not limited to: HEDIS, Behavioral Health Care, and Quality of Care
- Staff member and performance goal accountability for each activity, as indicated
- Monitoring of key performance outcomes in departments supporting QI Programs that correlate to specific components and objectives of the overall Quality program. Monitoring is comprised of quarterly review and update of each activity provided by the delegated business owners and presentation of materials to the oversight committee as appropriate

To better address the needs of our SNP members the QI Program is designed to improve the quality of care and the quality of care management received by this population. While the QI Program incorporates information from multiple sources, the program is specifically intended to improve member access to care, health status, satisfaction, readmission reduction and care coordination. These objectives specifically tie back to the overarching goals of the MOC outlined above

The QI Program incorporates specific requirements objectives and health outcome goals of the Special Needs population. The QI Program is an ongoing, comprehensive, and integrated system which objectively and systematically monitors and evaluates the quality, safety and appropriateness of medical and behavioral health care and service offered by the health network and to identify and act on opportunities for continuous improvement for all Medicare members including the SNP population. The goals and health outcomes for the SNP population are collected, assessed, and acted upon with unique processes and interventions to improve care. These requirements are executed by the Quality Department and/or departments that support the Quality Department. Oversight of these activities occurs through departmental management meetings and subsequent reporting to the Corporate MQMC.

REFER to the SNP GOALS TABLE within MOC 4B for full identification of the SNP goals, timelines, and re-measurements.

MOC 4B: Measureable Goals and Health Outcomes for the MOC

MOC 4B.1 & 2: Identify & define the measureable goals & health outcomes used to improve the health care needs of SNP beneficiaries and identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level

The table below is the MOC goals, measurement source, and timelines for reporting, analysis, and reassessment. The determination if the goals have been achieved will occur by monitoring reports generated from any of the following systems: claims, provider services, utilization, HEDIS database, case management or a combination. Parameters for the reports are defined and generated on set schedules, and monitored and reported. Some reports can also be generated on an on demand basis. Official reporting for oversight will occur annually in the plan performance monitoring and evaluation (PPME) universe or a similar tool. Periodic monitoring as determined by the business area occurs based on the available reporting. Twice a year, depending on the measure, preliminary and final results are reported to the designated oversight committee including the Medical Operations Committee, and C-MQMC. The goals are monitored and actions taken by the business areas based on results. The Plan Performance, Monitoring and Evaluation (PPME) universe or equivalent tool, is updated annually to allow a year over year comparison of the results. As determined by CMS, the plan may use a similar tool to document plan results. Results are monitored by the business owners and progress toward meeting the benchmarks, action plans and status is reviewed by the oversight committees bi-annually with full year review as part of the annual program evaluation.

Delegated providers may be given accountability for monitoring and reporting goals. If a delegate is responsible, processes to monitor the goals in their internal policies and procedures or program descriptions. A delegate may only be responsible for a subset of the goals based on the delegation agreement and may be required to report results to be integrated into internal documents. Depending on the delegates program, additional goals or variations to the goals below may be included in the documents.

Examples:

- A delegate may have a program in place to perform a home visit within 30 days of discharge, an additional goal with benchmarks may be monitored and reported by the delegate which would only apply to that population.
- A delegate may have a telemonitoring program offered as part of the provider practice and members that are assigned only to that delegated provider. A goal may be determined by the provider that would measure outcomes related to the program.

For delegates, a process is put in place to report quality program goals and outcome results to the Corporate Medicare Quality Management Committee on a semi-annual basis. As part of the delegation oversight process reporting and documents are reviewed for compliance as determined in the delegation agreement.

The table below is a core set of goals that are monitored.

SNP GOALS and HEALTH OUTCOMES

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reported
Improve access and affordability	Provider Availability	Meet CMS adequacy requirement of 90% of members able to access (time and distance) each HSD required specialty.	90%	Semi-annual	Provider Services	Annual
	Member Complaints	Complaints related to provider network access will not exceed 10 per 10,000 members	10/10,000	Bi-annual	Grievance and Appeals Data	Annual
	Inpatient (IP) admissions	IP Admissions/ 1000	Annually based on membership and experience	Quarterly	UM Data	Bi-annual

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reported
	Emergency Dept. (ED) utilization	ED Visits/1000	Annually based on membership and experience	Quarterly	UM Data	Bi-annual
Improve Care Transitions across all healthcare settings and providers	Follow up visit with practitioner post medical hospitalization	Members discharged from the hospital will have a follow up visit within 30 days which includes either with the PCP, Specialist or home health provider	Percent based on annual review and reporting will reflect Benchmark average 50-75% will have follow up visit within 30 days	Quarterly	Claims	Bi-annual
	Follow up visit with BH practitioner post BH hospitalization	Members will have a follow up visit post discharge from a mental health facility within 30 days	35% will have follow up visit within 30 days (actual benchmark determined during annual review)	Quarterly	Claims	Bi-annual
Ensuring appropriate utilization for condition specific services	Care for Older Adults: Medication Review	Yearly Review of All Medications and Supplements Being Taken	Meet or Exceed CMS 4 STAR Rating. Percent based on monthly HEDIS review and will change, reporting will reflect benchmark	Annually/ Monthly HEDIS admin review	HEDIS	Annually
	Care for Older Adults: Functional Status Assessment	Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living	Meet or Exceed CMS 4 STAR Rating. Percent based on monthly HEDIS review and will change, reporting will reflect benchmark	Annually/ Monthly HEDIS admin review	HEDIS	Annually
	Care for Older Adults: Pain Assessment	Yearly Pain Screening or Pain Management Plan	Meet or Exceed CMS 4 STAR Rating. Percent based on monthly HEDIS review and will change, reporting will reflect benchmark	Annually/ Monthly HEDIS admin review	HEDIS	Annually

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reported
	Controlling High Blood Pressure	HEDIS Specifications	Meet or Exceed CMS 4 STAR Rating. Percent based on monthly HEDIS review and will change, reporting will reflect benchmark	Annually/ Monthly HEDIS Admin Review	HEDIS	Annually
	Pharmacotherapy Management of COPD Exacerbation (Corticosteroid)	HEDIS Specifications	Quality Compass 75th Percentile Percent based on monthly HEDIS review and will change, reporting will reflect benchmark	Annually/ Monthly HEDIS Admin Review	HEDIS Specifications	Annually
Improve coordination of care and appropriate delivery of services	Completion of the HRA	Complete the HRA within 90 days of member's enrollment date. OR documentation of member or caregiver refusal	100% new members	Monthly	Case Management	Bi-annual
	Completion of the annual reassessment	Completed reassessment (HRA) within 365 days of the previous HRA OR documentation of refusal by member or caregiver	100% eligible members	Monthly	Case Management	Bi-annual
	Completed care plan	Completed care plan OR documentation to show refusal to participate	100% eligible members	Monthly	Case Management	Bi-annual
	Documented ICT	Minimal annual documentation of an ICT until documentation of refusal to participate	100% eligible members	Monthly	Case Management	Bi-annual

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reported
	PCP Visit	Members who have been in the program one (1) years will have at least one (1) PCP visit	10-75% eligible members (benchmark determined during annual review)	Quarterly	Case Management	Bi-annual

MOC 4B.3: Describe how the SNP establishes methods to assess and track the MOC's impact on SNP beneficiaries' health outcomes

The method to assess and track the quality related goals in the MOC is through HEDIS rate collection, claims, and monthly HEDIS administrative rate monitoring. Monthly and annual HEDIS rates are reviewed for monthly trends and year over year trends at a regional level. Annually, CAHPS and HOS scores are analyzed to determine areas for specific improvement in member satisfaction and health outcomes in addition to the above goals.

The quality department creates quality action plans based on systematic subjective and objective analysis. Progress toward identified goals and actions outlined in the action plan are monitored monthly by the appropriate departmental management teams and reported to C-MQMC quarterly or as needed. Monthly work groups are in place to evaluate STARS, HEDIS, and SNP quality measures to provide recommendations in how to improve the measures.

To determine if all the program goals have been met, all departments and business owners conduct ongoing monitoring of their individual goal results. Goals that are developed initially at the outset of the year are reviewed monthly or quarterly (as determined by measure and reporting) and supporting business owners update based on review of results. Due to the population and the complexity of the clinical picture, results may vary throughout the year and goals or benchmarks could require modification. Finally, all goals are reviewed in a formal annual evaluation that measures actual performance against predetermined performance goals. Goals and benchmarks for performance are reviewed after the previous year's program evaluation has been completed and adjusted based on performance levels or improvements recommended as part of the program evaluation. The program elements are monitored during the year at designated intervals with a mid-year progress toward benchmark review and a formal annual program evaluation that occurs during the second quarter of the next year. For example, the previous year's formal program evaluation will be completed during the third quarter of the next year and presented to the Medical Operations Committee and to the C-MQMC.

Designated committees or key leadership have the responsibility of providing oversight to the program and ensuring reports are generated and reviewed ongoing during the reporting year. (Oversight responsibilities are described in section 3).

Progress towards meeting the goals or performance against benchmarks is monitored at determined intervals (monthly, quarterly, or annually) and may be adjusted based on results or trends. A corrective action plan is implemented after a minimum of two reporting periods to determine if a trend has been identified requiring further action. The management team, work groups and committees, including Medical Operation Committee and the C-MQMC have responsibility to review the results and determine actions.

After the formal program evaluation of the prior year's results, the program description is reviewed and any required updates to the program completed.

MOC 4B.4: Describe the processes and procedures the SNP will use to determine if health outcome goals are met

Each of the previously mentioned performance and outcome measurements are used to report on the goals and objectives as defined above. The quality department creates an annual work plan for HEDIS measures. The appropriate department monitors and reports progress toward identified goals and actions Anthem collects, analyzes, and reports Part C and Part D data elements through standardized processes and enterprise systems. The required reports extracted and compiled utilizing standardized procedures and techniques in the data extraction and analysis processes. Data sets are then analyzed by the reporting analytical resources dedicated to Medicare Advantage and transformed into formats required for CMS Part C Reporting, either through standard file upload formats or through HPMS submission, as dictated by Part C Report Technical Specifications.

Standard processes and procedures are followed to pull data for the reporting period, with checklists and tracking to insure all underlying reporting data is accounted. Data is routinely reviewed for accuracy by each accountable department. Quality checks are performed on extraction logic, and counts are verified by business owners. Business owners look for variances against previously submitted data and against regularly reported business metrics for the reporting period in question. Taking into account each specific measure, complementary metrics are used in comparison to verify any changes in the data used in reporting.

Data and metrics that comprise the Part C reporting elements are used in monitoring performance and effectiveness of the MOC program, including aspects of care and service, such as provider access and availability, over/underutilization and member satisfaction with care and services.

To determine if the program goals have been met, ongoing ad hoc data reports are generated and the quality team or department responsible for the goal results, analyzes the data for trends. In the Quality department HEDIS indicators are monitored, including SNP specific members' data, on a monthly basis and trends in markets for outliers are identified. As trends and outlying scores are identified, cross functional teams collaborate to work on creating improvement plans. These teams convene at the enterprise, regional, and health plan level to create the best action plan for the identified outlier measure. Some measures such as beneficiary level measures may be better managed at the plan level while enterprise level measures and improvement plans (completion of the HRA, CP, and ICT) may be better managed at the enterprise level to monitor trends and best practices. Member and provider satisfaction

results are compared to identify best practices and barriers. Medicare and SNP corporate and regional quality leads and staff development, implement, and assess improvement plans. Other business areas monitor goals and reviews results during management or team meetings, ad hoc work groups or established work groups that have the appropriate representatives to facilitate review of results, discussion of possible actions and approval of any interventions or corrective action plan.

After the formal program evaluation of the prior year's results, the program description is reviewed and any required updates to the program completed.

MOC 4B.5: Describe the steps the SNP will take if goals are not met in the expected time frame

If a downward performance is noted or goals are not being met, improvement opportunities are identified and interventions are implemented timely to improve performance and member results. A formal corrective action plan is typically not created until a trend is verified usually after two reporting periods when progress toward the benchmark is not occurring. Ongoing oversight and management of all of our goals is part of each business unit. It is the responsibility of the department leadership to address any issues that may be identified including development of a formal corrective action plan.

Any of the following actions may occur if we determine our goals are not being met within the specified timeframes:

- Modifications to set timeframe to measure goal (may move to monthly from quarterly to provide more oversight in areas not meeting targets)
- Changes and review of member educational material
- Hiring temporary staff to improve results and outreach
- Changes in outreach activities to target areas where goals are not being met
- Changes to care planning and discharge tools including development of new materials
- Targeted education provided to members or providers through mail or by posting to the provider web portal
- Changes in policy and procedures to capture new processes
- Changes in staffing patterns or personnel to enhance outreach to members or providers, or to perform core functions
- Use of vendors to support initiatives or when deficiencies are identified such as a vendor to perform outreach post discharge, perform home assessments, perform chart audits
- Changes in systems of operation including enhancements to functionality , use of new screens to capture data, or new programs
- Creation of new reporting or obtain further drill down on data to determine cause of negative trend (goal not being met)
- Changes in provider or facility network including recruitment of new providers
- Development of new programs or supplemental benefits to address areas targeted for improvement.
- Development of work groups to address deficiencies or areas of improvement.
- Evaluation of the goal and review of the population to determine if goal requires modification or if another measure is more appropriate for the population.

- Provision of training concerning the goal and desired results.
- Development of new training materials
- Use of IVR technology to outreach to members

MOC 4C: Measuring patient Experience of Care (SNP Member Satisfaction)

MOC 4C.1 & 2: Describing the specific SNP survey used and rational for selection

The Health Plan has established a goal to improve beneficiary health outcomes through improved satisfaction with health status and healthcare services. The Quality department evaluates satisfaction with clinical care and services utilizing the annual CAHPS survey to compare performance against national benchmarks and state performance goals to identify improvement opportunities. The Medicare CAHPS surveys produce comparable data on the patient's experience of care that allow objective and meaningful comparisons between Medicare Advantage, SNP and PDP contracts on domains that are important to consumers.

The survey is administered to members by a CMS approved CAHPS vendor. The results of the annual CAHPS survey are disseminated to quality leadership. Quality Medicare leadership and dedicated work teams comprised of network, provider relations, customer service, health care management and quality staff to develop meaningful activities geared at addressing patterns of low member satisfaction.

Contractual standards, evidence based practice guidelines, and other nationally recognized sources such as CAHPS, HOS, and HEDIS may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measureable and based on current knowledge and clinical experience. The indicators reflect potential areas of improvement related to structure/process/outcome of care or administrative and service systems within the delivery of care to include utilization management, credentialing, member satisfaction, monitoring and resolution of member complaints and appeals, availability and accessibility of practitioners, plan benefits/services/accessibility, health management systems to monitor/manage chronic conditions, patient safety, preventive care and disparities in care.

The Health Plan conducts appropriate studies to evaluate and improve upon clinical care, outcomes, services and satisfaction. Data sources utilized to identify population specific opportunities for improvement include but are not limited to member demographics, epidemiological factors, service utilization patterns, case management program data, and HEDIS/CAHPS/HOS results.

Members that are enrolled in our complex case management program are encouraged to participate in a survey to evaluate the level of satisfaction with the program. The results are provided quarterly to the case management leadership and reviewed. If any trends or actionable issues are identified during the quarterly or annual review actions are taken to address the situation as determined appropriate by the clinical leadership. Annually the results are analyzed and included in the program evaluation.

MOC 4C.3: Describing how results of patient experience surveys are integrated into the overall performance improvement plan

An annual review is conducted of the CAHPS information to determine patterns for low performing marks such as provider communication, member customer service results and overall satisfaction with the Health Plan. Work groups are in place to develop strategies for improvement in areas where patterns of responses are noticed and meaningful change can be implemented to better service our SNP population. Our annual analysis of CAHPS, as well as additional managerial monitoring activities such as surveys extended to membership at end of member service calls, spot check surveys on member satisfaction, and phone observation and monthly evaluation of administrative HEDIS scores through the year are integrated into our overall performance improvement plan. Cross-functional departmental teams review the results from our CMS driven CAHPS and HOS surveys as well as internal process improvement tools and work collaboratively to develop action plans to improve the member experience. Actions include modifying member materials, addressing and changing processes related to member complaints, modifying internal procedures related to member outreach, or other member centric activities.

Data elements collected from tools like CAHPS are used to evaluate the effectiveness of the SNP Model of Care. This data is analyzed and the results of the analyses are reported to the C-MQMC as part of the annual evaluation.

MOC 4C.4: Describing steps taken by the SNP to address issues identified in survey responses

The methodology includes continuous tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained for survey measures. Based on the outcome results a workgroup meets to discuss enhancing the member experience and addressing items that did not receive high marks. The results of the annual CAHPS survey are reviewed and analyzed by the Regional and Corporate Quality departments as well as the STARS team and shared with cross-functional departmental work groups encompassing local health plan leadership, regional Medicare leadership, customer service, healthcare management services, provider relations and network management. CAHPS is the primary tool utilized to determine the members' experience with their healthcare providers and the health plan's programs and services. Activities to address areas not meeting internal thresholds are identified, short term and long term improvement goals are identified and strategies for improvement are implemented, and monitored with the goal of exceeding member expectations and satisfaction. Clinical research is done to look at best practices across the industry. Key focus areas are identified and targeted for improvement of processes to ensure greater member satisfaction, enhanced provider satisfaction and a more positive overall member care experience.

MOC 4D: Ongoing Performance Improvement Evaluation of the MOC

MOC 4D.1: How the organization will use the results of the quality performance indicators & measures to support ongoing improvement of the MOC

The Health Plan uses the results of the quality performance indicators and measures to create quality action plans based on systematic subjective and objective analysis. Progress toward identified goals and actions outlined in the action plan are monitored monthly or as determined appropriate by the management teams responsible for the goal results and reported to Medical Operations Committee and CMQMC bi-annually or as needed.

The health plans' develop specific quality improvement projects that will improve the model of care MOC performance and member outcomes. Continuous quality improvement activities implemented to support and achieve ongoing improvement may include any the following:

- SNPs that measures health outcomes and indices of quality pertaining to the management of care for SNP populations at the health plan or delegated entity level
- SNPs that measures access to care, including service and benefit utilization rates
- SNPs that measures improvement in members' health status utilizing chronic disease outcomes
- SNPs that measures staff implementation of the SNP MOC utilizing the NCQA
- SNPs that measures comprehensive risk assessments, including timeliness of initial assessments or annual assessments
- that measures use and adequacy of the provider network having targeted clinical expertise, by evaluating service and pharmacy claims, diagnostic reports, and other applicable data
- that measures providers' use of evidence-based practices and/or nationally recognized clinical protocols
- that measures the effectiveness of communications, using call center utilization rates, rates of member involvement in care plan development, and analysis of member or provider complaints, to improve involvement in effectiveness and communications;
- that measures CMS-required data on quality and outcomes measures that will enable beneficiaries to compare health coverage options; these data include HEDIS, HOS, and CAHPS data
- that measures CMS-required Part C Reporting Data Elements that will enable CMS to monitor the health plan's performance
- that measures CMS-required MTM) measures that will enable CMS to monitor the health plan's performance

These data are used to evaluate the effectiveness of the SNP MOC. These data are analyzed and the results of the analyses are reported to the Medical Operational Committee and C-MQMC as part of the annual evaluation. Quality improvement actions are implemented based on the recommendations of all pertinent committees. Potential quality improvement actions are prioritized based on impact, cost, and feasibility.

MOC 4D.2 & 3: How the organization will use the results of the quality performance indicators & measures to continually assess & evaluate quality and to timely interpret & respond to lessons learned through the MOC performance evaluation

The Quality Management Program encompassing the evaluation of the MOC reflects a continuous quality improvement (CQI) philosophy and mode of action. All work is examined as a process. Each process is

continuously improved by analyzing and acting to minimize variation over time to become more efficient and effective.

Multiple indicators of quality of care and service are identified for evaluation. Compliance with desired outcomes is measured and results reviewed. Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving clinical and service performance goals. Barriers for achieving desired outcomes and interventions or strategies recommended are considered in the analysis. When variations are noted root cause analysis, action plans and re-measurement occur to ensure progress toward established goals. Results are monitored and actions plans may not be created until two consecutive reporting periods where results continue to not meet expected outcomes. This allows the leadership to monitor for trends as some variations are expected during the year based on situations such as seasonality. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Quantitative and qualitative analyses of clinical, service and administrative data, cost benefit analysis and industry benchmarks and trends, are the basis for prioritizing, monitoring and measuring performance, and evaluating the overall effectiveness of the quality program. MOC initiatives occur at least annually, and the performance measures are formally evaluated through data analysis, barrier analysis and prioritization of measures and activities for the following year. The Regional Quality department maintains a work plan that encompasses quality aspects of the MOC and evaluates these on a quarterly basis. If goals are not met and barriers are identified cross-functional departmental work groups encompassing local health plan leadership, regional and corporate Medicare leadership, customer service, provider relations and network management are put into place to implement programs and processes to achieve the desired programmatic goals and health outcomes.

MOC 4D.4: How the performance improvement evaluation of the MOC will be documented & shared with key stakeholders

The clinical team participates in the program evaluation process by performing an evaluation of clinical elements including the annual results of the MOC goals. This evaluation is presented for review and approval at the Medical Operations Committee and included as an attachment to the minutes. The results of the goals are taken twice a year to the Medical Operations Committee (MOC) and C-MQMC.

The documentation of the presentation and discussion is documented in the meeting minutes, which contain future recommendations and action planning. The minutes and supporting documentation are available in the meeting materials of the C-MQMC and are kept as historic documents. Recommended improvements or changes to the MOC are owned by the each applicable department. After the committee has reviewed these documents, any changes are incorporated into the MOC document and any policies and procedures are updated to reflect the changes.

The Medical Operations Committee reviews and/or approves documents and reports related to clinical guidelines, utilization management policies and procedures inclusive of the MOC day-to-day operation oversight as defined by the committee charter. Reports are designed to evaluate the program as defined in the goals and objectives section. Activities/ reports related to the MOC are reviewed and analyzed monthly, quarterly and annually as determined appropriate by the business owners of the individual goal

or process. When appropriate, the goal/ process business area will identify action plans and makes recommendations to the Medical Operations Committee.

The quality team participates in the program evaluation process by performing a quality evaluation at the regional level. The annual Quality Improvement Program Evaluations include a comprehensive review of the following areas.

Reports and documents for committee review, analysis, recommendations and/or approval may include, but are not limited to:

- Trilogy Documents and Templates
- Downstream Committee Updates
- CCIPs and QIPs
- Model of Care: Program Description and Goals, Program Evaluation
- HEDIS rates, trends and analysis: Medicare, DSNP, MMP
- HEDIS Interventions
- DSNP Quality Monthly Workgroup update
- HOS/Stars report and interventions for improvement
- CAHPS/Stars report and interventions for improvement
- Annual Stars Overview and Results
- HCMS (CM/UM/Model of Care) Medical Operations Committee Summary
- Physician Interrater Reliability (IRR) Assessment Results (Medicare and MMP)
- Clinical Practice Guidelines
- Network reports
- Medicare Call Centers reports
- Medicare Pharmacy Programs
- Enterprise Delegation Oversight & Management annual report
- Behavioral Health Programs
- Annual Medicare Compliance Update
- Medicare Quality Policies
- Quality program and results from delegated entities for clinical services

There is a specific section in the Quality Improvement Program Evaluation for the Model of Care as it relates to Quality and Health Care Management. These Regional Quality Improvement Program Evaluations are presented for review and approval with key stakeholders annually at the Corporate Medicare Quality Management Committee (C-MQMC) and Medicare Medical Advisory Committee (MMAC).

MOC 4E: Dissemination of SNP Quality Performance Related to the MOC

MOC 4E.1: Sharing Performance Results and Other Pertinent Information with Multiple Stakeholders

During the second or third quarter of the year, the QI Program Evaluations are presented at the C-MQMC and MMAC. Any changes or recommendations generated from this review will be incorporated into the current year's program description.

During the second or third quarter of the year, the previous year's Health Care Management (HCM) program evaluation is presented to the designated oversight committee, typically this is the Medical Operations Committee. Elements of this program evaluation related to the goals may also be presented at the C-MQMC for further review and oversight. The HCM program evaluation addresses those elements outlined in the Model of Care that are aligned in the clinical areas of Utilization Management and Case Management. The annual results of the MOC goals are also included in the HCM program evaluation.

Throughout the year, if performance results appear deficient during the ongoing assessment by the business owners, departmental leads may convene work groups in their area to address areas of poor or underperformance. Cross-functional improvement meetings are also facilitated with the leads of respective areas ad hoc to address concerns throughout the year and share lessons learned. Any final revisions to the MOC are noted in the final MOC program evaluation and presented annually at the CMQMC for approval.

While the formal review takes place annually, each goal has an owner for managing the outcome measures. The goal owners may include any of the following: the National Medical Director, Regional Medical Directors, Regional Directors of Health Services, Early Intervention Director, Medicare finance and reporting, the Regional and Corporate Clinical Quality Management, Provider Network, Medicare Appeals and Grievances, and Behavioral Health Leadership.

MOC 4E, 2-4: Communication with Stakeholders

Quality and HCM staffs are members of the C-MQMC that meets a minimum of eight times per calendar year. During this meeting, the evaluations are reviewed and the team provides additional recommendations. If changes are made to the program the information is communicated to case managers and other internal staff responsible for implementing the MOC. The Training Department is engaged to make necessary revisions to the training program. If changes to the MOC program are recommended as part of the evaluation process, the recommendations are brought to the executive team for discussion and adoption. The executive team is comprised of leaders from the Quality department, Health Care Services Department, Complaint and Grievance Department, Member Service Department, Compliance and the National and Regional Medical Directors.
After the program evaluation has been approved the results of the evaluation are communicated to stakeholders in any of the following ways:

- Distribution in the Health Plan Provider Newsletter
- Annual Update in the Provider Manual
- Posting to the Health Plan Provider Website
- Posting to the Health Plan member website
- Distribution in member newsletters
- Dissemination to internal departments and committees
- Incorporation into training materials

The medical management program evaluation and the quality improvement program evaluation are examples of program evaluations that are used to measure the previous year's performance.

The program evaluation from medical management included items in the program descriptions and work plan. The program descriptions and work plan is created and reviewed annually. The program evaluation is completed by the regional medical management teams with feedback from multiple functional owners for the different components. This evaluation is presented and approved annually at the Medical Operations and applicable components to the C-MQMC.

The Quality Management Program Evaluations are also an evaluations that are used to measure the previous year's performance in each region. The program descriptions and work plans are created and reviewed annually. The program evaluation is completed by the regional quality teams with feedback from multiple functional owners for the different components. The regional quality leaders will present for approval the regional quality evaluations annually at the C-MQMC committees.

Other business areas perform a program evaluation that is all considered part of a holistic program review and evaluation. Each program evaluation is taken to the designated committee for review and approval.