H9306-Alterwood Advantage Dual Plan

Model of Care

2022

Table of Contents

MOC 1 – Description of the SNP Population (General Population)

Element A: Description of the Overall SNP Program

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. It must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations, if relevant to the target population served by the SNP. The description of the SNP population must include, but not be limited to, the following:

- **Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.**

Alterwood Advantage Dual Plan offers services to a targeted population, which includes fully dual-eligible beneficiaries that meet the following criteria:

- Qualify for Medicaid with subsidy level as a Full Benefit Dual Eligible (FBDE) or Qualified Medicare Beneficiary (QMB); or, Qualify as a Specified Low-Income Medicare Beneficiary
- Are entitled to Medicare Part A and are enrolled in Medicare Part B.
- Permanently reside in the counties within the CMS approved service area for Alterwood Advantage Dual Plan in Maryland which include Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Cecil, Charles, Dorchester, Howard, Harford, Kent, Montgomery, Prince George's, Queen Anne's and Talbot.
- Are a United States (U.S.) citizen or a legal resident for at least five years.

Member identification eligibility requirements for the Dual Plan:

The Dual plan is intended to meet the needs of beneficiaries who receive certain Medicaid benefits. In order to be eligible for this plan the beneficiary must be eligible for Medicare and for Medicaid.

The following Medicaid beneficiary categories are eligible based on benefit plan:

- Full Benefit Dual Eligible (FBDE)
- Qualified Medicare Beneficiary (QMB)
- Specified Low Income Medicare Beneficiary (SLMB)

Alterwood Advantage Dual Plan's Enrollment department is responsible for accepting enrollment applications and information from potential members. The Enrollment Department follows the Centers for Medicare & Medicaid Services (CMS) compliant policies and procedures (P&Ps) which outline detailed enrollment verification and eligibility tracking procedures for the enrollees in this SNP.

Alterwood Advantage Dual Plan's Enrollment Department accepts enrollment requests from eligible members through the following options:

- *In-person*: Dual eligible members may request a face-to-face visit with a licensed sales agent to learn more about this SNP product and/or to enroll in the program.
- *Telephonic enrollment*: Dual eligible members may contact Alterwood Advantage Dual Plan's Telephonic Sales Department to enroll via telephone between the hours of 8:00 a.m. to 8:00 p.m., seven (7) days a week during October 1 through March 31 and 8:00 a.m. to 8:00 p.m., five (5) days a week April 1 through September 30. Telephonic enrollment will be completed using online enrollment tool using a CMS-approved call script on a recorded line.
- *By mail*: Dual eligible members may contact Alterwood Advantage Dual Plan Sales Department at the above number to request a sales and enrollment kit. Members may complete the CMS-approved enrollment form and return it to Alterwood Advantage Dual Plan for processing and data entry.
- *Medicare.gov Website*: Dual eligible members may complete the CMS-approved enrollment form on the CMS online system and the Enrollment Department will download the application for processing and data entry.

At the Alterwood Advantage Dual Plan, the Field Sales Agent/Broker conducts field marketing activities including in-home presentations to prospective members and presentations in seminar settings at community centers and similar venues. Once a presentation attendee expresses interest in our plan, the Field Sales Agent/Broker verifies the potential member's eligibility for the plan: enrollment in Medicare Parts A and B, residence within Alterwood Advantage Dual Plan's service area. Field Sales Agents/Brokers are state licensed and have either America's Health Insurance Plans (AHIP) or Gorman certification. They have expertise in Alterwood Advantage Dual Plan's D-SNP eligibility requirements and assist members in understanding what is considered valid proof of eligibility, i.e., a Medicare card, a Medicaid card, an award letter from the Social Security Administration, an award letter from the State of Maryland for Medicaid, etc. In addition, at the time of the Sales appointment, for applicants with full Medicaid benefits, the Field Sales Agent/Broker verifies Maryland eligibility in the State of Maryland through the Broker Support Unit (BSU). The BSU has access to the Eligibility Verification System (EVS) through the state of Maryland, which verifies Medicaid eligibility and type of eligibility, such as Full Benefit Dual Eligible (FBDE) or Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare Beneficiary (SLMB). These three eligibility types are the only three that would qualify a member for the Alterwood Advantage, Dual Special Needs Plans (D-SNPs). Activities of the Field Sales Agents/Brokers are monitored by the Sales management team, who monitors Sales productivity and turn over, particularly rapid disenrollment which could signify a need for re-training or other action. The Sales management team, in conjunction with Compliance, also ensures that the Field Sales Agent/Broker conduct their sales activities in compliance with the Medicare Improvements for Patients and Providers Act (MIPPA) and other CMS regulations.

In order to demonstrate proof of Medicare Part A and B entitlement, the applicant must be able to provide their name, Medicare number, Part A entitlement date, and Part B entitlement date as it appears in the MARx system (which the Enrollment Department uses to verify Medicare eligibility). When being assisted by an agent, the beneficiary can do this by showing one of the following: 1) a copy of their Medicare card, 2) Social Security Administration (SSA) award notice, 3) a Railroad Retirement Board (RRB) letter of verification; or 4) a statement from SSA or RRB verifying the individual's entitlement to Medicare Part A and enrollment in Part B.

Alterwood Advantage Dual Plan will limit enrollment to individuals who meet the specified Medicaid eligibility requirements, either SLMB, QMB, or FBDE. In addition to the eligibility requirements as set forth by CMS in Chapter 2 of the MMCM applicable to the target population. Before processing an enrollment into Alterwood Advantage Dual Plan D-SNP, the Enrollment Department will confirm Medicaid eligibility by using the State of Maryland eligibility verification system (EVS). If the Enrollment Department is unable to verify dual eligibility using EVS, then Alterwood Advantage Dual Plan's acceptable proof of Medicaid eligibility will be a letter from the state agency that confirms entitlement to Medical Assistance.

New enrollments are processed within seven (7) calendar days of receipt of the completed enrollment request. Once the Enrollment Department has completed initial verification and deems the application complete, a Batch Eligibility Query (BEQ) is sent.

Daily enrollment files are transmitted to CMS, and the associated enrollment responses are received in the Daily Transaction Reply Report (TRR). The Alterwood Advantage Dual Plan Enrollment Department processes these reports and takes appropriate actions to complete the enrollment, resolving rejections and correcting errors. The corresponding confirmation of enrollment letters are triggered from the TRR for printing and mailing.

Once the Enrollment Department has received the confirmation of enrollment from CMS, all membership data will be transmitted to the Alterwood Advantage Dual Plan's systems utilized by the Claims, Health Management and Member Services Departments. This data is utilized by administrative and clinical staff to ensure eligibility and provide services to the newly enrolled members. Daily, a Health Insurance Portability and Accountability Act (HIPAA) standard transaction is sent to first tier and downstream vendors providing additional benefits and services.

Alterwood Advantage Dual Plan will process the Monthly Membership Report (MMR) to reconcile payments related to Alterwood Advantage Dual Plan's membership.

The Alterwood Advantage Dual Plan Enrollment Department understands that the Low-Income Subsidy (LIS) or any other Medicaid status flag in CMS' systems are not acceptable evidence for an enrollee's initial or ongoing Medicaid eligibility verification for the purposes of determining D-SNP eligibility. The Plan will verify continuing D-SNP eligibility at least once a year as per the State of Maryland regulation, COMAR 10.09.24.03-3C(4)(a).

Alterwood Advantage Dual Plan's Medicare Enrollment polices are reviewed no less than annually by the Enrollment Department and the Compliance & Regulatory Committee and are updated as required by CMS. Alterwood Advantage Dual Plan's Security and Privacy Policy ensures the appropriate handling of protected health information (PHI).

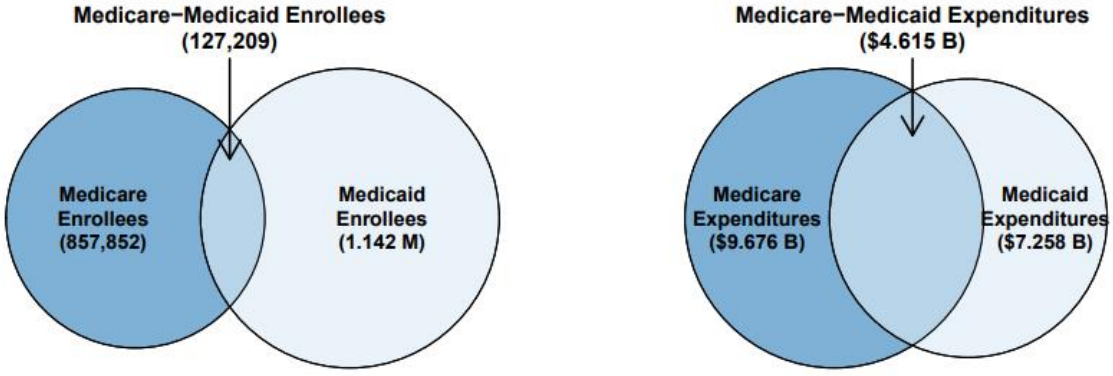
- **A detailed profile of the medical, social, cognitive, environmental, living conditions, and comorbidities associated with the SNP population in the plan's geographic service area.**

- **Identification and description of the health conditions impacting SNP beneficiary's, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).**

The D-SNP specific target populations of the Alterwood Advantage Dual Plan Dual Plans include: (1) Full Benefit Dual Eligible Beneficiaries (FBDE) and Qualified Medicare Beneficiaries (QMB), or (2) Specified Low Income Medicare Beneficiaries SLMB) Medicaid. D-SNP enrollment is voluntary and provides the beneficiaries specialized services based on its population needs.

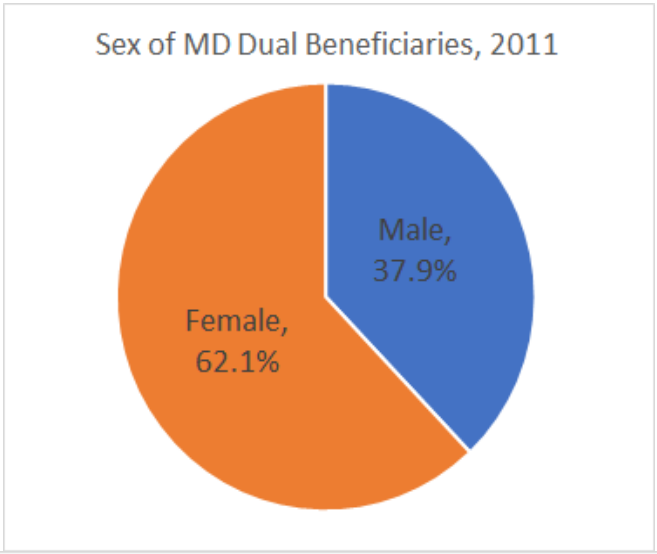
According to the most recent Medicare-Medicaid Enrollee Information Maryland, 2011 from the Center of Medicare & Medicaid Services *http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html* this subgroup of the Maryland dual population makes up approximately 15% of the Maryland Medicare population and 28% of total Medicare expenditures:

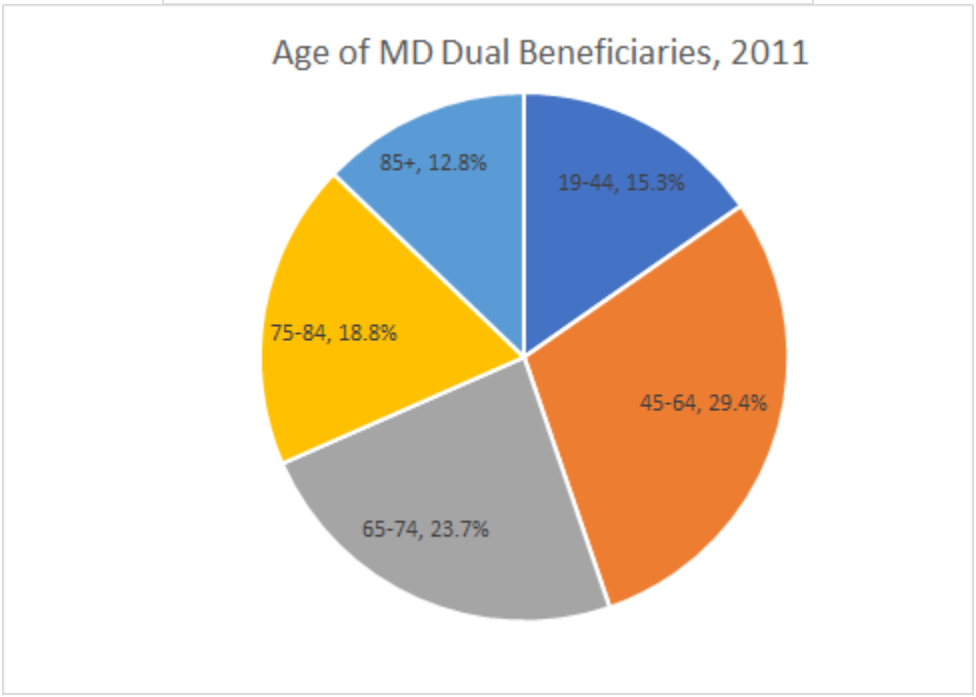
Figure 1. Total Medicare, Medicaid, and Medicare-Medicaid Dually Enrolled Populations[1]



According to the Data Analysis Brief: Medicare-Medicaid Dual enrollment 2006-2019 from the Center for Medicare and Medicaid Coordination Office from November 2020 http://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf the Dually eligible beneficiaries continues to grow nationwide, with 59.4% of the enrollees being female , 48% from a minority race/ethic group and 38% younger than age 65.

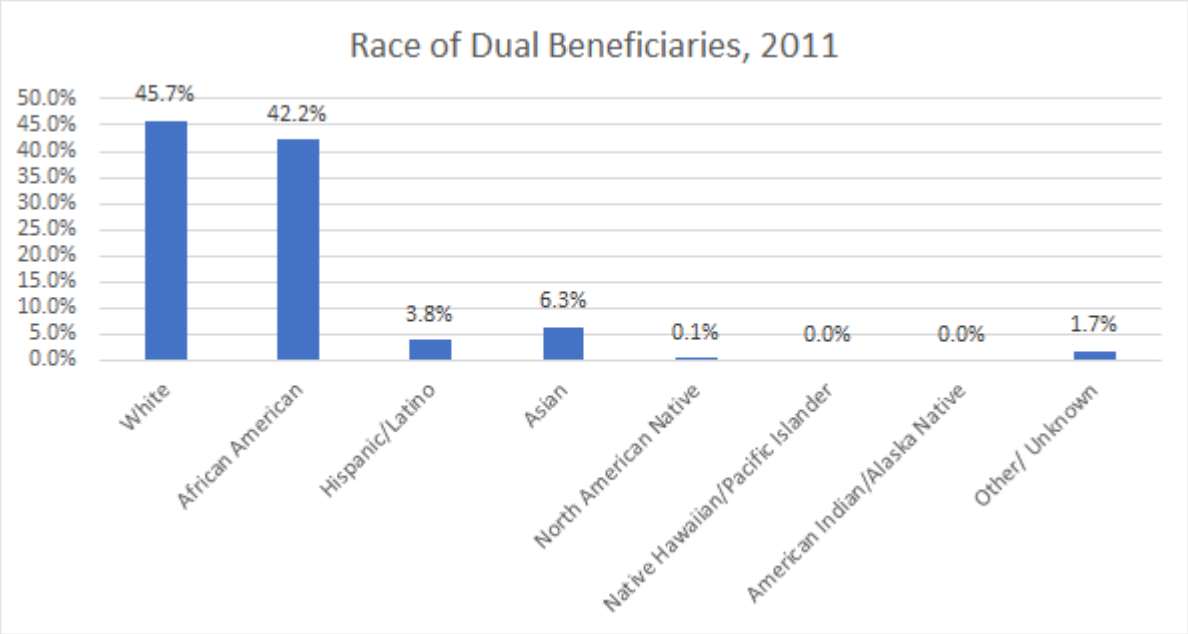
In Maryland, approximately two thirds (62%) of the Dual Medicare/Medicaiis female. Fifty-five percent (55%) are over the age of 65 (See Below).





http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

The figure below represents the racial makeup of Duals in Maryland. Whites and African Americans each represent 45% of dual beneficiaries. Hispanic/Latino Marylanders make up just under 4% of Duals and Asians represent over 6% of beneficiaries.

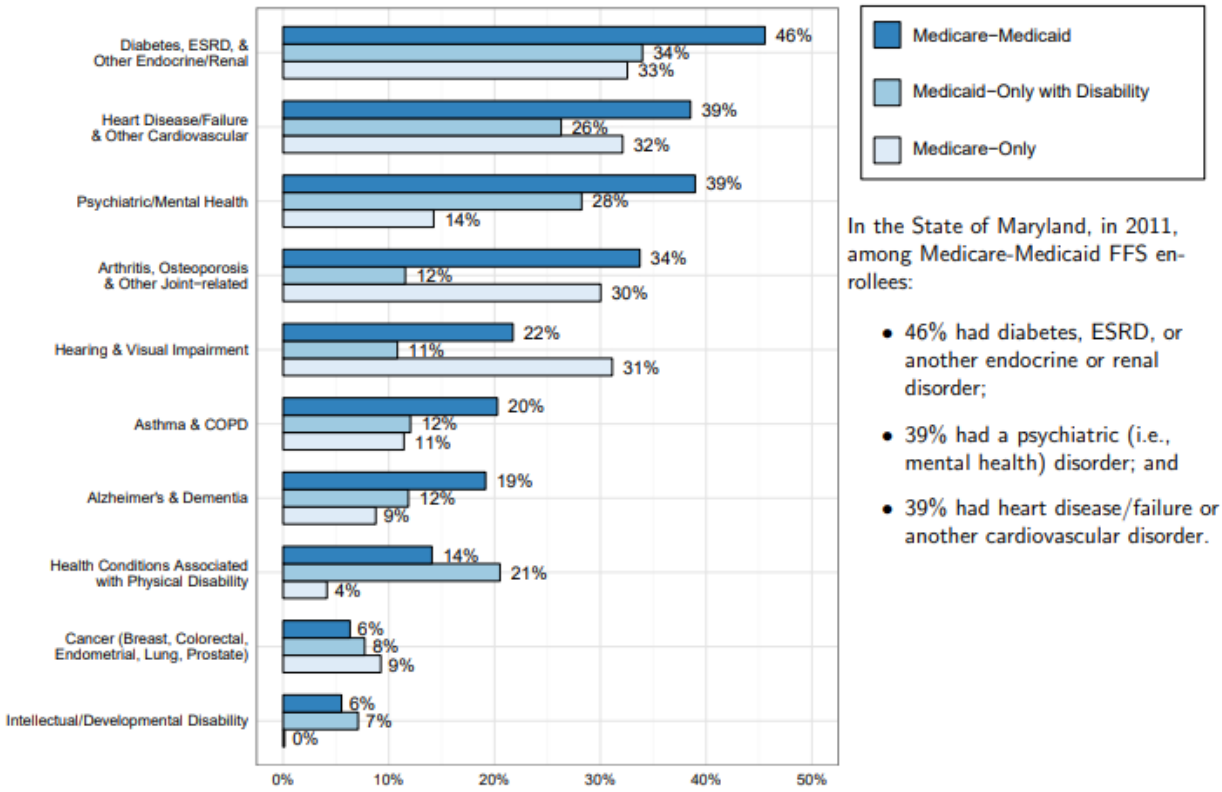


http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

The dual-eligible beneficiaries have a much higher prevalence of multiple chronic conditions. According to CMS Medicare-Medicaid Enrollee State Profile data in Maryland, "the full benefit duals were nearly 2.3 times more likely than Medicare-only beneficiaries to have 5 or more chronic conditions" *http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html*.

There tends to be a higher rate of heart disease, diabetes, depression, congestive heart failure (CHF), arthritis, and respiratory disease, including chronic obstructive pulmonary disease (COPD) among the dual population. In addition, there are higher rates of modifiable risk factors including smoking, substance use disorders, and obesity. These chronic and modifiable factors present another opportunity for our dual health plan to engage the beneficiary and subsequently improve their care through meaningful interventions. The figure below represents the health condition categories for Duals in Maryland compared the beneficiaries with only Medicare or Medicaid.

In addition, there are higher rate of modifiable risk factors including smoking, substance abuse, and obesity. These individual are also more likely to have challenges with the Social Determinants of Health such as home and food insecurity.



http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

Dual-eligible beneficiaries over 65 are more likely to need the Alterwood Advantage Dual Plan's assistance with multiple ADLs (activities of daily living) due to worsening chronic disease and disabilities such as depression; different types of cancer; diabetes, renal, lung, heart and vascular diseases, specifically CHF and COPD. Dual-eligible elderly tend to be in worse health than non-duals on all chronic disease and disability measures and are more likely to have a mental illness or Alzheimer's disease. Since many are living at, or near, poverty levels they are more likely to be home bound, be socially isolated, have poor nutrition, require more social supports and be at risk of institutional level of care. Dual-eligibles constitute 15% of the Medicare beneficiaries 28% of total Medicare spending. Forty-five percent (45%) of the Duals have aged in and fifty-three percent (53%) are disabled as part of the disabled Medicaid beneficiaries' populations. At least three times as many Full Benefit Medicare-Medicaid enrollees originally became eligible for Medicare because of a disability compared to the Medicare-only (Medicare with no Medicaid coverage) population.

- **D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.**

As mentioned above, the Dual-eligible beneficiaries over 65 are more likely to need Alterwood Advantage Dual Plan assistance with multiple ADLs (activities of daily living) due to worsening

chronic disease and disabilities such as depression; different types of cancer; diabetes, renal, lung, heart and vascular diseases, specifically CHF and COPD. Dual-eligible elderly individuals tend to be in worse health than non-duals on all chronic disease and disability measures and are more likely to have a mental illness or Alzheimer's disease. Since many are living at or near poverty levels, they are more likely to be home bound, be socially isolated, have poor nutrition, require more social supports and be at risk of institutional level of care.

Sufficient data is not currently available to quantify the barriers of the D-SNP population in Maryland in terms of health literacy and cultural beliefs. Knowing about a beneficiary's culture and language is key in determining how health literate the beneficiary is in each situation. Low health literacy, cultural barriers and limited English proficiency have been coined "the triple threat" to effective health communication by the Joint Commission (Schyve, 2007). As such, our health plan recognizes the importance that beneficiaries understand health conditions, disease processes, and interventions in order to self-manage their health. Our aim is to identify beneficiary preferences, gaps in care, at-risk areas, and knowledge deficits in self-management. Our care management team will adapt communication approaches to meet the individual needs of the D-SNP population.

The Alterwood Advantage Dual Plan understands the potential challenges of the coordination of benefits between Medicare and Medicaid. Beneficiaries may be confused when transitioned from one care setting to another, such as from the acute setting to a nursing facility, and the shift in program coverage and requirements (Health Affairs, 2011). Members of the Alterwood Management Executive Staff have experience in running a Medicaid MCO offering for the State of Maryland. Thus, bring the experience of managing Medicaid MCO beneficiaries with complex needs and have found that care coordination is essential in minimizing health risks and ensuring proper care of this population. Identification of beneficiary needs, and preferences is necessary to facilitate care coordination with different providers who are treating the same patient, including end-of-life needs and considerations. Sharing information with providers will reduce the risk of medication interactions, avoid duplication of services, and avert unnecessary hospitalizations.

There is a dichotomy of the costly beneficiaries across two disparate federal programs in that they are in contrasting community care settings. The beneficiaries most costly to Medicaid are those who are institutionalized. Those most costly to Medicare are those using extensive acute care services due to chronic conditions. Thus, efforts to improve care coordination for high-cost dually eligible beneficiaries might be directed at nursing homes, while care coordination for high-cost Medicare beneficiaries might be better focused on keeping patients healthier and out of the hospital.

Element B: Most Vulnerable Beneficiaries

As a SNP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members

with multiple hospital admissions within three months, "medication spending above $4,000"). The description must differentiate between the general SNP population and that of the most vulnerable members, as well as detail additional benefits above and beyond those available to general SNP members. Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

- **A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.**

Dual-eligible elderly live at, or near, poverty levels, and therefore are more likely to be home bound, be socially isolated, have poor nutrition, require more social supports and be at risk of institutional level of care. These social factors contribute to the complexity of impacting clinical outcomes for chronic conditions with this subpopulation. The most prevalent chronic diagnoses among this vulnerable population are:

- Diabetes
- Heart disease
- Lung disease
- Mental illness or Alzheimer's disease

In identifying this vulnerable population, there is specific focus on multiple domains including: claims data; medical records data including but not limited to pharmacy claims and lab results; beneficiary outreach, and assessments covering: medical, mental health, psychosocial, functional, cognitive and nutritional needs. During assessment and re-assessment, our clinicians will strive for cost savings by avoiding duplicative services and allowing the beneficiary to remain in the least restrictive environment, for example-home versus nursing home.

Alterwood Advantage Dual Plan's approach in identifying the most vulnerable beneficiaries utilizes a comprehensive Health Risk Assessment Tool (HRAT) which gathers information pertinent to a beneficiary's overall health status, as well as identify health risks in the following categories:

- Barriers: to meet the goals and /or comply with the individualized care plan
- Behavioral/Lifestyle: tobacco, alcohol and drug use; physical activity, nutrition, and oral health
- Benefits/Coordination of Benefits: benefits available and level of understanding; work status; disability
- Cognitive Status: educational level, understanding of health conditions, and ability to follow self-management instructions regarding health; memory/thought processing issues
- Communication: language, visual or hearing limitations, preference or needs

- Cultural/Religious: complementary and alternative medicine utilized; any religious or cultural needs, preferences or limitations that may impact healthcare and/or the individualized care plan
- Functional Level: activities of daily living (ADLs), instrumental ADLs, history of falls; elimination, pain and sleep issues; DME usage/needs
- Health Status/Clinical History: General health history, co-morbidities, allergies, and treatment/surgical history
- Internal Health Management Process: member contact information; HIPAA considerations; consent for engagement/participation; marital status; living arrangement; Care Management status
- Life Planning: Healthcare power of attorney, advance directives, living will, life goals
- Preventative Health/Key Metrics: Sexual health, preventative screenings, and immunizations
- Psychosocial/Mental Health Status: Coping status; depressions/stress/anger; loneliness/risk for social isolation; family and social support
- Resources & Support: Caregiver resources/ level of involvement, external resources utilized
- Safety: health and personal well-being issues: safety concerns
- Utilization/ Treatment: Inpatient and Emergency Department (ED) utilizations, PCP and specialist utilization, current treatment plan and planned interventions

Regardless of opportunities identified, every dual eligible beneficiary is contacted to offer health management services due to the population's high vulnerability identified above. Once engaged, those beneficiaries that can be located, and/or consent to health management services, are engaged in the next steps for health management.

Beneficiaries who consent to health management services are further engaged to ensure they have input into the health management opportunities/barriers identified for the ongoing care plan agreement. Beneficiaries and the Health Manager also agree to the intensity of their care management support. Beneficiaries are sent a copy of the agreed upon care plan. The beneficiaries also agree to have their primary care physician (PCP) allow input into the care plan by having the completed document available for review on the provider portal. The beneficiary and/or health plan health manager agree to share this document for the PCP input. Sharing will occur via U.S. mail, follow up input to or from the PCP via telephonic notes and/or during the visit of the beneficiary with their PCP.

The intensity of health management contacts is based on the following definitions:

High Risk Members – Beneficiaries with high resource use and risk, including high frequency of visits, more than 3 hospitalizations or ED visits within three months, treatments, multiple co-morbid conditions, non-adherence with treatment, adults with special needs, and polypharmacy. Note: Includes beneficiaries potentially at-risk or at-risk for misuse or abuse of

frequently abused drugs (FADs). The Health Manager will collaborate with the Clinical Pharmacist regarding the Drug Management Program.

Medium Risk Members – Beneficiaries with a moderate resource use and risk, and a combination of the following: usually beneficiaries with limited number of co-morbidities (typically 3 or less), 1-2 visits to the ED or inpatient hospitalization within previous 90 days, and limited number of gaps in care.

Low Risk Members – Beneficiaries with a low resource use and risk, and a combination of the following: usually individuals with 2 or less co-morbidities, less than 2 ED visits or inpatient within the previous 90 days, and limited number or no gaps in care.

Alterwood Advantage Dual Plan manages chronic conditions such as Asthma, Diabetes and Chronic Heart conditions taking a population-based approach to the clinical and quality management of these conditions. This approach identifies individuals with chronic conditions, and using disease-specific interventions, attempts to alter the course of the disease. Referrals may be received from several sources: Alterwood Advantage Dual Plan staff, practitioners, facility staff, vendors, or self-referral by a beneficiary or caregiver. The Health Management team works collaboratively with other clinicians and licensed professionals at Alterwood Advantage Dual Plan to improve disease state outcomes and maximize individual member functioning.

All dual beneficiaries are referred to our Health Management program for assessment of their needs. Program components include mailed educational materials, provider education on evidence-based clinical guidelines, telephonic member education, and care coordination. The clinical basis for our program was established by using both the State of Maryland and Alterwood Advantage Dual Plan guidelines for chronic conditions.

- **A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.**

Dual-eligible beneficiaries are among the sickest and poorest individuals covered by Medicare and Medicaid. The dual-eligible beneficiaries living in our service areas reflect national data and have significant medical, behavioral health, and social service needs. Past research has demonstrated that there is considerable diversity within the dual-eligible population in Maryland. This diversity has important implications for these beneficiaries' health spending especially between our target population: FBDEs, QMBs, and SLMBs. About three-quarters of dual-eligibles are "full duals" and entitled to all Medicaid benefits, including long-term care services. In addition, Medicaid pays Medicare cost sharing for the FBDEs and QMBs. The balance of dual-eligibles that are called partial duals such as SLMBs, do not receive Medicaid benefits except for help with Medicare premiums. Dual-eligible beneficiaries are at greater risk

for having more chronic conditions, mental illness, and impaired functional abilities putting them at greater risk for nursing home admissions as well as an increased utilization of emergency room, inpatient stays and readmissions. Within this dual population, there are vulnerable subpopulations that require additional services. These include frail beneficiaries having multiple, complex and/or chronic conditions, the disabled (both under 65 and over 65), those with end stage illnesses such as cardiovascular and respiratory, and beneficiaries near the end of life. Due to the specialized needs of this identified population, there is a need to prioritize beneficiaries through stratification.

Dual-eligible beneficiaries who are under 65 tend to have a higher rate of serious physical, behavioral, or mental illness and have more comorbidities, are socially isolated, and are more likely to have difficulty with permanent housing, and higher rate of substance abuse. Language barriers and deficits in health care knowledge of the beneficiary can be obstacles in providing the best care possible. All these factors have an impact to the health outcomes of our D-SNP population. Our multi-faceted clinical team (clinicians, special needs coordinators and social workers) assesses these potential obstacles and uses tools and resources to adjust in these situations. Alterwood Advantage Dual Plan has implemented special provisions to accommodate the beneficiaries in their preferred communication method. Bilingual staff is available and TTY services to better communicate with beneficiaries and caregivers. In addition, Alterwood Advantage D-SNP members may be offered supplemental benefits which are designed to meet the needs of and improve health outcomes for our vulnerable members. The following is a brief description of some of these specialized benefits:

- Dental Services: Including but not limited to the following services: preventive care (such as cleaning, routine dental exams, and dental x-rays), emergency care visits, including X-rays, dentures, and oral surgery.
- Durable Medical Equipment: Including but not limited to such items as canes, wheelchairs, walkers, commodes, special beds, and monitoring equipment.
- Medical/Surgical Supplies: Including but not limited to items such as urinary catheters, wound dressings, glucose monitors, and diapers.
- Home Delivered Meals, post discharge: A value added benefit which includes preparing, packaging, and delivering meals to member homes during critical transitions of care.
- Home Health: All home health care services, including durable medical equipment (DME) associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.
- Transportation: Ambulance services for emergency and for non-emergent medical reasons to doctor appointments by taxi or car transportation
- Vision Care Services: Including the professional services needed for the purpose of diagnosing and treating all pathological conditions of the eye, including eye examinations, vision training, prescriptions, and glasses and contact lenses.
- Over-the-Counter products allowance
- Preventive Services and Immunizations

Due to the complexity of the population across multiple variables including demographic, social and disease burden parameters, Alterwood Advantage Dual Plan places special emphasis on supporting the beneficiaries in the highest risk category exhibiting impactable behaviors that when changed, can support ongoing health and wellness.

- **The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiary's, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiary's and/or their caregiver(s).**

Alterwood Advantage Dual Plan established partnerships with various community organizations that assist in identifying resources for the most vulnerable beneficiaries and/or their caregiver(s). Working closely with community partners and local health departments, our team can assist the vulnerable beneficiaries and/or their caregivers in accessing community services and receiving additional support as needed. After identifying a service need, our team actively solicits, in person or by telephone, a relationship with a service agency if one is not already established. Alterwood Advantage Dual Plan provides the beneficiary and/or caregivers with information including contact name and location. Appointment coordination and/or transportation assistance is also available through Alterwood Advantage Dual Plan.

These established partnerships include, but are not limited to, the following agencies serving adults and seniors:

- Local health departments by county
- Adult day services
- Respite care
- Residential care
- Home delivered meals
- Homemaker services
- Adult companion services
- Transportation
- Health clinics
- Women's health
- Men's health
- Substance Abuse
- Mental health clinics
- Domestic violence
- Specialty health clinics (i.e., Asthma, HIV/AIDs)
- Specialized medical and supplies and office equipment
- Immunizations
- Cognitive development centers
- Senior community centers
- Transitional support services
- Family and caregiver training and education services

If there is already an established relationship between a beneficiary/caregiver(s) with a community resource or agency, the Alterwood Advantage Dual Plan team ensures that relationship is maintained in order to facilitate continuity of care.

MOC 2 – Care Coordination

Care coordination helps ensure that SNP beneficiary's healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the beneficiary's caregiver(s). The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other.

Element A: SNP Staff Structure

Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:

- **Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.**
- **Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.**
- **Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.**

Alterwood Health Management Company provides management services to Alterwood Advantage Dual Plan. The Executive, Clinical, Quality, and Operational Leadership Structure is as follows:

Alterwood Health Management Companies Senior Leadership	Employed/Contracted	Description
President/CEO	Employed	Oversight of all operational, financial, clinical, and relational functions of all Alterwood Advantage plans.
Chief Medical Officer MD	Employed	Oversight of clinical policy, training, and management responsibilities for external clinical relationships.
Chief Operations Officer	Employed	Oversight Claims Configuration, Claims Processing, Member Services, Enrollment, Provider Network, Provider Credentialing, and Appeals and Grievances.
Chief Financial Officer	Employed	Oversight of financial operations including, billing, financial reporting, analytics management and bid planning.

Chief Health and Quality Officer	Employed	Responsible for all clinical operations, health management, utilization management, pharmacy and quality improvement functions.
Chief Marketing Officer	Employed	Oversight of marketing, sales, and external affairs. Responsible for ensuring the training, licensing, credentialing of sales team, the development of required materials such as Provider Directories, Summary of Benefits, and Evidence of Coverage, websites, specialized letters, brochures, posters, and the submission and approval of all materials through CMS.
Chief Information Officer (IT)	Employed	Responsible for all medical claim data submission, CMS attestation reporting, CMS payment report, Part C and Part D data and Member Services and Claims performance reporting based on contract and CMS standards. Also, responsible to capture and reconcile all CMS MMR and TRR files and fills role of Chief Security Officer.
VP Business and Regulatory Affairs	Employed	Responsible for ensuring the Plan's Federal and statutory compliance, and compliance with Alterwood Advantage policies and procedures.
Enrollment, Claims Administration, and Member Service	Employed/Contracted	Description
Member Services Manager	Employed	This role is responsible for the operational components of the Member Services functions including eligibility verification, claim inquiries, benefit questions, new member verification calls, appeals and grievance intake.
Appeals & Grievances Manager	Employed	This role is responsible for the for day-to-day oversight for the correct and timely resolution of all member and provider appeals and grievances.
Member Enrollment Manager	Employed	Responsible for all the Membership Accounting functions including enrollment/disenrollment processing, eligibility verification and CMS enrollment file management (MMR and TRR).
Member Fulfillment Management	Contracted	Responsible for all new member enrollment packet, ANOC/EOC, other regulatory and/or supplemental member information mailings when applicable.
Claims Analyst	Employed	Responsible for claims adjudication. In addition, they will perform EOB and EOP generation, encounter submissions to CMS, suspected fraud, waste and abuse reporting and subrogation reporting. They will follow all current CMS and

		state guidelines in the accurate and timely processing of claims.
Member Services Representatives	Employed	Responsible for all Member Services functions, including eligibility verification, claim inquiries, benefit questions, new member verification calls, appeals and grievance intake. Trained and knowledgeable on benefits and who is eligible to receive from both the Medicare and Medicaid programs. Well-trained in giving members clear explanation of benefits and claims, cost sharing and coordination of benefits between Medicare and Medicaid. Skilled in giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and/or the state Medicaid program. Engages member for initial and reassessment HRAs.
Network Development and Maintenance	Employed/Contracted	Description
Provider Services (Telephonic) Representatives	Employed	Responsible for telephonic Provider Services including eligibility verification, claim inquiries and benefit questions. Member Services will be well-trained and knowledgeable in all HIPAA and federal and state compliance regulations and trained to answer Medicare/Medicaid questions.
Provider Relations (Field Based) Representatives	Employed	Communication and education will occur through the Plan's Provider Relations Representatives. These professionals will be versed in covered benefits under Medicare and Medicaid, Medicaid/Medicare Coordination of Benefits (COB) issues, and administrative processes under both programs as part of their toolkit when they visit or talk with network providers. These subjects will also be covered in the Provider Manual available in hard copy and/or on the Provider website. They will also perform contracting to supplement the existing network
Provider Credentialing Specialists	Employed	Responsible for all providers credentialing, including initial credentialing and re-credentialing. This role will also include regular review of relevant provider bulletins and monitoring any actions or sanctions against contracted providers.
Administrative Services	Employed/Contracted	Description
Analytics Management	Employed	Alterwood Advantage's CFO is responsible to perform all work ensuring the correct capture and submission of HCCs.

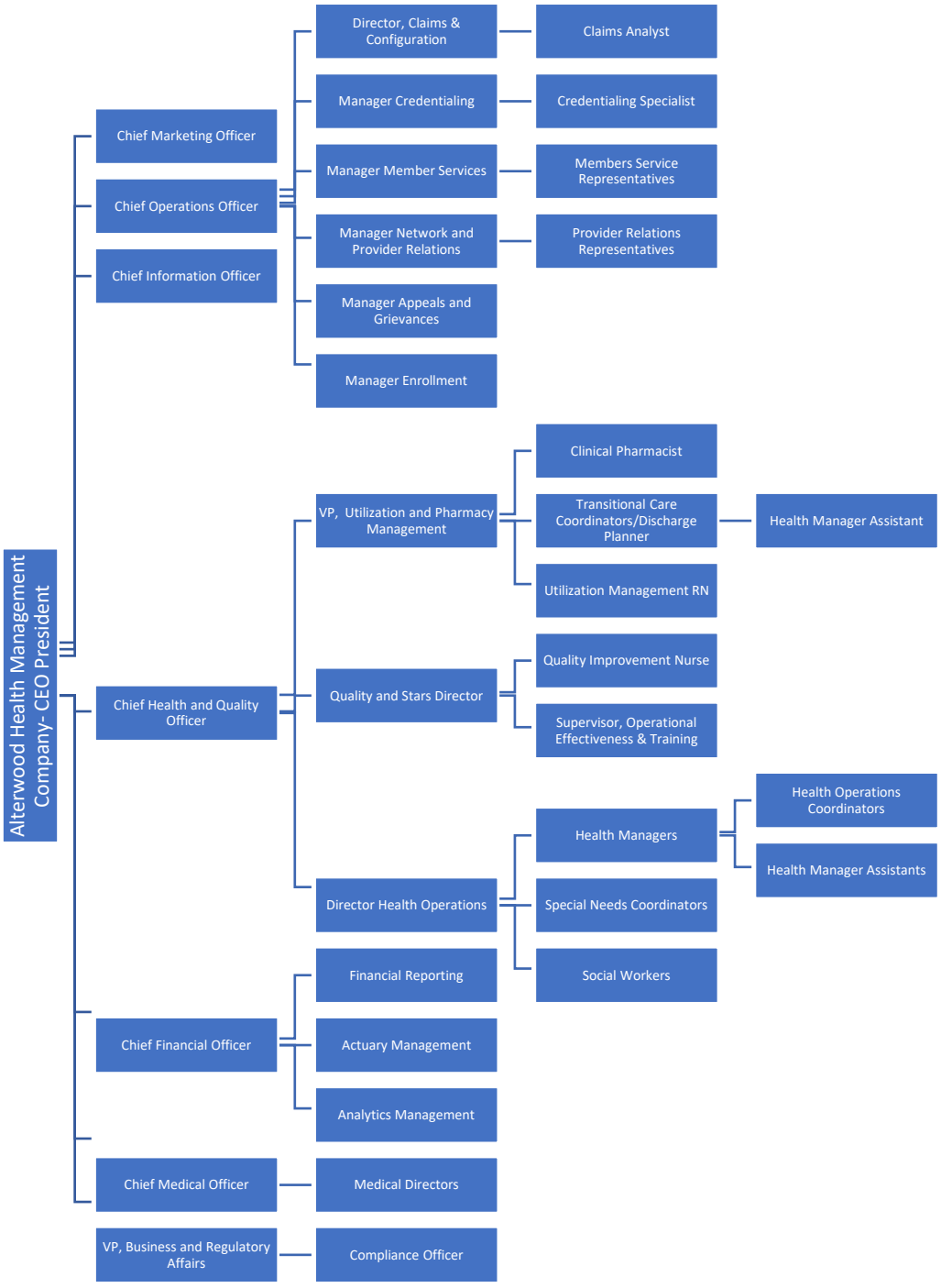
Actuary Management	Contracted	Preparation, completion and submission of annual bids. CFO is responsible for the oversight
Financial Reporting	Employed	The CFO is responsible to capture and report all financial information and required NAIC.
Operational Effectiveness and Training Supervisor	Employed	This role oversees the training of all DE Management Model of Care as well as ensuring the auditing of all Health and Quality operational areas.
Health Management and Quality	Employed/Contracted	Description
Medical Director MD	Employed	Oversight of clinical policy, training, and management responsibilities for external clinical relationships.
Quality and STARs Director	Employed	This role is responsible for direction and oversight of the day-to-day quality activities of the Plan and for the development and continuous improvement of the SNP Model of Care. This position also coordinates health education and preventive care outreach campaigns related to quality initiatives. Quality Improvement staff have the responsibility of monitoring the goals and key performance indicators for the SNP Model of Care Program. He/She is also responsible for the Health Services Model of Care Program's analysis, evaluations and works side-by-side with the medical director in developing new initiatives/programs.
Vice President of Medical & Pharmacy Management	Employed	Day-to-day oversight of all utilization and pharmacy management activities of clinical and non-clinical staff. Evaluation clinical performance to metrics, analyzes deficiencies, and leads in developing plans to address those deficiencies.
Health Operations Manager	Employed	Day-to-day oversight of all care management activities. Evaluates clinical performance to metrics, analyzes deficiencies, leads in developing plans to address deficiencies, supervises clinical and non-clinical health management staff
Clinical Pharmacist - Medicare	Employed	Provides oversight of the pharmacy benefit program for the D-SNP in conjunction with the CMO and the delegated PBM. ALTERWOODAdvantage's Clinical Pharmacist for Medicare is an integral team member working with PCPs, specialists and the member's complex Health Managers.

Health Managers	Employed	This role is responsible for the day-to-day management of care management activities for the Plan, assessment, planning, facilitation and advocacy for an individual's health needs which all play a role in the delivery of the SNP Model of Care. There is a dedicated behavioral health manager that supplement the health management staff to ensure behavioral health needs of each beneficiary are met.
Transitional Care Coordinators/Discharge Planner	Employed	This role is responsible for the day-to-day management of beneficiaries experiencing transitions of care. They actively engage the beneficiary to ensure proper care transition protocols are adhered to and for assisting the UM RN and hospital staff in ensuring a smooth transition at a lower level of care.
Special Needs Coordinators/Social Workers	Employed	Ensure that members are receiving access to PCPs and specialty providers. Work with primary, acute and specialty care providers on behalf of the member. Participate in hospital discharge planning. Participate in pre-admission hospital planning for non-emergency hospitalizations. Engage both the member and the family when applicable. Refer to community services groups for additional supports and services.
Utilization Management RN	Employed	This role is responsible for the day-to-day management of utilization management activities for the Plan, such as prior authorization, concurrent review, retrospective review, which all play a role in the delivery of the SNP Model of Care.
Health Operations Coordinators	Employed	Clinical Operations Coordinators work in conjunction with Health Managers to coordinate health care services by facilitating, scheduling, and arranging a variety of treatment and services.
Quality Improvement RN	Employed	This role includes data collection and performing or coordinating member outreach activities such as mailings, newsletters and phone reminders for preventive care or other key services related to improvement initiatives. In addition, monitoring, auditing and evaluation activities as outlined in the QI Work Plan, coordinates QI projects and supports the QI Program.

Health Manager Assistant	Employed	The role supports the health manager in all aspects of outreach, ongoing management of beneficiaries.

Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job titles.

Attachment A: The SNP's Organizational Chart.



Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions.

Alterwood Health Management Company has implemented a contingency plan for Alterwood Health Advantage in order to avoid a disruption in services and ensure ongoing business functions.

Alterwood Health Management Companies leadership team oversees four Medicare lines of business in both Maryland and Delaware and as such, will have the ability to manage their teams as needed to meet the requirements of the businesses.

Our Disaster Recovery Plan (DRP) will provide procedures for continuation of normal business functions for Alterwood Advantage. The procedures identify specific steps and resources required to recover critical processes. Also, the DRP includes detailed plans to address critical business functions until normal business operations are resumed. The plan includes:

- Procedures to follow if on-site or field based
- Contact information and notification procedures
- Alternate methods of communication
- Business recovery information (e.g. critical functions)
- Step by step process to establish temporary work locations, employee redeployments, contacts, and contracts and resources
- Business recovery teams (e.g. skill set documentation, primary and alternate assignments)
- Vital records (e.g. inventory, local and access information, restoration and recovery procedures)
- Assets and inventory

There is a testing and revision plan in place to provide detailed steps, type of test(s) that will be conducted and the schedule to be followed for DRP testing and revision. The DRP is kept current through a formal change control process. The plan is updated at least annually with additional updates when key staff changes occur, or significant environment changes occur.

Please see Attachment B to review the Disaster Recovery Policy for more information.

Attachment B: Screenshot of the Disaster Recovery Policy.

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Policy & Procedure

DEPARTMENT: Information Technology	POLICY #: AHMI.OP.SOL.38	VERSION # 1.0
POLICY TITLE: Disaster Recovery Plan		EFFECTIVE DATE: 1/1/2022
PRODUCT: Medicare ☒	REVISION DATE:	NEXT REVIEW DATE:

POLICY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, all Alterwood Health ~~Management~~(AHMI) officers, employees and agents of units within a Covered Entity must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

POLICY

The purpose is to establish and implement, as needed, procedures to restore any loss of data.
The disaster recovery plan applies to major, usually catastrophic, events that deny access to the normal facility for an extended period. A disaster recovery plan refers to a Solutions (IT)-focused plan designed to restore operability of the target system, application, or computer facility at an alternate site after an emergency.

A disaster recovery plan provides a blueprint to continue business operations in the event that a catastrophe occurs. The disaster recovery plan must include contingencies for the period of time of the disaster and until the recovery plan can be completely implemented. The price for not developing a disaster recovery plan is that AHMI may find it difficult to continue to be in business or potentially suffer a significant loss.

This specification provides guidance for ~~AHMI~~'s Security Officer in adopting the Contingency Plan standard [45 CFR 164§.308(a)(7)].

AHMI is responsible for ePHI and will take reasonable and appropriate steps to maintain a documented and detailed plan to recover ePHI that is lost, damaged, or corrupted in the event of a disaster or other emergency.

The Disaster Recovery Plan will include:

- The conditions under which the Disaster Recovery Plan may be activated
- AHMI 's workforce members' roles and responsibilities in executing the Disaster Recovery Plan

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Policy & Procedure

DEPARTMENT: Information Technology	POLICY #: AHMI.OP.SOL.38	VERSION # 1.0
POLICY TITLE: Disaster Recovery Plan		EFFECTIVE DATE: 1/1/2022
PRODUCT: Medicare ☒	REVISION DATE:	NEXT REVIEW DATE:

- Recommended procedures that contain the actions to be taken to restore ePHI, and to return ePHI Systems to normal operations, within a defined timeframe
- Documented order in which ePHI will be restored and the ePHI Systems will be returned to operation
- Documented reporting and notification procedures to AHMI's ePHI security officer or designated workforce members
- In the event of a disaster or other emergency, documented procedures for permitting appropriate specified workforce members physical access to AHMI's facilities, and to any backup media on which ePHI is stored whether onsite or offsite, in order to carry out the recovery plan in accordance with the Emergency Access Procedure implementation specification policy.
- Procedures that specify how and when the plan will be tested and maintained as indicated in the Test and Revision Procedure implementation specification policy.
- An Emergency Mode Operation Plan as set forth in the Emergency Mode Operation Plan implementation specification.

AHMI is responsible for ePHI and will provide current copies of the Disaster Recovery Plan and training and awareness on that plan to AHMI 's Security Compliance Officer and to the appropriate AHMI's workforce members named in the Disaster Recovery Plan, on a periodic basis, as well as keep copies of the plan off-site.

DEFINITIONS
See AHMI.AD.EA.101 Defined Terms for Policies and Procedures

PROCEDURE
AHMI will define a formal process that will be followed by the designated individual or team to develop the following plans.

A. Disaster Recovery Plan

The DRP will provide procedures for resumption of normal business for AHMI departments. These procedures will identify specific steps and resources required to recover critical processes. Also, the DRP

DEPARTMENT: Information Technology	POLICY #: AHMI.OP.SOL.38	VERSION # 1.0
POLICY TITLE: Disaster Recovery Plan		EFFECTIVE DATE: 1/1/2022
PRODUCT: Medicare ☒	REVISION DATE:	NEXT REVIEW DATE:

will include detailed plans to address critical business functions until normal business operations are resumed. A disaster recovery plan will be developed for AHMI. This plan will minimally include the following:

- Initial Instructions
  - Procedures to follow if at work
  - Procedures to follow if away from work
- Contact Information and how contacts will be notified
  - Call-out Lists
  - Employee Contacts and alternatives
  - Alternate Communications
- Business Recovery Information
  - Critical Functions
  - Functions to perform days 1 – 8 and beyond if necessary
  - Critical function Documentation
- Step by step process
  - Temporary work location requirements
  - Employee redeployment information
  - Contacts, contracts and resources
- Business Recovery Teams
  - Contact Information
  - Skill set documentation
  - Primary assignment
  - Alternate assignment
- Vital Records
  - Inventory
  - Location and access information

DEPARTMENT: Information Technology	POLICY #: AHMI.OP.SOL.38	VERSION # 1.0
POLICY TITLE: Disaster Recovery Plan		EFFECTIVE DATE: 1/1/2022
PRODUCT: Medicare ☒	REVISION DATE:	NEXT REVIEW DATE:

  - Restoration and recovery procedures

- Assets and inventory
  - Inventory
  - Acquisition procedures
  - Required instructions

B. Testing and Revision Plan

The testing and revision plan will provide detailed steps, type of test that will be conducted and the schedule to be followed for DRP testing and revision. The testing and revision plan will include the following testing requirements:

- Paper Test
- Table Top Test
- Limited Scope Test
- Simulated full-scale test

The disaster recovery plan will be kept current via a formal change control process. The plan will be updated at least annually with additional updates when key staff changes occur, or significant environment changes occur. Events that would result in a plan update include (list not all inclusive):

- Change in disaster recovery personnel
- Change in contact information for disaster recovery personnel
- Significant changes to technical or physical infrastructure
- Change in key suppliers
- Significant change in threats to facilities or information systems.
- Changes in AHMI such as significant expansion or acquiring new lines of business.

DOCUMENTS/FORMS/LETTERS/WORK FLOW/JOB AIDS
N/A

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Policy & Procedure

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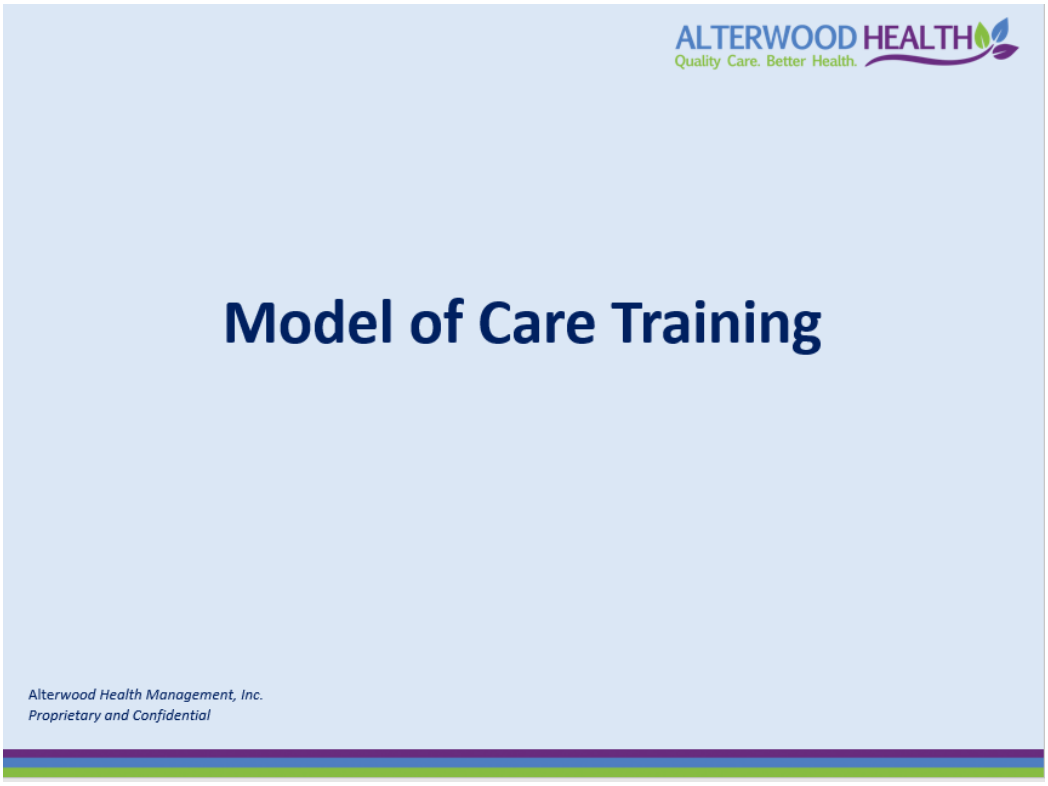
REGULATORY REFERENCES

Regulation	Regulation Reference
Federal	Contingency Plan standard [45 CFR 164.308(a)(7)(i)].
NCQA	
Maryland	
Delaware	

- **Describe how the SNP conducts initial and annual MOC training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.**

The Corporate Training team is responsible for ensuring initial and annual follow-up training occurs for employees on the Dual SNP (D-SNP) Model of Care. The training can be conducted in a classroom setting, via a web conference, or via an asynchronous online eLearning course. The Compliance and Legal Affairs Department is responsible for ensuring that all First Tier, Downstream and Related Entities (FDR), including contractors complete the MOC within 90-days of contracting and annually thereafter. All participation in the MOC training will be documented and retained in records showing that training has been satisfactorily completed. MOC training will be required for all staff, FDRs, and contractors that interact with the Special Needs Population (SNP).

Attachment C: Screenshots of the Model of Care training tool.



Model of Care Training

- The Model of Care (MOC) is Alterwood Health Management, Inc.'s (AHMI) documentation of the Centers for Medicare and Medicaid Services (CMS) directed plan for delivering coordinated care and case management to members within a Special Needs Plan (SNP).
- CMS requires all AHMI staff and contracted medical providers to receive basic training about the AHMI MOC.
- This course will describe how AHMI and its contracted providers work together to successfully deliver the dials MOC program.

Training Objectives

After the training, attendees will be able to:

- Describe the basic components of AHMI's MOC
- Explain how AHMI medical staff coordinates care for all dual eligible members
- Describe the essential role of providers in the implementation of the MOC
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)

All educational materials will be available as print or web-based documents.

The Health Management team will undergo an intensive Model of Care training program upon hire, and annually thereafter addressing community services, transitions of care, utilization management protocols, advance planning, end of life issues and palliative care, and specific clinical conditions and syndromes. Depending on the location of the staff, the training will either be face-to-face or web-based.

Annual evaluation of the Model of Care training program is completed prior to the new plan year to ensure any changes mandated to the MOC elements are identified and the training updated with those changes.

Alterwood Advantage requires clinical staff to maintain appropriate licensure and provides time and resources to allow staff to do so. Additionally, Alterwood Advantage encourages Health Managers to complete continuing education classes offered through professional organizations or publications, and to receive professional health management certification. In addition, our Health Managers maintain memberships in care management and disease-specific organizations and participate in collaborative efforts to develop, review, and revise practice guidelines. Regular review of disease-specific scientific findings ensures that our staff remains current with new emerging technologies and medical advances.

A listing of some of the topics on which Alterwood Advantage will train our clinical staff would include, but not limited to:

- Reinforcement on the management of D-SNP cases
- Licensure training – Provide educational opportunities for medical and nursing staff alike to ensure they are compliant with state and medical nursing requirements and provides financial resources for external educational opportunities.
- CMS FWA and general compliance training – Ensures staff remains compliant with CMS mandated training
- Disability competency training- Teach, model and reinforce key concepts, including understanding the importance of sensitive etiquette practices, personal prejudices, barriers, needs, community resources and procedures/policies that accommodate persons with disabilities. Utilize resources from the local community, including community-based organizations and thought-leaders on disability policy to assist in developing and conducting the training session.

- **Describe how the SNP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records.**

The successful completion of required training is tracked, documented, and maintained for every Alterwood Advantage employee. For all in-person training sessions, participant attendance is captured via dated attendee lists. For web-based training, participation is captured via successful completion of the online course. Completion tracking, and employee training outcomes are available as part of on-demand eLearning reporting.

In addition to those with responsibilities directly interacting with beneficiaries, all Alterwood Advantage employees (i.e., administrative staff) are required to complete web-based annual trainings for Compliance Policy, HIPAA, and Fraud, Waste and Abuse. Web-based trainings capture individual attendance through secure login, post session testing results, and employees must maintain a minimum passing competency.

- **Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MOC training has not been completed or has been found to be deficient in some way.**

Alterwood Advantage has incorporated the MOC training into its new hire and annually required training process for all employees who work with the Special Needs Population. The Director of Operational Effectives & Learning Management, in coordination with the Director of Human Resources and Director of Compliance, evaluate compliance of training requirements on an ongoing basis. Any staff member that has not completed the required training within the required timeframe is forwarded a notification via email or letter notifying them that they must complete the training. In addition, correspondence regarding non-compliance with Model of Care training is forwarded to a staff member's manager.

If training requirements are not completed, corrective action measures will be implemented. This may result in termination of employment from Alterwood Advantage.

Element B: Health Risk Assessment Tool (HRAT)

The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MOC include the following:
A clear and detailed description of the policies and procedures for completing the HRAT including:

- **Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MOC Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MOC Element 2D).**

Alterwood Advantage's Health Risk Assessment Tool (HRAT) is utilized to assess and assist beneficiaries eligible for both Medicare and Medicaid benefits with the identification of need and coordination of appropriate services with the primary goal of allowing the beneficiary to be maintained in the least restrictive environment (i.e., home versus nursing home). In addition, the HRAT identifies opportunities for potential cost-effective service utilization by avoiding unnecessary or duplicative services.

Comprehensive assessments are necessary in providing appropriate care for beneficiaries with numerous and complex care needs. Alterwood Advantage's HRAT focuses on multiple domains including medical, behavioral health, psychosocial, functional, cognitive and nutritional needs. Additionally, the HRAT assesses adequate caregiver support, restorative therapy, DME, skilled nursing services and ADL/IADL needs.

D-SNP beneficiaries are at a greater risk for having more chronic conditions, mental illness and impaired functional abilities. They are also at high risk for nursing home admissions, multiple service utilizations, as well as an increased utilization of emergency room, inpatient stays and readmissions. Capturing the needs of the beneficiaries is an important part of establishing a holistic plan of care.

The HRAT, in addition to the comprehensive health management assessment, is a thorough assessment tool which gathers information pertinent to the beneficiary's overall health status and identifies health risks in the following categories:

- Barriers: to meet the goals and /or comply with the individualized care plan
- Behavioral/Lifestyle: tobacco, alcohol and drug use; physical activity, nutrition, and oral health
- Benefits/Coordination of Benefits: benefits available and level of understanding; work status; disability
- Cognitive Status: educational level, understanding of health conditions, and ability to follow self-management instructions regarding health; memory/thought processing issues
- Communication: language, visual or hearing limitations, preference or needs
- Cultural/Religious: complementary and alternative medicine utilized; any religious or cultural needs, preferences or limitations that may impact healthcare and/or the individualized care plan
- Functional Level: activities of daily living (ADLs), instrumental ADLs, history of falls; elimination, pain and sleep issues; DME usage/needs
- Health Status/Clinical History: General health history, co-morbidities, allergies, and treatment/surgical history

- Internal Health Management Process: member contact information; HIPAA considerations; marital status; living arrangement; Health Management status
- Life Planning: Healthcare power of attorney, advance directives, living will, life goals
- Preventative Health/Key Metrics: Sexual health, preventative screenings, and immunizations
- Psychosocial/ Mental Health Status: Coping status; depressions/stress/anger; loneliness/risk for social isolation; family and social support
- Resources & Support: Caregiver resources/ level of involvement, external resources utilized
- Safety: health and personal well-being issues: safety concerns

Utilization/ Treatment: Inpatient and Emergency Department (ED) utilizations, PCP and specialist utilization, current treatment plan and planned intervention.

The assessment questions and responses are designed so that responses will be added into the comprehensive individualized care plan that the health manager can customize towards the beneficiary's personal healthcare preferences. The HRAT responses are shared among the ICT as the ICP is being developed. Care pathways identify multiple, individualized, potential opportunities which concentrate on gaps in care, at risk areas, knowledge deficits, and self-management issues. The opportunities are then linked to an associated goal with correlating interventions for the ICT and actions for the beneficiary.

- **Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.**

The initial HRAT is conducted telephonically within ninety (90) days of enrollment. Alterwood Advantage Health Management teams conduct the assessment or schedule an appointment to conduct the assessment. If the beneficiary cannot be reached after a period of 45 days, a mailing (trying to reach you postcard) will be sent encouraging the beneficiary to call and to complete the HRAT. If the beneficiary cannot be reach by day 90, they are moved to an unable to locate status.

HRAT reassessments will occur within 365 days of the initial or last assessment. However, should a beneficiary's condition change, reassessment can occur sooner. Additionally, higher risk beneficiaries may have more frequent assessments to evaluate the impact of interventions and potentially move beneficiaries to a lower or higher risk category, as necessary.

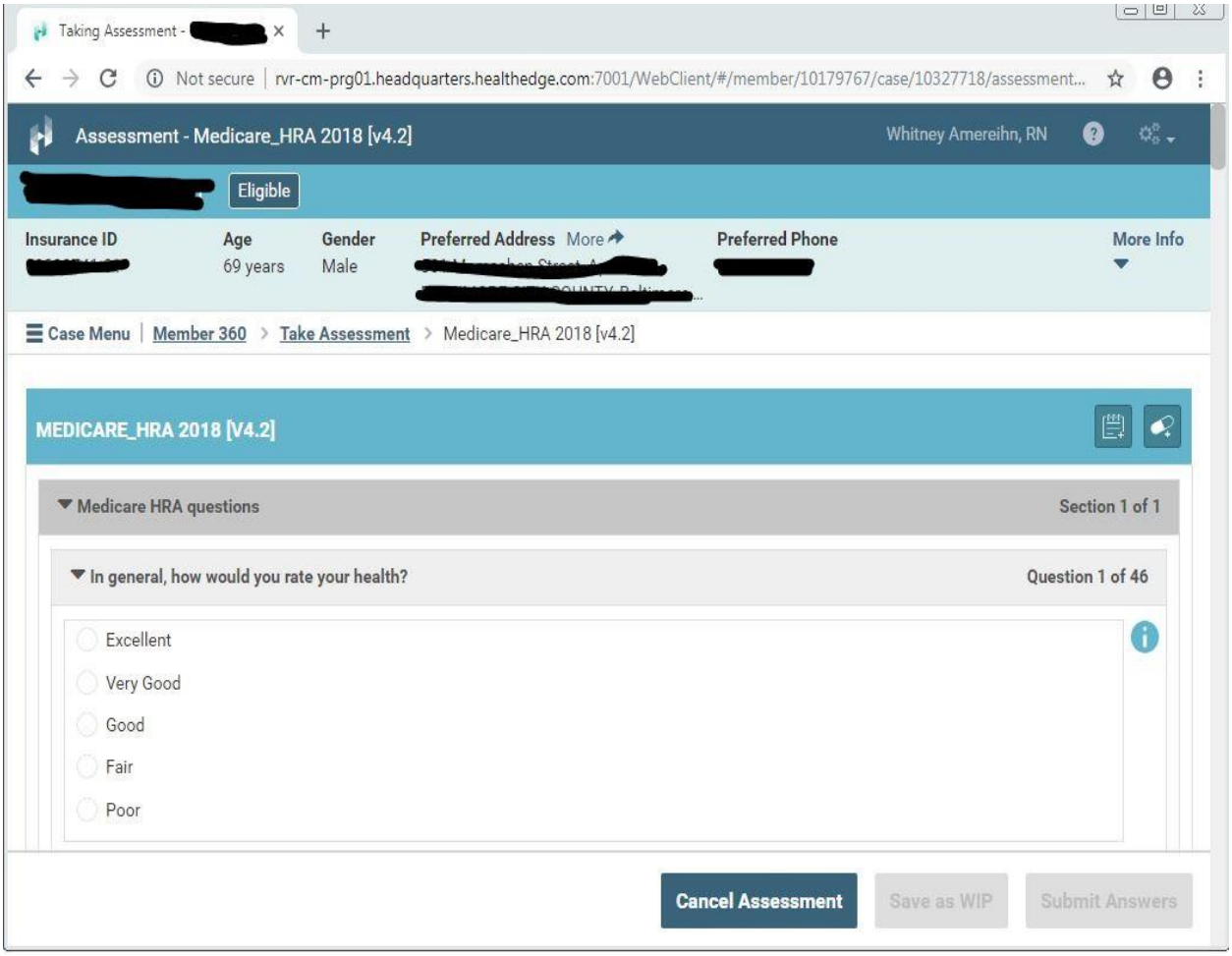
- **Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiary's and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary's plan of care. If stratified results are used, include a detailed description of how the SNP uses the**

stratified results to improve the care coordination process.

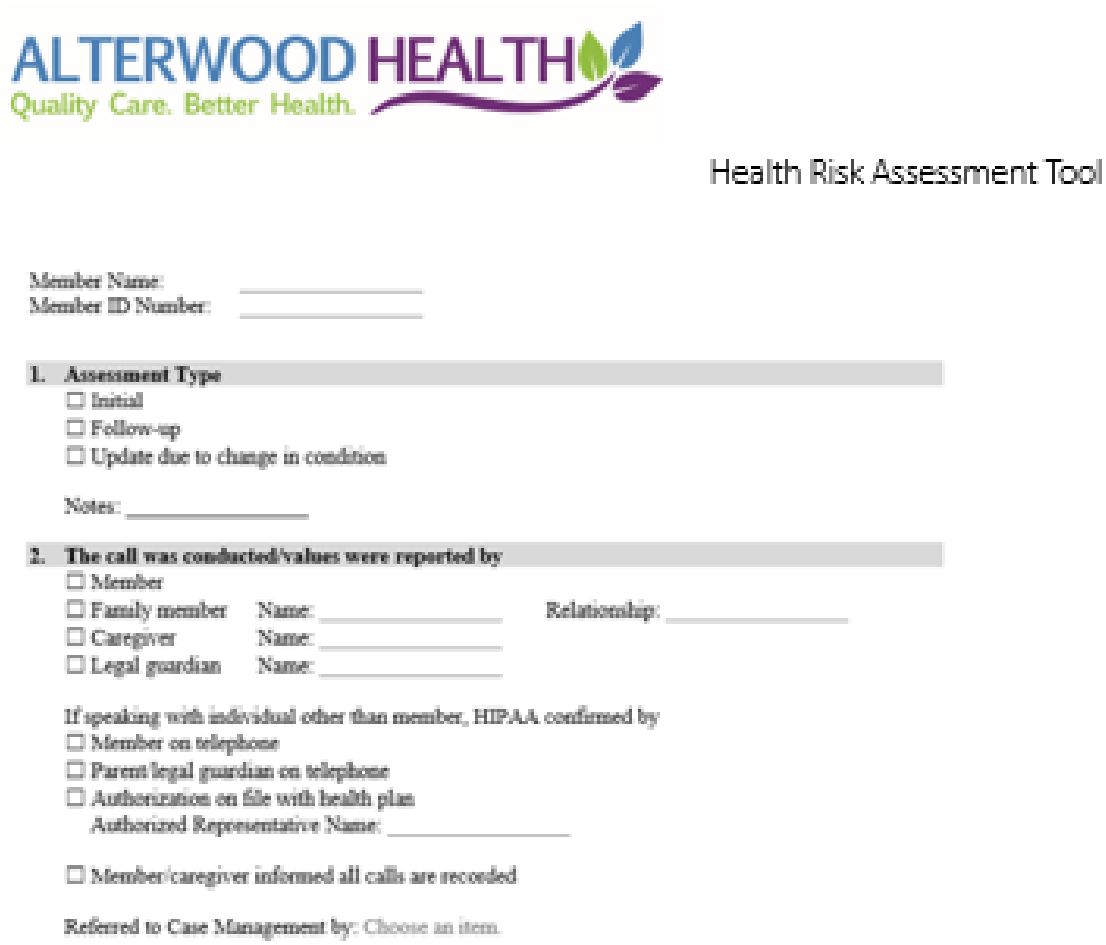
The Alterwood Advantage clinical team utilizes a HRAT/comprehensive health management assessment that allows for identification of gaps in care and/or health goals that are currently lacking for each beneficiary.

An integrated team approach is utilized to maintain the beneficiary care plan with input encouraged from all team members. All updates across the team, whether with beneficiary/caregiver(s) or providers are documented into the health management system and suggested updates incorporated into the ICP. As the ICP is re-evaluated and goals are met, the ICP is updated in the care management system to reflect achievement of the goal and the completion date. If goals are not met, the ICT will determine if goal remains appropriate for the beneficiaries' current health care needs, or new goals need to be established.

Attachment D: Sample HRAT



Attachment E: Sample of Comprehensive Assessment Tool



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Health Risk Assessment Tool

Member Name: _____
Member ID Number: _____

1. Assessment Type
☐ Initial
☐ Follow-up
☐ Update due to change in condition

Notes: _____

2. The call was conducted/values were reported by
☐ Member
☐ Family member Name: _____ Relationship: _____
☐ Caregiver Name: _____
☐ Legal guardian Name: _____

If speaking with individual other than member, HIPAA confirmed by
☐ Member on telephone
☐ Parent/legal guardian on telephone
☐ Authorization on file with health plan
Authorized Representative Name: _____

☐ Member/caregiver informed all calls are recorded

Referred to Case Management by: Choose an item.

Element C: Individualized Care Plan (ICP)

- **The ICP components must include but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiary's' caregiver(s); and identification of goals met or not met.**
  - **When the beneficiary's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.**

The Individualized Care Plan outlines a comprehensive care plan consisting of opportunities, interventions, goals and actions. The HRAT and comprehensive health management assessment questions and responses are configured so that designated responses will automate algorithms and the auto-creation of a comprehensive ICP that the health manager customizes towards the beneficiary's personal healthcare preferences. Care pathways identify multiple, individualized, potential opportunities which concentrate on gaps in care, at risk areas, knowledge deficits, and

self-management issues. The opportunities are then linked to an associated goal with correlating interventions for the ICT and actions for the beneficiary.

As the beneficiary's goals are met, the Health Management staff captures the date within the ICP and continues to focus on those goals that still need to be addressed. On a regular basis, , the Health Management staff reassesses the beneficiary against all achieved goals to monitor and ensure beneficiary/caregiver(s) adherence to therapy and other elements of self-care. The Health Management team routinely reviews claim data, as well as hospital ED and/or admission/discharge data, via the State of Maryland CRISP Report which allows for real time snapshots of these events. If beneficiary activity via either data sets demonstrate usage which is not consistent with positive self-management, the Health Management team outreaches to the beneficiary to re-engage them in the health management process.

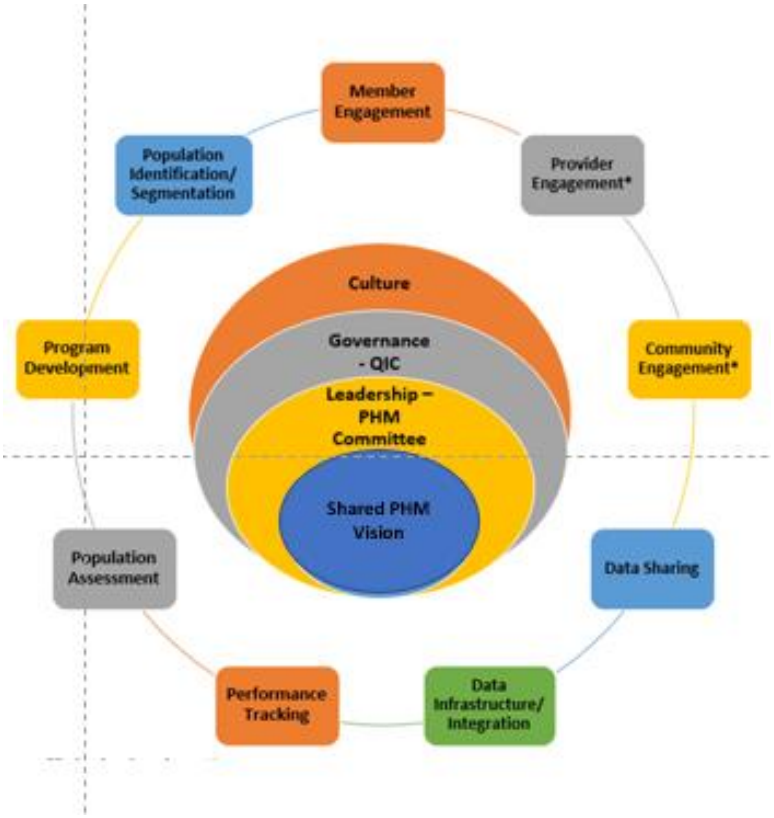
The closure of any beneficiary goals is agreed upon between the beneficiary and the health manager.

If the beneficiary does not meet an assigned goal, the Health Manager, with input from the beneficiary/caregiver(s), and any other applicable members of the ICT, will have input into a plan to modify the goal. The modification of the goal should provide interventions that the team feels are more achievable for the beneficiary/caregiver(s).

In summary, the ICP is utilized as a snapshot in time to move the beneficiary through the medical and psychosocial needs that present at the time of the HRAT. It is not meant as a rigid guide, but more a road map to meet a beneficiary's healthcare needs at that point in time. The ICP, based on the beneficiary/caregiver(s) needs are continuously assessed and reassessed – driven by the primary Health Manager – to ensure the beneficiary can stay at his/her optimal level of wellness. This reassessment includes the ongoing review of claims data and any visits to the emergency department or inpatient hospitalizations, as available on any business day, through Maryland CRISP data.

- **Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining SNP beneficiary's' health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary's ICP.**

Alterwood Health Management company has adopted a Population Health Management (PHM) strategy. The foundation of our strategy is to improve health outcomes of targeted populations by ensuring access to quality care and preventative care services. Our PHM framework is displayed graphically below.



This strategy utilizes existing data to stratify our DSNP membership into appropriate segments. Segmentation allows Alterwood Advantage to categorize our members into sub-populations when appropriate, as in chronic conditions, to ensure the appropriate resources are available and supporting these sub-populations. Our segments consider the following parameters:

- Demographic inclusions
- HRAT responses
- Open Quality (i.e. HEDIS, CAHPS, STARS) gaps
- Number of chronic condition(s) such as Diabetes, Hypertension, CHF, COPD, Asthma
- Clinical/lab results (e.g., HgA1C, blood pressure, etc.)
- Healthcare use (e.g., inpatient admission, emergency department, urgent care)
- Medication use (e.g., polypharmacy)
- At Risk Conditions/Compounding Situations
- Social Determinants (e.g., physical disability, homelessness, substance abuse, etc.)
- Other: No PCP visit, no HA

These parameters are then used to assign a member into one of five Continuum of Care Stages:

- Preventative Health Management
- Wellness Management
- Safety, Special Needs & Outcomes Across Settings

- Chronic Conditions
- Complex Health Management

Each stage has various programs available to our members to maintain or improve their health and wellness depending on their condition (target population) and placed within the continuum. Alterwood Advantage establishes measurable goals for each targeted population that can be used to measure individual member health as well as evaluate the overall effectiveness of each program based on the health of the entire targeted population. Thus, based on where a beneficiary falls in the Continuum of Care, will drive opportunities and goals in the development of the ICP.

The owner of the beneficiary's ICP is an assigned primary Health Manager. The Health Manager then coordinates with all applicable ICT members to develop the initial ICP. The primary Health Manager, in conjunction with the PCP, ensures continuity of care across all care transitions and multiple modalities of care. The results of these meetings/conversations are captured in the Health Management system as "Case Round" notes.

For those beneficiaries that have refused health management services, or are unable to be located, the Health Manager Assistant continues to monitor those members via claims activity and/or inpatient census reports and assists in updates to the ICP.

The Health Management team and beneficiary/caregiver(s) will review the ICP at designated intervals (at least bi-annually) and/or at any significant care transition (hospitalization, discharge from home care, etc.) to manage and revise the ICP based on the changes in beneficiary's status or progress toward the goals. Alterwood Advantage will partner with the PCP, any specialists involved in the care and/or any service providers to help navigate the beneficiary's health care needs and goals.

Outlined is a high-level example of how a Complex Health Management Individualized Care Plan (ICP) is managed, presented, and updated.

- The Health Manager reviews the ICP after the HRAT is completed (initial and re-assessments)
- The Health Manager reviews the ICP with the PCP and the beneficiary/caregiver(s). The Health Manager may also receive input from all service entities involved in the beneficiary's care (i.e., Home Health, etc.) as well as any specialists.
- The Health Manager, with assistance from the ICT, decides at the time that the ICP is completed if additional ICT members are needed based on the needs of the beneficiary identified in the ICP.
- The Health Manager collaborates with all internal members of the ICT (which may include, if applicable, utilization review staff, pharmacy, social worker and special needs coordinators).
- The Health Manager documents each meeting with ICT members via Case Round notes in the health management system.

- The Health Manager will provide an ongoing overview of all interventions, progress and any new challenges/barriers.

The process above is intended to be ongoing and collaborative to ensure the beneficiary needs are met across the healthcare continuum. The Alterwood Advantage teams strongly believe that effective care coordination can be accomplished only through regular monitoring of the patient's health status, needs, and services, and through frequent communication and the free exchange of information across the ICT. This exchange requires multiple modes of communication (in person, by phone, or in writing).

The primary Health Manager, in order to appropriately update the ICP, ensures that the frequency of communication across the ICT is as needed, based on the beneficiary need, and that the communication occurs at the following levels:

- between health care professionals and beneficiary/caregiver(s) to ensure they understand the ICP and their responsibility for self-care, and/or any other help that is available.
- across the entire care spectrum, particularly when individuals transfer between care settings (for example, hospital, rehabilitation facility, nursing home, or community residence).

If care is to be coordinated effectively, all communication must be timely, and it must include the information that each team member must know in order to provide care that is congruent with the beneficiary/caregiver(s) preferences without subjecting the team to information overload.

- **Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).**

ICP development, re-evaluation, modification will take place in the ICP housed within the health management system. Alterwood Advantage provides updates and modifications to the beneficiary/caregivers, and the ICT via telephone, mailings and/or fax when applicable. As the ICP is re-evaluated and goals are met, the ICP is updated in the care management system to reflect achievement of the goal and the completion date. If goals are not met, the Health Manager in conjunction with any applicable ICT member, will determine if goal remains appropriate for the beneficiary's current health care needs, or new goals need to be established.

- **Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders as necessary.**

When the ICP is completed, a copy is sent via mail) to the beneficiary/caregiver(s). The PCP is notified that a new care plan has been added for their member to the provider portal. The ICP is sent to other providers, specialists and stakeholders if requested. The Health Manager strives to have the ICP available to providers prior to scheduled visits and the Health Manager documents all submissions of ICP's to all interested stakeholders.

Beneficiaries receive two (2) copies of the ICP. Beneficiaries are encouraged to share the ICP with their providers during scheduled clinical visits. All changes, revisions or modifications made by the beneficiary's clinical team to the ICP are communicated back to the beneficiary and or caregivers to ensure understanding and agreement. Health Managers work closely with the beneficiary and/or caregiver to re-negotiate and re-prioritize identified goals. All changes are documented in the health management system.

Example 1:
John is identified into the Complex/Catastrophic risk category, which indicates that in addition to standard care management, ancillary interventions will be offered including, but not limited to, increase telephonic and in person contact, in-home assessments, increased social support, and transition of care program interventions and add-on benefits. The ICP created includes dates for goal completion and follow-up. Interventions are listed with responsible party identified.

The Health Manager utilizes the ICP tool to accomplish set goals, track interventions, and document progress toward set goals. ICP contains identified opportunities, information, and progress reported by all members of the ICT. During the completion of the HRAT the beneficiary is identified with the following problems:

- Lack of education regarding a condition (diabetes and coronary artery disease)
- Lack of transportation and medical home (beneficiary lacks medical home due to no transportation)
- Lives alone, needing assistance with cleaning and preparing meals.

Identified goals for this beneficiary would include the following:

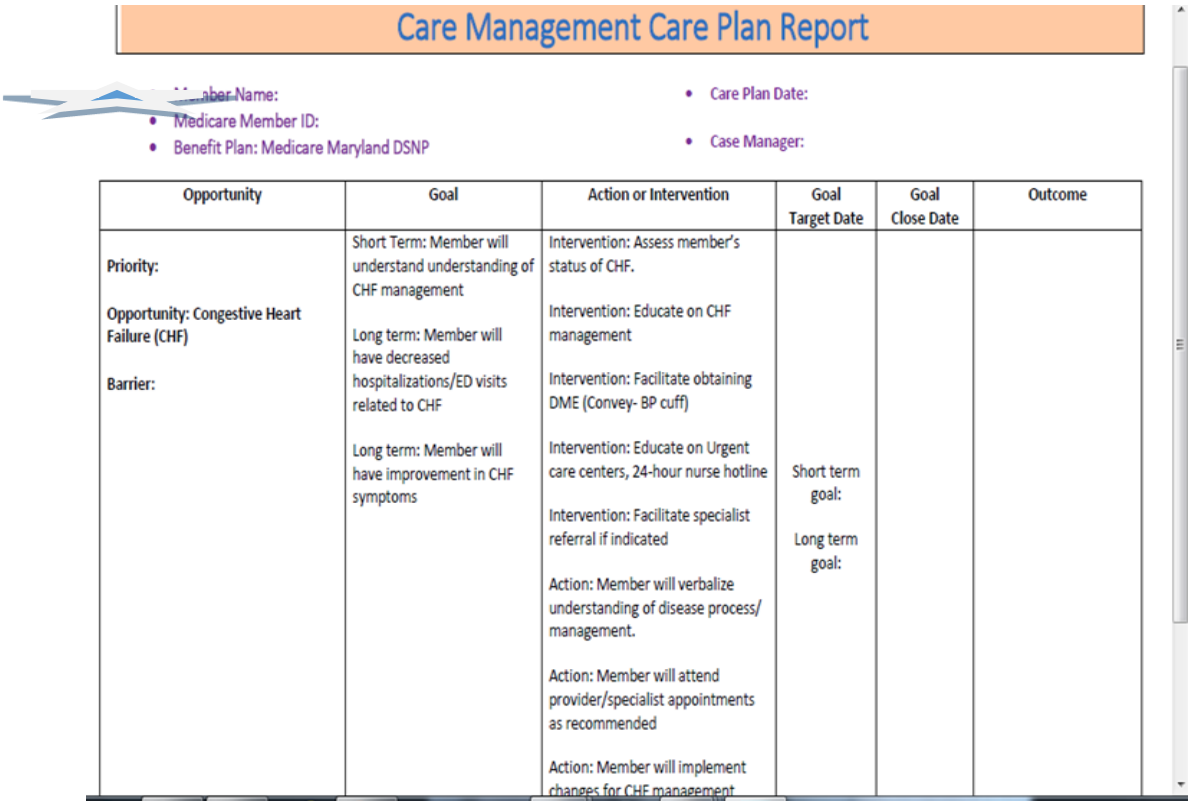
- John will verbalize understanding of his condition state – "I want to understand how to manage my medical conditions."
- John will obtain needed transportation – "I need transportation to get to my appointments, and that transportation needs to be reliable."
- John will have appropriate nutritious meals and clean environment – "I want to eat 3 meals a day that taste good and are good for me. I would like some help to keep my home clean."

The interventions for this beneficiary would be as follows:

Action Item	Accountable Person
Provide beneficiary with written educational materials for the Health manager and beneficiary to review	Health Manager
Health manager will evaluate, identify gaps of beneficiaries understanding of their condition	Health Manager
Continue following up with beneficiary to provide ongoing education on Diabetes and CAD	Health Manager
Discuss with the ICT the need for an endocrinologist and cardiologist	Health Manager and Beneficiary
Review beneficiary transportation benefits and available related community resources to include family support	Health Manager
Educate beneficiary on the value and services that his medical home can provide and how the emergency department is not a place to receive routine care	Health Manager and Beneficiary
Health manager will communicate with the ICT to discuss possible need for RN evaluation/social worker consult	Health Manager and PCP
Health manager will review community resources and available family support related to meals and housekeeping (keeping the beneficiary in the community)	Health Manager, Social Worker or Special Needs Coordinator

In the health management system Case view, the beneficiaries Care Plan is displayed. The details of the beneficiaries ICP opportunities, interventions, goals and actions are listed.

Attachment F: Sample of Care Plan



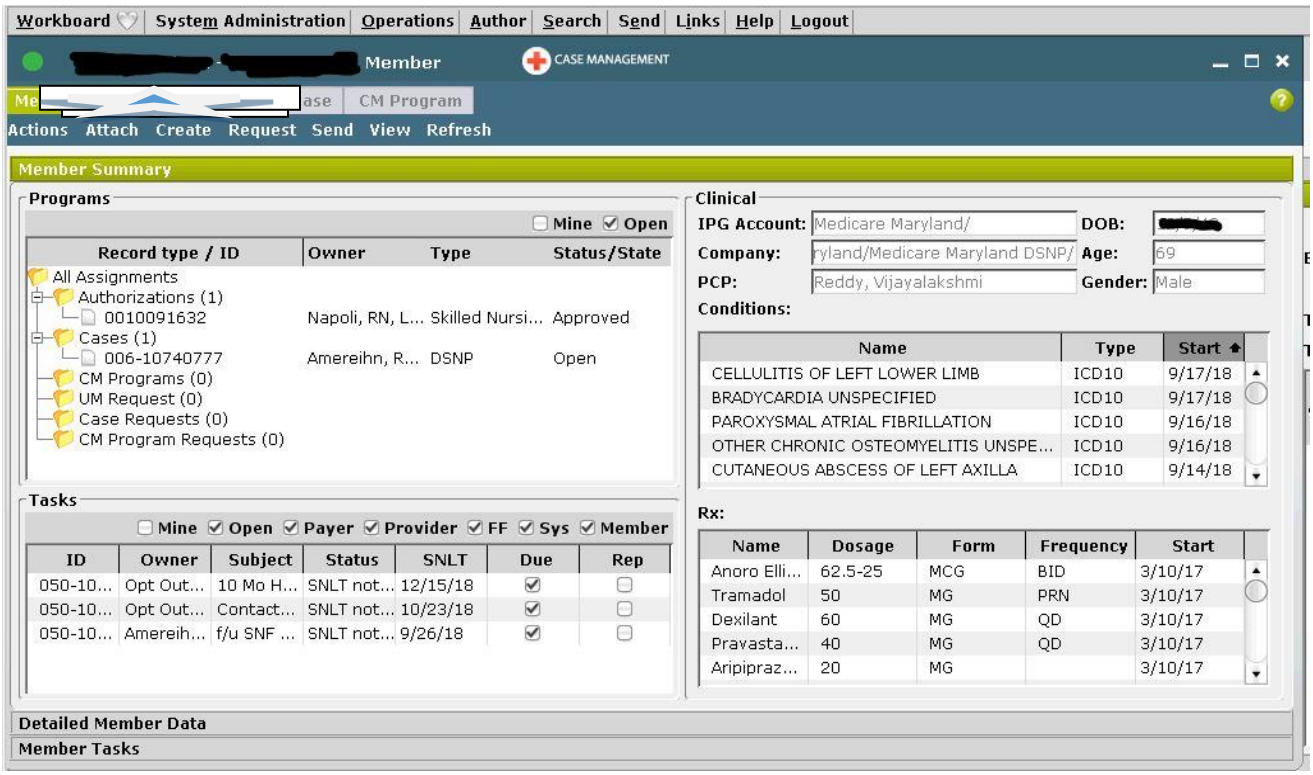
Care Management Care Plan Report

- Member Name:
- Medicare Member ID:
- Benefit Plan: Medicare Maryland DSNP
- Care Plan Date:
- Case Manager:

Opportunity	Goal	Action or Intervention	Goal Target Date	Goal Close Date	Outcome
Priority: **Opportunity: Congestive Heart Failure (CHF)** **Barrier:**	Short Term: Member will understand understanding of CHF management Long term: Member will have decreased hospitalizations/ED visits related to CHF Long term: Member will have improvement in CHF symptoms	Intervention: Assess member's status of CHF. Intervention: Educate on CHF management Intervention: Facilitate obtaining DME (Convey- BP cuff) Intervention: Educate on Urgent care centers, 24-hour nurse hotline Intervention: Facilitate specialist referral if indicated Action: Member will verbalize understanding of disease process/ management. Action: Member will attend provider/specialist appointments as recommended Action: Member will implement changes for CHF management	Short term goal: Long term goal:		

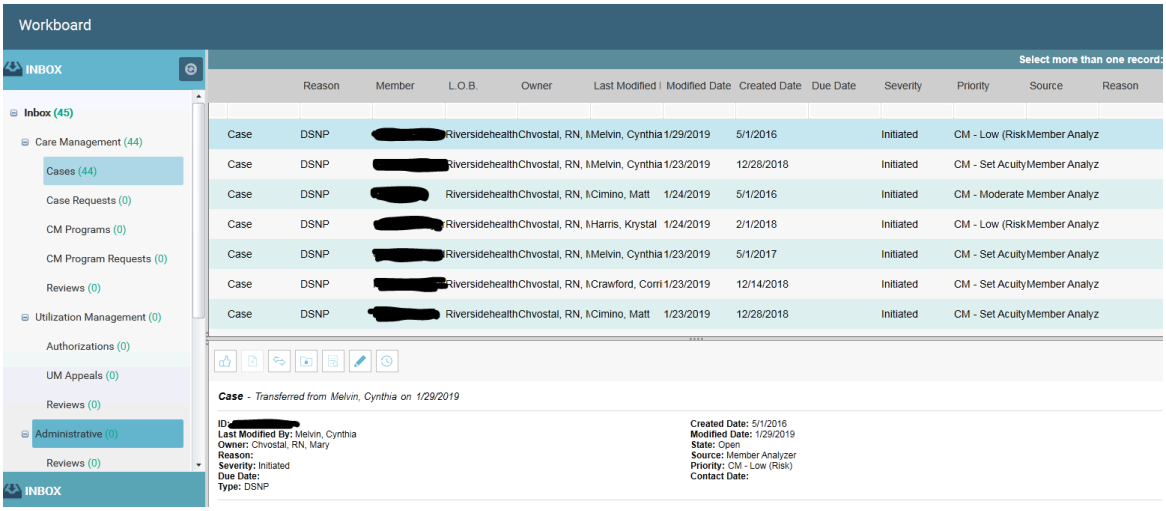
In the health management system Member Summary view, a consolidated overview is provided of information about the beneficiaries' case, programs and services. The ICT members with access privileges can view beneficiary information, as dictated by role-based security.

Attachment G: Sample of Member Summary Screen



The health management system has task functionality to allow the ICT to create calendar entries prompting them to complete tasks specific to each beneficiaries ICP at planned intervals. Follow up tasks can be generated systematically based on the creation of the ICP, or manually at the time of an interaction. When the Health Manager accesses their "Workboard" they can view their list of tasks that are prioritized.

Attachment H: Sample of Health Manager Work Board Tasks



Upon enrollment with Alterwood Advantage Plan the Health Management team will reach out to the beneficiary to complete the HRAT. Upon completion of the HRAT, and agreement to enroll into a health management program, a member of the health management team will review and begin follow up with the member to begin care coordination efforts. The Health Management team will then facilitate the active involvement of the beneficiary and/or caregivers, the beneficiary's primary care physician (PCP), and a variety of specialist(s) as well as ancillary care providers. The PCP may recommend needed health care services and may also facilitate information exchanges among the treating providers. The Health Management team will then create a comprehensive treatment plan, in collaboration with the beneficiary and any other identified providers. The plan will include an identified list of opportunities and their priority, and identification of prioritized goals and objectives the action plan on how to achieve progress towards goals. The treatment plan is developed by an integrated care team (ICT) and is specific to the beneficiary's needs and preferences and each beneficiary will have an individualized care plan (ICP). ICT composition may involve Care Coordinators, a Clinical Pharmacist, Health Management Assistants, Behavioral Health Providers and/or other support staff working closely with the beneficiary's PCP, Specialist(s), Discharge Planners, and UM staff and other ancillary providers, where appropriate, that will assist in the coordination of care for the beneficiary. The Health Manager will serve as the lead of the ICT.

The foundation of the ICP is based on the beneficiary's level of engagement to become an active participant in care delivery. ICP interventions are aimed to educate, empower and facilitate the beneficiary to exercise their rights and responsibilities. ICP development includes detailed and in-depth understanding of the beneficiary's strengths and vulnerabilities. If a beneficiary is unable or unavailable to participate, an authorized member representative can participate on behalf of the beneficiary. The ICP identifies specific services and benefits that have measurable impact and outcomes. A member of the Health Management team discusses the ICP with the beneficiary and/or caregivers and ensures availability of the information and

support for the beneficiary to make appropriate decisions regarding their health whenever feasible. The Health Management team works closely with the beneficiary and their caregiver to outline an agreed upon set of prioritized goals.

The Health Management team makes certain that ICPs are kept current and update to date on our Provider Portal. Availability of an updated ICP prior to the appointment ensures that providers will be aware of the beneficiary's point of view and preferences, in care when the beneficiary is unable to participate in decisions. In addition, the Health Management team places special emphasis on assisting the beneficiary in recognizing their role as the daily self-care manager and caregivers' engagement in the beneficiary's overall self-care management.

If the beneficiary is unable to contact or refuses to participate in care coordination efforts or programs, the PCP is contacted. The goal is to communicate with the PCP and obtain beneficiary information for a member of the health management team to create an ICP. Subsequently, the Health Management team will add the information received from the PCP to tailor the care plan to the specific beneficiary. The Health Management team is trained to develop ICPs that are realistic, practical, and yet have a high probability of leading to successful outcomes. The Health Management team is comprised of RN health managers, health manager assistants, Social workers, discharge planners, care coordinators, and other staff who may support beneficiaries and providers through all phases of care.

The ICP follows the traditional principles of care management, incorporating the assessment of individual needs via telephonic interview and developing a plan of care that incorporates prioritized goals. Alterwood Advantage Health Managers are licensed nurses who supervise the plan of care process. If information for the ICP is gathered by non-licensed personnel, the final ICP is reviewed and signed off by an RN as part of the ICP completion process. The ICP is documented in the beneficiary's record and the progress towards the beneficiary's prioritized goals is updated as each intervention is implemented, and actions are evaluated. The Department of Training and Operational Effectiveness supervises, educates and coordinates the activities of Alterwood Advantage staff to ensure the staff understands and functions in accordance with the Model of Care.

The Health Management team coordinates the inter-disciplinary services provided to the beneficiary. The goals are to provide the beneficiary quality services, utilizing a care plan that defines the planned interventions and coordinate the provided services to avoid duplication, making changes to the care plan as needed. The Health Management team identifies any special needs of the beneficiary and will serve as a liaison between the beneficiary and providers, ensuring the beneficiaries are receiving appropriate medical care. The Health Management team determines the beneficiary's social support and assists those who are unable to access necessary care due to their medical or emotional condition, or who do not have adequate community resources to comply with their care. The Health Management team assists the beneficiary and caregivers in obtaining available community resources to manage their condition. Beneficiaries near the end of life are counseled regarding palliative and hospice care and the range of available services.

Example 2:

Joann is a 57-year-old female who was diagnosed with Coronary Artery Disease, diabetes, hypertension, COPD, hyperlipidemia, GERD, bipolar disorder and episodic mood disorder. Joann has been enrolled with Alterwood Advantage since its inception in 2016. General assessment identified several recent ED visits and inpatient hospitalizations, positive Patient Health Questionnaire (PHQ-9) test and access to reliable transportation. She currently lives with her significant other.

Joann was assigned to a Health Manager who contacted her and successfully enrolled her into a care management program. The assessment identified the following issues:

Member: Joann Smith
Member ID: XXXXXXXXXX
Medicare D-SNP Plan of Care

OPPORTUNITY	INTERVENTIONS	GOALS	START	END	OUTCOME
Ineffective medical home as evidenced by the lack of coordination between PCP, cardiologist, and behavioral health specialist.	Joint rounds are coordinated between providers, Health Managers, and other supporting staff to discuss the optimal treatment plan to address Joann's healthcare needs	Effective communication between providers providing seamless care coordination			
Poorly controlled diabetes with random blood glucose ranging 300-600mg%	Assist with coordinating a medical follow-up with the Beneficiary's medical home provider (PCP) to evaluate medication regimen. Discuss nutritional counseling options and conduct a home evaluation to assess Joann's social and environmental status.	Controlled glucoses ranging from 80 - 120			
Homicidal and suicidal ideation-the condition is stable as evidenced by weekly counseling in progress with no current threats to self and others.	Continue follow up with behavioral health and counseling. Health Manager assists with coordinating collaborative rounds with the counselor and psychiatrist to ensure that the psychotherapy and medication therapy are in sync. Provide Joann with crisis intervention services.	Maintain stability of MH disorder			

Element D: Interdisciplinary Care Team (ICT)

- **Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiary's, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used for determining SNP beneficiary's' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.**
    - **Explain how the SNP facilitates the participation of beneficiary's and their caregivers as members of the ICT.**
    - **Describe how the beneficiary's HRAT (MOC Element 2B) and ICP (MOC Element 2C) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual beneficiary.**
    - **Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs on a continuous basis.**

Alterwood Advantage relies on an Interdisciplinary Care Team (ICT) to support care planning, implementation and monitoring of individualized care plans for its beneficiaries. The team manages the medical, cognitive, psychosocial and functional needs of each beneficiary. ICT members may include primary care physicians (PCP) and other licensed practitioners, concurrent review staff, social workers, integrated health management specialists, behavioral/mental health practitioners, member services representatives, quality management, clinical pharmacist and Medical Directors.

ICT composition is driven by the Health Manager, beneficiary/caregiver(s) and PCP based on the input into the HRAT and comprehensive assessment. The inclusion of additional department representatives will be based on specific beneficiary needs and the ICT's request for additional members. In addition to their technical qualifications, ICT clinical members have extensive knowledge and experience with working with dual-eligible beneficiaries, will be familiar with the beneficiary's needs, serve as subject matter experts in their respective fields and will be able to impact care.

For example: The ICT would be involved with the management of an inpatient admission for treatment of drug-drug interaction between a medication prescribed by the PCP for management of chronic obstructive pulmonary disorder (COPD) with another psychotropic medication prescribed by a behavioral health provider. The Health Manager will convene an ICT meeting that might include the beneficiary and/or caregiver, PCP (prescribing physician), Medical Director, clinical pharmacist, social worker and administrative support staff as needed.

The ICT plays a critical role in ensuring that the beneficiary's desired health outcomes are met. The Health Manager and beneficiary/caregiver(s) along with members of the ICT, will review the ICP at designated intervals (at least bi-annually) and/or at any significant care transition (hospitalization, discharge from home care, etc.) to manage and revise the ICP based on the changes in beneficiary's status or progress toward the goals. Alterwood Advantage will partner with the PCP, any specialists involved in the care and/or any service providers to help navigate the beneficiary's health care needs and goals.

Outlined is a high-level example of how an Individualized Care Plan (ICP) is managed, presented to the ICT, and updated.

- The Health Manager reviews the ICP at designated intervals or at a significant care transition.
- The Health Manager reviews the ICP with the PCP and the beneficiary/caregiver(s) and any specialists involved in the beneficiary's care. The Health Manager may also receive input from any service entities involved in the beneficiary's care (i.e., Home Health, etc.).
- The Health Manager will provide an overview of all interventions, progress and any new challenges/barriers as she performs case rounds with any member of the ICT.
- The Health Manager updates the ICP based on all input from the above.

The process above is intended to be ongoing and collaborative to ensure the beneficiary's needs are met across the healthcare continuum. The Alterwood Advantage teams strongly believe that effective care coordination can be accomplished only through regular monitoring of the patient's health status, needs, and services, and through frequent communication and the free exchange of information across the ICT. This exchange requires multiple modes of communication (in person, by phone, or in writing).

The primary Health Management team, in order to appropriately update the ICP, ensures that the frequency of communication across the ICT is as needed, based on the beneficiary need, and that the communication occurs at the following levels:

- between health care professionals and beneficiary/caregiver(s) to ensure they understand the ICP and their responsibility for self-care, and/or any other help that is available;
- across the entire care spectrum, particularly when individuals transfer between care settings (for example, hospital, rehabilitation facility, nursing home, or community residence).

If care is to be coordinated effectively, all communication must be timely, and it must include the information that each team member must know in order to provide care that is congruent with the beneficiary/caregiver(s) preferences without subjecting the team to information overload.

In summary, the ICP is reviewed bi-annually, at minimum. It is modified on a regular basis as the beneficiary's health care needs change.

Upon enrollment, Alterwood Advantage will make multiple efforts to engage beneficiaries and their caregivers in the development of their individualized care plans. Multiple attempts are made to reach the beneficiary at different times and on various days. The attempts and results are documented within Alterwood Advantage's Health Management System and kept as part of the beneficiary record.

Beneficiary awareness of the ability to participate in their care planning is the first step in engagement. This is communicated to the beneficiary's during the telephonic and face-to-face interactions with Alterwood Advantage team.

If requested, beneficiaries and providers will be informed of the names of the ICT participants who were involved in the development and implementation of the care plan.

Once the beneficiary agrees to participate and is enrolled in one of the DSNP Health management programs, the individualized care plan is developed with beneficiary and caregiver input. The plan is created in a manner to allow the beneficiary to be an active participant in their care and to help them self-monitor the progress of their plan. All interventions are aimed at increasing the beneficiary's knowledge of their condition and improving their ability to manage their disease or conditions. This is accomplished through the use of the following mechanisms but not limited to: initial HRAT responses; annual assessment survey responses; assessment of the beneficiary's physical health and behavioral health conditions, social needs, barrier use, understanding of their healthcare conditions, management of those conditions, current medications, and access to care; an assessment of the beneficiary's self-efficacy or a motivational level; education on the beneficiary's diseases that has been provided; individualized feedback that is provided to the beneficiary regarding their progress. Member(s) of the ICT will work with beneficiaries to update their health management plan with numerous, subsequent follow-up contacts.

In the event the beneficiary is unable to be contacted or refuses health management services, then other outreach is conducted that includes:

- Mailing care management brochures to the beneficiary, available in English and Spanish and other languages per request.
- Contacting the PCP to obtain updated demographic information and providing the PCP with health management contact information to refer the beneficiary to health management
- Sending initial communication plans to providers for those beneficiaries whose provider lacks additional information on the beneficiary to individualize the care plan
- Sending a letter(s) to the beneficiary with information regarding the health management program and contact information to reach the health management department, available in English and Spanish and other languages per request.

- Continuous follow up by the Health Management teams to ensure preventative and health care screenings are being completed

A member of the Health Management team will engage beneficiaries who may be receiving care at a different setting including when a beneficiary becomes hospitalized. In such event the a member of the Health Management team will attempt to contact the beneficiary telephonically or in person during the hospitalization stay. Outreach to beneficiaries also takes place when a referral is received from an internal or external source.

When a referral is made, the process of managing the referral is documented from start to finish in the health management system. For example, a concurrent review nurse identifies a member as being enrolled in the D-SNP health management program by the open case in the health management system. The request is forwarded to the health management department to make the health manager aware of the care transition. A member of the Health Management team outreaches to the beneficiary for coordination of care such as: DME, transportation, handicapped accessible living arrangements and any other specific beneficiary needs. The referral and subsequent activity are managed and documented.

Example 3:

The following is an example of the individualized care plan for a beneficiary with diabetes. For example, John is a 57 years old male who was diagnosed with coronary artery disease, diabetes, hypertension, asthma, hyperlipidemia, GERD, bipolar disorder and episodic mood disorder. John has been enrolled with the health plan since its inception a few months ago. The initial assessment identified several recent ED visits and inpatient hospitalizations, a positive Patient Health Questionnaire (PHQ-9) test and difficulties with access to reliable transportation. He currently lives with his significant other. John was assigned to a Health Manager who contacted John and successfully enrolled him into care management program.

Attachment I: Sample of Care Plan

MEMBER OPPORTUNITY	Start Date	End Date	
Knowledge deficit related to congestive heart failure	3/1/18		
PRIORITIZED GOALS	**Status**	**Outcome**	
Prioritized Goal #1- Member states "I want to understand my congestive heart failure."	Initiated	Ongoing	
INTERVENTION	**Outcome**	**Status**	**Next Review Date**
Schedule an on-site visit to member's home to assess the members home environment support system and overall cognitive capabilities in order to determine the most appropriate educational interventions	Successful and completed on 3/22/13 by the health manager	3/22/13 Health Manager (CM) met with John and his significant other and identified that John has a supportive family that can assist with reinforcement of his primary care physician's treatment plan. The CM identified that John has a difficult time comprehending written materials and prefers to go to a class with his significant other.	Member agreed to follow-up call on 3/29/13
Provide member with educational materials and/or external services that will provide appropriate understanding of congestive heart failure	Identified a free educational class in John's community that will provide heart healthy management and chronic disease management	CM assisted with coordinating attendance for the 4/3 class	Member agreed to follow-up call on 3/29/13

Alterwood Advantage's ICT will ultimately serve as the vehicle to facilitate communication and coordination of services between PCPs and specialists, behavioral health providers, ancillary services, home care agencies, hospitals, skilled nursing facilities, and community services. Alterwood Advantage's ICT ensures that beneficiaries have timely access to care, improves health outcomes, eliminates barriers to accessing services, and ensures the appropriate use of health care services.

- **Identify and explain the use of clinical managers, health managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.**

A primary Health Manager acts in the role of the "air traffic controller" overseeing the beneficiary's health care needs and ensuring communication across the beneficiary's service providers and/or ICT.

The below grid defines a high-level listing of ICT members and the roles they may play in ensuring the beneficiary has the individual's needed for an effective interdisciplinary care process.

Interdisciplinary Care Team (ICT) Member	Operational Activities	Outcome
Beneficiary/Caregiver	At enrollment each beneficiary chooses a Primary Care Physician (PCP) and is assigned to a Health Manager (HM) Participates in development of the care plan	Individualized Care Plan
PCP	Overall clinical direction of the beneficiary's care including: • Medical oversight • Primary care services • Initial and ongoing assessments • Collaboration in care plan development • Participates with ICT to identify a change in beneficiary status • Participates with ICT to identify service needs/issues	
Nurse or Social Worker Health Manager	• Develops and implements the care plan • Acts as a single contact point for the ICT, beneficiaries, physicians, social workers, community resources and all caregivers involved in the beneficiary's care • Responsible for communication and dissemination of information to ICT • Coordinates with other health managers (facility, etc.) • Reports to all stakeholders	
Utilization Management RN	• Provides input on concurrent review if beneficiary is hospitalized in acute, subacute or rehab setting	
Health Manager Assistant	• Participates with the PCP, CM and Pharmacist to integrate non-medical support services (such as transportation) into the ICP	
Clinical Pharmacist	• Assesses medication adherence, sub-therapeutic regimens, medication conflicts or duplications, reconciliation of medications at time of care transitions, and high-risk medications	
Behavioral Health and other specialists (as needed)	• Additional input is sought after the core team has made initial and ongoing assessments of the beneficiary, such as behavioral health or ancillary services.	

- **Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following:**
  - **Clear evidence of an established communication plan that is overseen by SNP**

personnel who are knowledgeable and connected to multiple facets of the SNP MOC. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiary's, caregiver(s), community organizations and other stakeholders.

- **The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.**
- **How communication is conducted with beneficiary's who have hearing impairments, language barriers and/or cognitive deficiencies**

During the care plan development, the following information, at a minimum, will be discussed between the ICT members: beneficiary diagnoses and health status, functional status, pharmacy profile, resource utilization (ED, outpatient and inpatient), behavioral health issues (if applicable), social support, risk category, and when applicable the reason or need for ICT evaluation. ICT will identify all relevant issues; identify the success and failure of previous interventions; determine subsequent action items; perform a barrier analysis; and explore all available options and action items to meet those goals and objectives. The above information will be incorporated in the formulation of new or updating of an existing care plan. ICT participants will review their deliverables and timelines for completion.

Care plans will be made available to the PCP via the ALTERWOOD ADVANTAGE provider portal and will be modified based on their feedback. Beneficiaries will be sent two copies of the care plan in order to take one to the PCP at their next visit. Beneficiary care plans and other documentations are kept on the care management shared files, and all ICT members will be able to access it as needed.

Alterwood Advantage's health management system will serve as the fundamental technology platform that will link the ICT, beneficiaries and caregivers, and providers. ICT participant activities will be documented and will become a part of the beneficiary's record as case round notes. All individual ICT meetings will be documented in the system. The Health Manager will update the existing care plans as well as reports that will be shared with beneficiaries and providers.

The ICT, at a minimum, must include the beneficiary and/or caregiver, the primary care physician and the assigned Health Manager. The team may communicate via fax, mail and email. However, the beneficiary or any other member of the ICT may request a team meeting at any time in order to meet the beneficiary's individual needs, levels of care required and complexity of the plan of care. All ICT meetings are documented in the health management system in the case notes related to the case by the primary Health Manager.

The ICT promotes the team-based care and care coordination by partnering with and supporting the PCPs, as well as other providers who are providing care to the beneficiary. As part of our "holistic" management approach, it is understood that care coordination and care management of individuals who are receiving services and supports through multiple systems is most effective when there is cooperation among the various entities. The scope of services

provided to our beneficiaries is unique, therefore, the providers may not be aware of all services that a beneficiary may be receiving. The ICT helps to bridge those gaps in communication.

The communication among the ICT is provided on an individual basis with calls to the PCP and providers involved in the beneficiary's care, facilities, or community agencies. ICT participants can meet with the PCP in their offices, hospitals, or meet beneficiaries in their homes or other community locations. The Health Manager is responsible for working with beneficiaries and their caregivers and providers to implement the action items. The care reviews and the recommendations generated by the ICT are documented in the system as part of the beneficiary's care plan. The ICT approach is a collaborative effort that easily identifies and addresses problems/shortcomings and finds resolution to health or care issues for the beneficiary.

Alterwood Advantage has implemented special provisions to accommodate the beneficiary's preferred communication method. Translation and TTY services are available to better communicate with beneficiaries and caregivers. Translation of printed materials is also available.

ICT case rounds are conducted based on the needs of the beneficiary's ICP.

Element E: Care Transitions Protocols

- **Explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).**

Alterwood Advantage recognizes that older and/or disabled adults who move between different health care settings are particularly vulnerable to receiving fragmented care, especially when transitions are poorly coordinated. In response to this, Alterwood Advantage works actively to coordinate the care transition process with beneficiaries.

The Alterwood Advantage Care Transitions Protocol aims to support beneficiaries and caregivers; increase communication among healthcare providers; enhance the ability of health information technology to promote health information exchange across care settings; implement system level interventions to improve quality and safety and develop performance measures. During this 4-week protocol, beneficiaries and caregivers receive specific tools and work with a member of the Health Management team to learn self-management skills that will ensure their needs are met during the transition between settings. The intervention focuses on four goals that have been key indicators as gap in care when a member goes from one healthcare setting to another or home:

1. **Medication self-management**: Beneficiary and/or caregivers are knowledgeable about medications, any medication changes that may have occurred and has a medication management system.

2. **Use of the beneficiaries revised ICP**: Beneficiary and/or caregiver understands any updates to the ICP based on the care transitions. The Care Management team utilizes the ICP to facilitate communication and ensure continuity of care plan across providers and settings.
3. **Primary Care and/or Specialist Follow-Up**: Beneficiary and/or caregivers schedules and completes follow-up visit (s) with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
4. **Knowledge of Red Flags**: Beneficiary is knowledgeable about indications that their condition is worsening and how to respond.

The four goals are operationalized through two mechanisms:

1. An updated ICP and
2. A series of structured phone calls with a member of the Care Management team

Both mechanisms are designed to empower and educate beneficiaries and/or caregivers to meet their healthcare needs and ensure continuity of care in the transition(s) following discharge from a hospital/skilled nursing facility.

Evidence supporting this type of approach during the transition of care process found beneficiaries were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five-months after the end of the one-month intervention. Thus, rather than simply managing post-hospital care in a reactive manner, imparting self-management skills pays dividends long after the program ends. Members who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery.

- **Describe which personnel (e.g., health manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.**

Members of the Health Management team that are responsible for coordinating the care transition process are as follows:

- RN Discharge Planner (either on site or telephonic based on facility)
- RN Transitional Care Coordinator
- RN Health Manager
- RN Utilization Management
- Health Manager Assistants

A Health Manager/ Health Management Assistant, in conjunction with the Utilization Management staff will engage beneficiaries who may be receiving care at a different setting including when a beneficiary becomes hospitalized. To coordinate the transition process, the Health Manager/ Health Management Assistant will continue to follow the member's care via the Utilization Management case. Outreach to beneficiaries after the first three days of an acute care transition setting is attempted to guide the member through this critical transition process.

- **Explain how the SNP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.**

  The ICT promotes the principles of a medical home by partnering with and supporting the PCPs, as well as other providers who are providing care to the beneficiary. In addition, the ICT participants will develop relationships within communities where our beneficiaries reside. The scope of services provided to our beneficiaries is unique therefore, the providers may not be aware of all services that a beneficiary may be receiving. The ICT helps to bridge those gaps in communication.

  In order to assess beneficiaries for the possibility of a transition of care, the Utilization Management staff are in close contact with the D-SNP Health Manager during a hospital stay. In addition to the communication with the Utilization Management staff, the use of daily management reports such as Daily Inpatient Acute Census, Daily Inpatient SNF/Sub-Acute/Transitional Care Census and Readmission reports, as well as daily CRISP (Chesapeake Regional Information System for our Patients) report help to identify beneficiaries in need of transitional care planning. The health manager coordinates with the beneficiary and/or the facility discharge planning staff to re-assess the beneficiary in order to determine any new opportunities, goals, interventions, or preferences. The health manager will educate the beneficiaries and/or caregivers about their condition. The beneficiary and/or caregivers will express a verbal understanding of changes in their condition and verbalize appropriate self-management activities. Education about signs and symptoms indicative of further changes and how to respond to such changes will be reviewed with the beneficiary and/or caregiver.

  For example, the focus of health management during a transition of care from inpatient to home would include an assessment that identifies eight (8) core points that would require monitoring to assist with preventing a readmission. Those core points are:

  - Any knowledge deficits related to existing/new diagnoses or conditions
  - Telephonic follow-up with the beneficiary
  - Medication reconciliation
  - Assistance with scheduling primary care and specialty appointments within seven (7) days of discharge
  - Provide transportation or other needs as identified by ICT
  - Assess home health and DME needs and coordination of delivery of services
  - Periodic follow-up calls for thirty (30) days post-discharge to ensure services are received, appointments are scheduled, and education is provided for self-management
  - Evaluation of ongoing needs for health management program referrals

- **Describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have**

access to and can adequately utilize the beneficiary's' personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.

All SNP beneficiaries can access their personal information 24 hours a day, 7 days a week, via our online Member Portal. The tool provides access to personal health information, such as the services received, prior authorizations, eligibility information, and the ability to search for in-network providers and pharmacies.

Core functionality for the Member Portal includes:

- Ability to view services which were received
- List of services which have been submitted for prior authorization
- Verification of eligibility
- Accumulator information such as deductibles and maximum out-of-pocket costs
- Ability to submit a PCP change request
- Initiation of request for ID Card replacement
- Links to tools in which beneficiary can search for providers and pharmacies in our network. Search results include contact information to enable beneficiary to contact provider directly.

Core functionality for the Provider Portal includes:

- Ability to view services which were rendered
- List of services submitted for prior authorization
- Member eligibility search
- For PCPs:
    - Panel Roster
    - Care Gaps for members in panel
- Submit request to update contact information
- Links to resources such as Credentialing forms and information, Prior Authorization Request forms, Clinical Practice Guidelines, Formulary, etc.

Access to all portals is administered through an automated registration process. To register, each beneficiary or provider must first provide key pieces of information to validate their identity.

The portals are HIPAA compliant and are monitored for performance and availability on a constant basis. All updates are managed through a change control process which includes testing of any changes in a separate controlled environment to ensure changes will not adversely impact the portals once implemented.

Underlying data is updated frequently to ensure the information presented is as current as possible. In addition, alerts have been implemented in which the IT team is notified if there is a failure in critical processes which support the portals.

- **Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.**

Throughout the entire process of working with a beneficiary and/or their caregiver (from the start of enrollment), the Health Management team does everything possible to understand the learning level of each. Understanding limited literacy levels, different learning skills and communication are all drivers in successful instruction and understanding. A critical part of the patient education that occurs during the health management process is helping the member to under their disease process(es) using key points, supplying education in small amounts over several sessions and avoiding medical jargon. Written patient education, highlighting important points and encouraging questions are techniques employed by the Health Management team.

Once a beneficiary and/or caregiver understand what their disease is, they can be educated on the key "red flags" that would mean their condition is worsening. Again, employing the same techniques as above, education is provided in small doses to ensure understanding. Allowing the beneficiary and/or caregiver to role play and explain step by step their disease and/or treatment is one of the techniques used to ensure education is being comprehended.

Reiteration and continuously building on the education with every engagement opportunity are applied in helping a beneficiary and/or caregiver gain appropriate self-management activities.

As reflected through this MOC, the beneficiary/caregiver(s) are an integral part of the ICT managing the care received. The ICP provides the beneficiary/caregiver(s) with the road map of opportunities, barriers, interventions and goals to appropriate self-management activities. This ICP is reviewed frequently and is updated if the ICT feels it is needed to ensure that the member is continuing the path to self-management activities or recommending changes or modifications the plan. The Health Manager (and ICT) continually involve the beneficiary/caregiver(s) in three critical steps of ensuring their education:

(1) Planning & delivery of care – i.e., development of ICP
(2) Evaluation of results by beneficiary/caregiver(s) and adjusting the ICP as needed
(3) Evaluation of overall program effectiveness & adjustment of the ICP as needed

- **Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.**

The primary Health Manager/Health Management Assistant, assigned to the member at that the time of enrollment, is responsible for following the beneficiary throughout the continuum of care. The Health Manager/Health Management Assistant, at the time the member accepts enrollment into the D-SNP Health Management program communicates her roles and

responsibilities so that the beneficiary/caregiver(s) clearly understand who to contact throughout the care continuum.

MOC 3 – Provider Network

Element A: Specialized Expertise

- **Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MOC Element 1.**

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Alterwood Advantage's existing provider network incorporates all provider types included in the SNP Model of Care Attestation. Alterwood Advantage has contracted with qualified providers in its service area with experience in caring for Alterwood Advantage's beneficiaries. In addition to direct medical care, beneficiaries are also referred to community services as needs arise. Alterwood Advantage is committed to developing and maintaining a comprehensive provider network that meets the medical needs of Alterwood Advantage's beneficiaries. An online provider directory is available on Alterwood Advantage's website or printed upon request.

The provider network is designed to meet the needs of Alterwood Advantage's member population. The network includes all required provider and ancillary specialty types per CMS guidelines. Examples of provider types covered in the network include:

- Acute care facilities
- Urgent Cares
- Laboratories
- Imaging Centers
- Specialty Clinics
- Long Term Care Facilities
- Pharmacies
- Rehabilitation Centers
- Primary Care Providers
    - Internal Medicine
    - Family Practice
    - Geriatrics
    - General Practice
- Specialists
    - All CMS required specialties for access and availability
    - Medical specialists pertinent to targeted chronic conditions and co-morbid conditions
- Home Health Care
- Physical, Occupational, and Speech Therapists
- Dialysis Clinics

- Medical Specialists
- Geriatricians
- Pain Management Specialists
- Nursing Professionals
- Mental Health Specialists
- Other Allied Health Professionals

These contracted providers are committed to working with Alterwood Advantage and implementing the Model of Care.

- Facilities pertinent to the care of the targeted special needs population:
    - Acute Care Facilities – Alterwood Advantage's provider network consists of both acute facilities and critical access facilities. The relationship between the health plan and the acute care facilities, as required by the MOC, places the health plan Health Manager and/or Mid-Level Provider in the transition of care decisions for admission and discharge of Alterwood Advantage's beneficiaries.

    - Nursing Facilities – Alterwood Advantage's network of nursing facilities serves transitional and rehabilitation needs for the community-based dual population. Nursing facilities must be Medicaid certified and employ certified and licensed staff capable of handling the specific needs of this population. Because of the crucial role that nursing facility staff plays in the ICT and the success of the Model of Care, Alterwood Advantage has established a strong relationship with all contracted facilities.

- Medical Providers:
    - Primary Care Physicians (PCP) – The PCP is often the provider who has the most interaction with a beneficiary. Each beneficiary chooses or is assigned to a PCP, and the PCP is responsible for oversight and coordinating the care with specialists. The PCP is a key member of the ICT for all of Alterwood Advantage's beneficiaries.

    - Specialists – Specialists are available to beneficiaries to support the medical needs of the dual population. Alterwood Advantage contracts with all CMS-required specialty types, understanding there might be higher utilization of the following specialties for the target population:
        - Cardiologists - cardiovascular disease (CHF)
        - Endocrinologists - diabetes
        - Pulmonologists - respiratory disease including COPD
        - Rheumatologists- arthritis

- Behavioral and mental health specialists – Contracted behavioral and mental health specialists provide mental health support, including Psychiatrists, Psychologists, and Licensed Social Workers. With a strong understanding of the unique needs of the dual

population, these specialists provide ongoing behavioral health coverage and participate in the ICT care team meeting when the situation requires behavioral health expertise.

- Nursing professionals – The Nurse Health Manager is a key member of the ICT, lending clinical expertise to the coordination of care to the beneficiary. All nursing staff are certified or monitored by the state licensing agencies. Nursing staff, which may include the Director of Population Health Management, RNs, LPNs, LVN's, CMAs, and CNAs, have crucial roles on the ICT.

- Allied health professionals – Alterwood Advantage contracts with CVS Caremark to provide pharmacy benefits. LabCorp and Quest Diagnostics will be providing laboratory services for the network providers. Every nursing facility also has a staff pharmacy consultant. Physical therapists, occupational and speech specialists are available in the network and also in nursing facilities. All are members of the ICT.

On a quarterly basis, as part of the internal auditing and monitoring program, Alterwood Advantage's network will be reviewed for adequacy and gaps in the types of specialty care needed to provide services to our beneficiaries, using the CMS Health Services Delivery (HSD) Tables. The Quest Analytics software will compare the existing membership to the required specialties and determine if the network meets the requirements for numbers of providers and geographic adequacy. Provider network and contracting strategies will be developed based on the outcome of the network analysis and needs. In addition, Alterwood Advantage will monitor PCP and specialist availability on a regular basis. Offices that do not meet the availability of appointment requirements will be placed on a corrective action plan to correct the deficiency. The plan benefit design allows our beneficiaries access to all the required Medicare providers, consistent with those specialties covered under traditional Medicare. The list below outlines the some of the different types of specialists that are a part of Alterwood Advantage's network.

Specialty List:

001 – General Practice
002 – Family Practice
003 – Internal Medicine
004 – Geriatrics
005 – Primary Care – Physician Assistants
006 – Primary Care – Nurse Practitioners
007 – Allergy and Immunology
008 – Cardiology
010 - Chiropractor
011 – Dermatology
012 – Endocrinology
013 – ENT/Otolaryngology
014 – Gastroenterology
015 – General Surgery
016 – Gynecology, OB/GYN
017 – Infectious Diseases
018 - Nephrology
019 - Neurology
020 - Neurosurgery
021 - Oncology - Medical, Surgical
022 - Oncology - Radiation/Radiation Oncology
023 - Ophthalmology
025 - Orthopedic Surgery
026 - Physiatry, Rehabilitative Medicine
027 - Plastic Surgery
028 - Podiatry
029 - Psychiatry
030 - Pulmonology

031 - Rheumatology
033 - Urology
034 - Vascular Surgery
035 – Cardiothoracic Surgery

Facility/Ancillary List:

040 – Acute Inpatient Hospitals
041 - Cardiac Surgery Program
042 - Cardiac Catheterization Services
043 - Critical Care Services – Intensive Care Units (ICU)
044 - Outpatient Dialysis
045 - Surgical Services (Outpatient or Ambulatory Surgery Center (ASC))
046 - Skilled Nursing Facilities
047 - Diagnostic Radiology
048 - Mammography
049 - Physical Therapy
050 - Occupational Therapy
051 - Speech Therapy
052 - Inpatient Psychiatric Facility Services
054 - Orthotics and Prosthetics
055 - Home Health
056 - Durable Medical Equipment
057 - Outpatient Infusion/Chemotherapy
061 - Heart Transplant Program
062 - Heart/Lung Transplant Program
064 - Kidney Transplant Program
065 - Liver Transplant Program
066 - Lung Transplant Program
067 - Pancreas Transplant Program

- **Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.**

All providers are licensed and determined to be approved for network participation through a formal credentialing process completed after the provider initially contracts with Alterwood Advantage. Providers are re-credentialed every three years, consistent with current regulations.

All licensed providers and providers who desire to become a provider in the network will undergo the credentialing process after a signed contract is received by Alterwood Advantage. Alterwood Advantage's credentialing of providers follows NCQA guidelines. The provider specifically agrees to participate in and provide care for participants enrolled in the Special Needs Program (SNP) via contractual amendment/exhibit.

In order to accomplish credentialing, Alterwood Advantage requires a completed credentialing application from the provider and performs the following verifications:

- Primary source verification of training and education – graduation from medical school and completion of an internship, residency, fellowship, specialty, subspecialty, or certification by a regional or national health care or medical specialty college, association or society or board certification, as applicable for physicians and primary source verification of professional education and training for non-physician practitioners through professional school or appropriate licensing agency as applicable

- Primary source verification of board certification if the practitioner claims board certification on the application
- Verification of work history for at least the past five years with gaps of six months or more explained
- Primary source verification of current valid license and registration to practice in the state
- Verification of individual Medicare and Medicare provider numbers
- Verification of clinical privileges in good standing at a participating hospital
- Verification of current adequate malpractice insurance coverage with limits not less than $1 million per occurrence and $3 million in the aggregate
- Verification of valid Drug Enforcement Agency (DEA) Certificate, or Controlled Dangerous Substance (CDS) Certificate as applicable
- Primary source verification of professional liability claims history during the prior five-year period that resulted in settlements or judgements paid by or on behalf of the provider. Such claims shall be verified by the National Practitioner Data Bank (NPDB) or the applicable insurance carrier and/or primary source verification history of pending professional lawsuits
- Checks the provider against the Medicaid Exclusion provider list
- Checks the provider against the Medicare Opt Out and Preclusion lists

All applicants are approved through a committee process. The credentialing process is completed within an average 30-45 days after the provider contracts with Alterwood Advantage. The provider is not approved for network participation until after the credentialing process is successfully completed.

Re-credentialing is conducted at least every 36 months.

State licensing issues are monitored on a continuous basis by review of issuing boards, monitoring of the National Practitioner Databank (NPDB), Council for Affordable Quality Healthcare (CAQH) and CMS sanctions. In addition to licensing board reviews, the credentialing department will review Medicare Opt Out and Sanction listings on a continuous basis to identify providers excluded or sanctioned by Medicare/Medicaid. Both licensure and Opt Out Sanction monitoring reports are provided to the Credentialing Committee for review and action at each regularly scheduled meeting. Additionally, Alterwood Advantage reviews providers for adherence to the program's quality performance standards.

Issues identified between credentialing cycles that may impact the practitioner's ability to participate in the network are brought to the attention of Credentialing Committee for review and action. Negative information that does not immediately impact the practitioner's participation in the network is tracked, trended and monitored for further activity and reviewed at the time of re-credentialing.

Alterwood Advantage's Credentialing Committee Program outlines the mission, functions, duties, and authorities of this committee. Committee membership consists of the Alterwood

Advantage's Medical Director and representative participating providers who are clinicians, are not employees of the organization, and are representative of those clinicians who most frequently provide services to our beneficiaries. The Medical Director oversees the development and guidance of the clinical aspects of the participating provider network. The Credentialing Committee makes recommendations to the Board of Directors who has final authority for approving or denying providers for network participation.

The Credentialing Committee is a peer review committee whose discussions are confidential, and perform the following duties:

- Review and provide input into credentialing policies and procedures
- Review credentials of providers and make recommendations for approval, denial or to pend for additional information
- Evaluate complaint and beneficiary satisfaction data as part of the re-credentialing process
- Evaluate quality improvement and performance related findings as part of the re-credentialing process
- Provide recommendations regarding appropriate follow-up actions

A separate committee, the Provider Advisory Committee (PAC), is responsible for reviewing clinical policies. The PAC reviews, revises, and adopts clinical practice guidelines and makes recommendations for implementing guideline changes.

- **Describe how providers collaborate with the ICT (MOC Element 2D) and the beneficiary, contribute to the ICP (MOC Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.**

The Health Manager is the leader of the ICT and the primary point of contact that facilitates communication between the PCP, the beneficiary and/or the beneficiary's family and any required specialty care or other social services. The Health Manager will help align performance measures between each link of the care delivery model. The Health Manager engages the PCP and PCP's clinical staff in order to develop trust, strengthen communication and coordinate the individual beneficiary's care plan. This relationship enhances understanding and coordinating services received outside the PCP's office and improve the beneficiary's care.

The Health Manager, beneficiary/caregiver(s) and PCP form the nucleus of the ICT. Other providers are added into the ICT as needed. The Health Manager is responsible for the day-to-day management of the beneficiary's care plan on behalf of the PCP. The Health Manager Assistant assists in completing non-clinical aspects of the care plan like appointment follow-up, helping arrange transportation, family communication of non-clinical information, etc. This process provides additional connectivity to the beneficiary and the beneficiary's family.

Care plan information is captured and maintained within Alterwood Advantage's care management system. As assessments are completed, services received, and beneficiary education performed, the care plan is updated. As care plan goals are met and/or objectives are modified, the updated care plan is shared with the PCP, the beneficiary and other pertinent care providers. The PCP has the option of reviewing all care plan activities including specialty care, information received from assessments, prescriptions filled, etc. online via the HIPAA-compliant provider portal of the system. The ICT will reach out to specialists as needed by the beneficiary to integrate the specialist treatment into the care plan and help enforce clinical protocols through disease management and education programs. Behavioral Health and Pharmacotherapy consultation in collaboration with the PCP and care team will be provided by behavioral health professionals and community pharmacists.

All care plan communication, interventions and outreach are captured by the Health Manager/Health Management Assistant within the care management system. This pertinent information is documented while updating the care plan and the care plan is then shared with the beneficiary/caregiver(s) and PCP.

Our Member Services Department will also assist the beneficiary regarding benefit questions, provider inquiries and clarification of services. Additionally, Member Services facilitates the intake of complaints. Member Services ensures the appropriate delivery of the complaints for resolution, so the beneficiary receives timely and satisfactory outcomes.

Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

- **Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.**

Alterwood Advantage contractually requires providers to deliver services to beneficiaries in accordance with nationally recognized clinical protocols and guidelines when available. The Chief Medical Officer facilitates the review and adoption of these guidelines for Alterwood Advantage through the quality improvement infrastructure. In addition, the Provider Manual will address provider practices and will be updated annually to reflect any newly adopted protocols or modified protocols.

Annually the Alterwood Advantage Provider Advisory Committee (PAC) reviews the health plan's clinical practice guidelines. The PAC is composed of network physicians representing a diverse array of specialties and regions within the service area. Based on population assessment data provided by the Quality Improvement Department, the PAC identifies clinical practice guidelines that are relevant to the needs of the population. The PAC selects clinical practice guidelines that are nationally recognized and are based on the most recently available clinical evidence. Upon approval of clinical practice guidelines by the PAC, the Provider

Relations and Quality Improvement Departments collaborate to distribute to clinical practice guidelines to the entire provider network via providers newsletters and the UMAH website.

Alterwood Advantage uses several methods to monitor the appropriate use of its selected clinical practice guidelines but its network physicians:

- ICPs are developed based on the nationally recognized protocols of the clinical practice guidelines. The structure of the ICP ensures that members of the ICT including physicians comply with clinical practice guidelines in the provision of care to beneficiaries. Alterwood Advantage regularly audits ICPs to ensure all aspects of the ICPs are complete.
- HEDIS and Stars measures are based on nationally recognized clinical practice guidelines. Alterwood Advantage uses these measures to monitor the provision of care to its beneficiary population. Alterwood Advantage tracks prospective HEDIS and Stars measure rates monthly. The prospective rates are reported to the Stars Committee, Clinical Monitoring Oversight Committee and the Quality Committee at least monthly. Benchmarks and goals for HEDIS and Stars measure are established. Through these committees Alterwood Advantage develops actions and strategies to ensure members receive clinically indicated care and are compliant for the HEDIS and Stars measures. If Alterwood Advantage identifies opportunities in HEDIS or Stars compliance it develops corrective actions to improve rates with the involvement of network physicians. Monthly Alterwood Advantage sends providers "HEDIS Gaps in Care Reports" which list beneficiaries on a physician's panel who are non-compliant for select HEDIS measures. Physicians are encouraged to outreach to their patients to ensure provision of care as indicated by the clinical practice guidelines.
- Alterwood Advantage tracks quality of care and service complaints it receives about its network physicians. Quality of care/service complaints can come from many different sources such as beneficiaries, health plan staff, other physicians, ect… If through such a complaint Alterwood Advantage determines that a network physician failed to adhere to clinical practice guidelines it has the right to act against that physician in a manner corresponding with the severity of the breach. Alterwood Advantage trends all quality of care/service complaints to identify trends in failures to adhere to clinical practice guidelines.

Alterwood Advantage's Chief Medical Officer, who has extensive experience and training in the care of the dual-eligible and the chronically ill (medically and behavioral), is responsible for the review and dissemination of the clinical practice guidelines to Alterwood Advantage's network providers. The Chief Medical Officer will also ensure that the clinical practice guidelines are utilized by Alterwood Advantage's provider network when providing care to a Alterwood Advantage beneficiary. During MOC training sessions, the Provider Relations Representative will reinforce the required use of the clinical practice guidelines. If it is identified that a Alterwood Advantage provider is not using clinical practice guidelines as required by the MOC, providers will be reported to Alterwood Advantage's Medical Director. Information will be shared with

the QIC and if deemed appropriate, the Medical Director will institute a corrective action plan. If a provider continues to remain deficient in complying with the protocols identified by Alterwood Advantage, the Chief Medical Officer may recommend that the provider be removed from Alterwood Advantage's network of providers.

Alterwood Advantage uses several evidenced-based practices and nationally recognized clinical protocols. In addition, Alterwood Advantage continues to consider several nationally recognized clinical protocols as listed in the table below.

Conditions	Guideline Sources
Acute MI	American Heart Association 2014
Preventive Care: Adult (21 years old & over)	U.S. Preventive Services Task Force 2014 (A & B Recommendations)
Preventive Care: Adult Immunizations (19 years old & over)	The Centers for Disease Control & Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP)
Asthma	GINA Report: Asthma Management 2018
Cardio-vascular Disease	American Heart Association 2011
Cardio-vascular Disease Women	American Heart Association 2011
Chlamydia	U.S. Preventive Services Task Force 2014
Cholesterol Management	National Heart Association 2013
Chronic Heart Failure	American Heart Association 2013
Chronic Obstructive Pulmonary Disease	Global Initiative for COPD 2017
Chronic Pain: Use of Opioid Analgesics in the Treatment of Chronic Pain Prescribing Opioids for Chronic Pain	Federation of State Medical Boards 2017 Centers for Disease Control and Prevention
Chronic Stable Angina	American Heart Association 2007
Depression	American Psychiatric Association 2010
Diabetes	ADA Standards of Medical Care in Diabetes 2018
Human Immuno-deficiency Virus (HIV)	CDC HIV CPG 2017
Hypertension	American Medical Association 2014

- **Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the ICT (MOC Element 2D) and acted upon.**

While clinical guidelines exist for some conditions, they do not exist for all conditions and general guidelines may not have been customized for Special Needs Populations. In addition, most Special Needs beneficiaries on Medicare have multiple physical, behavioral, and cognitive needs that clinical guidelines are often not intended to address. Thus, the ICT is challenged with overseeing beneficiaries that may not fit into the existing practice guidelines. With the limited established evidence or clinical practice guidelines specific to serving SNP, organizations must explore new opportunities to find effective strategies for reducing costs and improving quality of life for this population. Alterwood Advantage will use some of the following strategies to address these challenges:

- Using administrative, claims, CRISP, and interview data to identify SNP members.
- Stratify beneficiaries to prioritize those most at risk and potentially prevent acute exacerbations of chronic conditions.
- Reach out to caregivers to provide up-to-date clinical information and create integrated health management programs that foster links to ancillary resources.
- Provide care coordination services to beneficiaries and their caregivers and working with providers to establish and enhance a patient centered medical home.

Example:
John is a 57 years old male who was diagnosed with Coronary Artery Disease, diabetes, hypertension, asthma, hyperlipidemia, GERD, bipolar disorder and episodic mood disorder. John has been enrolled with the health plan since its inception in 2016. The initial assessment identified several recent ED visits and inpatient hospitalizations, a positive Patient Health Questionnaire (PHQ-9) test and difficulties with access to reliable transportation. He currently lives with his significant other. John was assigned to a Health Manager who contacted John and successfully enrolled him into care management program. While some of these conditions have clinical guidelines, other contributing factors do not. Therefore, Alterwood Advantage will utilize several techniques, including reaching out to John and his significant other, and reviewing available claim data on a regular basis to ensure John receives the right care at the right time.

Alterwood Advantage ensures its provider network is practicing evidence-based medicine and is continuously monitoring its membership. The Medical Director is available daily to communicate and consult with the medical staff regarding medical management cases, address issues related to network provider, medical chart reviews, and conduct physician peer-to-peer discussions on protocols and clinical guidelines as needed. Updates to clinical practice standards and guidelines are communicated to providers on a regular basis as appropriate. A variety of areas are regularly monitored to assist with early identification of issues including hospital compare, nursing home compare, OIG list of excluded providers, etc. If a provider is identified as potentially not complying with the standards set forth by Alterwood Advantage, the provider may be presented at a Credentialing Committee meeting where the provider's performance and practice is reviewed. The provider will coordinate with the ICT and the beneficiary to deliver needed care services. The provider, working with the health manager will confirm follow-up is scheduled and performed in a timely way. Reports on services delivered to

the beneficiary are shared with the Alterwood Advantage and discussed in the ICT. The ICT will determine the need for any medical records that require review and will share these records on an as needed basis under privacy regulations. All records will be maintained by the provider to assure a complete beneficiary record.

- **Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MOC Element 2E.**

The Health Manager will use daily management reports to ensure she captures any beneficiaries that may have transitioned to another level of care utilizing such reports as the Daily Inpatient Acute Census, Daily Inpatient SNF/Sub Acute/Transitional Care Census, and Readmission reports, as well as daily CRISP (Chesapeake Regional Information System for our Patients) reports to identify beneficiaries in need for transitional care planning. The health manager identifies a beneficiary for transitional care planning through their daily interaction and health management duties (change in health condition, transition of care setting, new care plan developed, etc.). The health manager coordinates with the beneficiary and network providers to re-assess the beneficiary in order to determine any new opportunities, goals, interventions, or preferences.

By following the standard Quality of Care processes, the Health Manager will identify network providers who do not follow the required care transition protocols. These activities are reported through the Quality Improvement committee structure which provides oversight.

Out-of-network providers that see beneficiaries on a routine basis may be sent materials to enable them to become a participating provider. This information will include a provider agreement and application materials. In addition to this information, they will also be provided details on their responsibilities under the Alterwood Advantage model of care. If an out-of-network provider cannot meet the requirements, they are asked to refer the member to an in-network provider who can do so.

Element C: MOC Training for the Provider Network

- **Explain, in detail, how the SNP conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.**

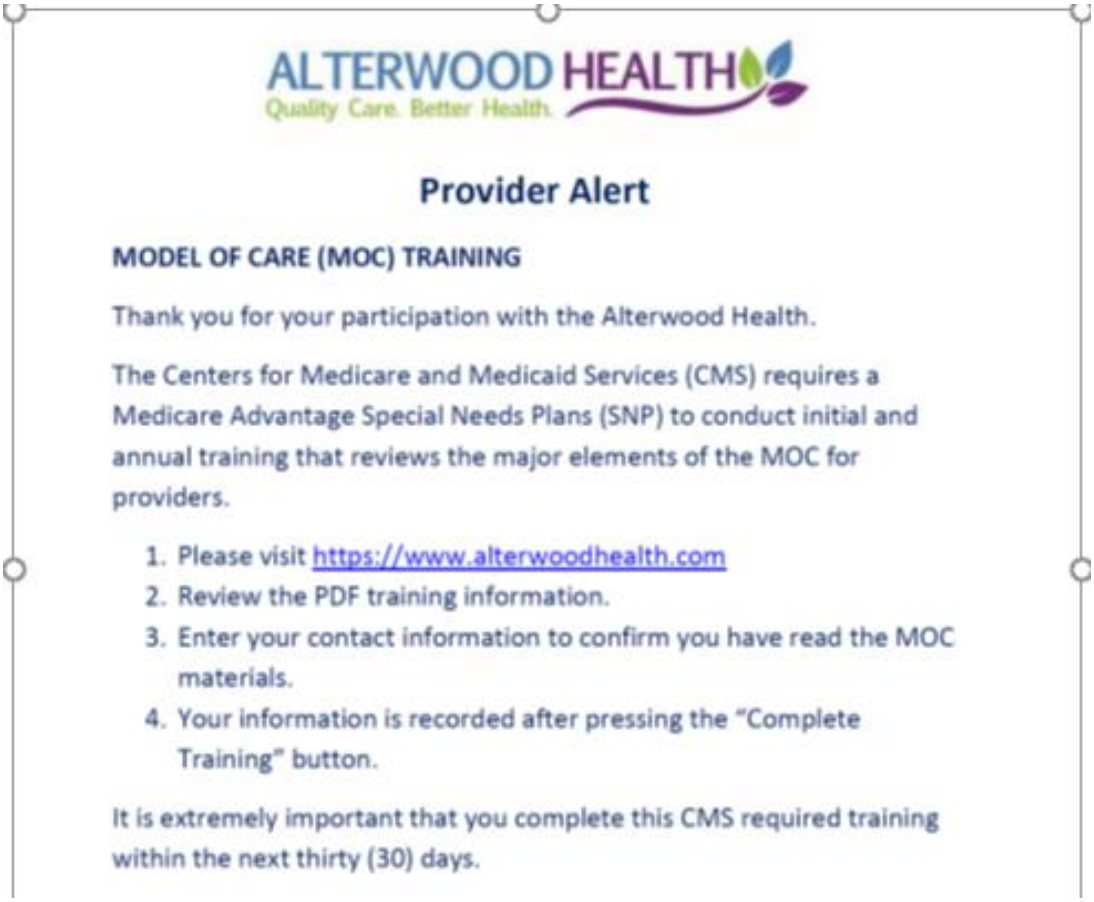
All contracted providers are required to complete initial and annual MOC training. Provider training on the MOC focuses on working in collaboration with the ICT and the implementation of the beneficiary care plan. Trainings are available in the form of a PowerPoint and are linked on our website for all contracted and non-contracted providers to access. The training is updated annually to reflect any Model of Care changes.

All newly contracted providers receive an orientation meeting which reviews the operational requirements of the plan. During this orientation, the providers review the training materials on the Model of Care. The signed attendance sheet from these orientations is placed in the provider's contract folder documenting their completion of the Model of Care training.

On an annual basis, providers are notified that they must complete the most current Model of Care training. This training is scheduled to be completed in the first quarter of the year. Providers are notified either via an email communication or via fax blast notification (example of fax blast noted below). The training is provided via a PowerPoint presentation available for review on our website or they may schedule an in-person training with the Provider Relations representatives to perform the training.

Alterwood Advantage reviews claims and authorization data to identify out of area or out of network providers that provide care to members. These non-contracted providers are contacted either telephonically, via email or via fax and instructed on the process required to complete the Model of Care training using the website (Alterwood Advantagetraining.com). All of these non-contracted providers are additionally offered contracts and credentialing materials to enable them to become a network provider.

Attachment J: An example of the fax communicationis as follows:



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Provider Alert

MODEL OF CARE (MOC) TRAINING

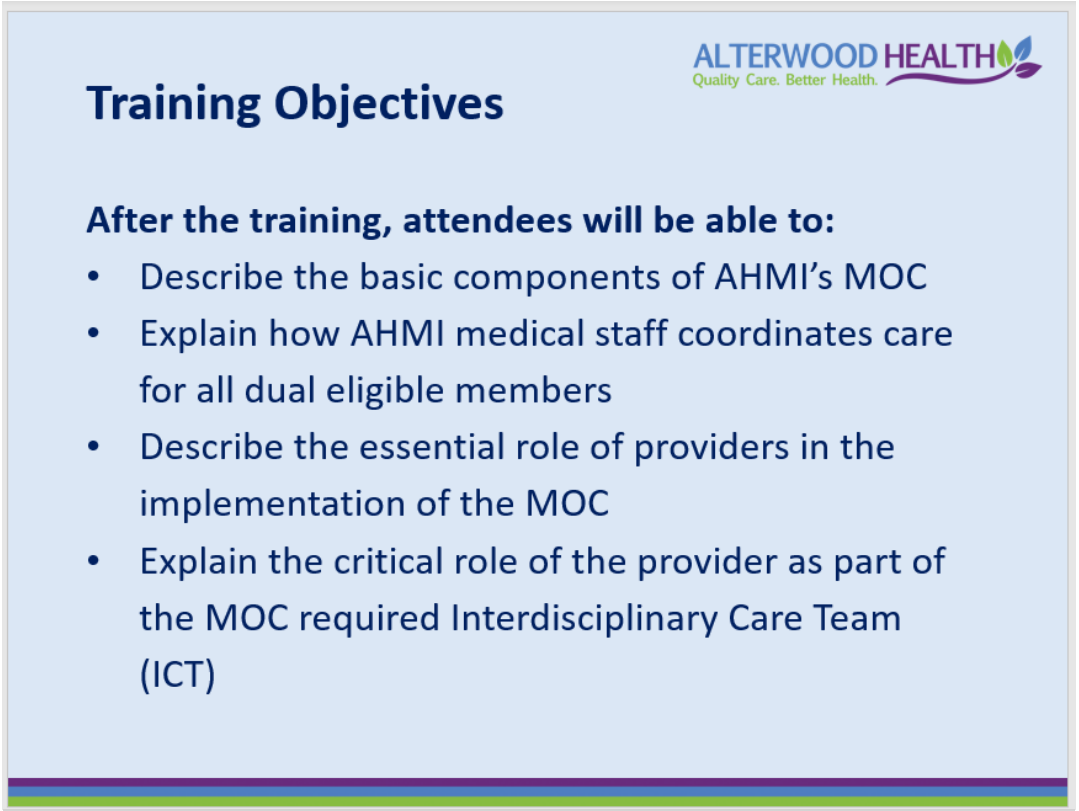
Thank you for your participation with the Alterwood Health.

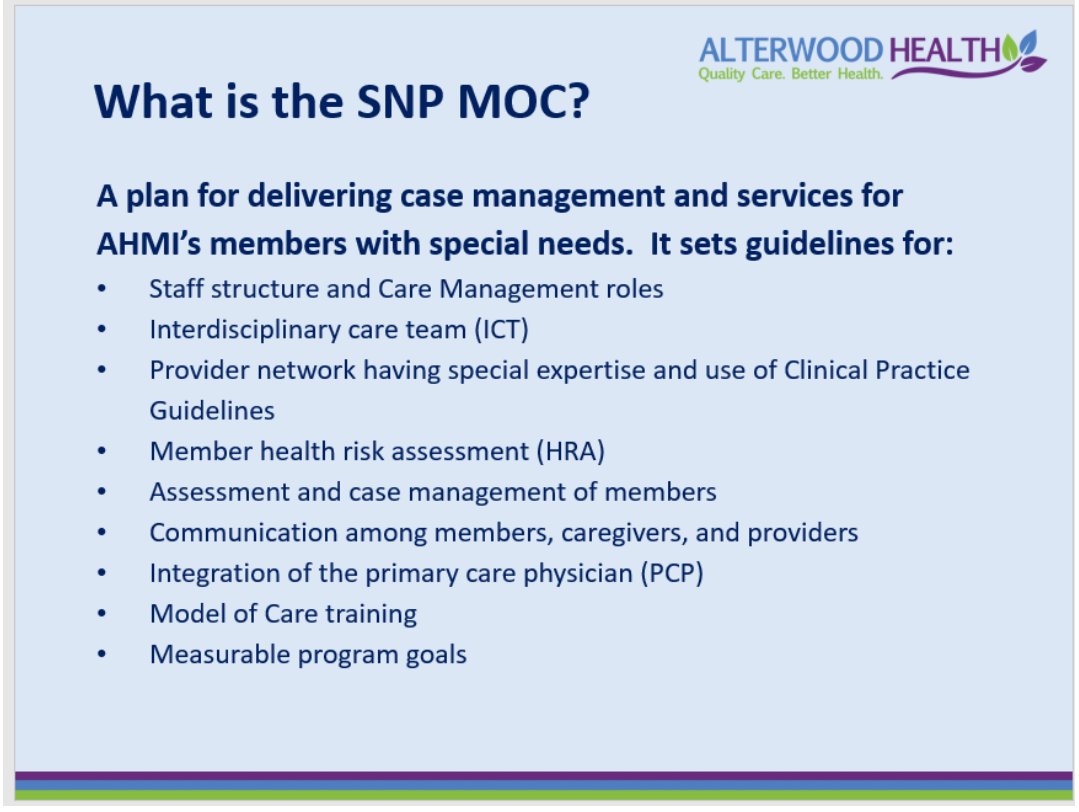
The Centers for Medicare and Medicaid Services (CMS) requires a Medicare Advantage Special Needs Plans (SNP) to conduct initial and annual training that reviews the major elements of the MOC for providers.

1. Please visit https://www.alterwoodhealth.com
2. Review the PDF training information.
3. Enter your contact information to confirm you have read the MOC materials.
4. Your information is recorded after pressing the "Complete Training" button.

It is extremely important that you complete this CMS required training within the next thirty (30) days.

Attachment K: Examples of slides from the MOC are shown below and Include:





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Interdisciplinary Care Team Goals

The Goals of the MOC are achieved by the coordinated efforts of ICT.

- ICT members include member/primary caregiver, nurses, physicians, pharmacists, licensed clinical social workers and care coordination technicians. Additional health care disciplines may be included as appropriate.
- The ICT, together with the input from the member, collaborate to develop and update individualized care plans (ICP).
- The team manages the medical, cognitive, psychosocial and functional needs of the member.
- The team communicates to coordinate the care plans.
- Through the team, problems/opportunities can be identified and possible resolutions can be presented to assist the member achieving solutions to health or care issues.

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Role of the Provider in the ICT

Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with:
  - AHMI Case Managers
  - Members of ICT
  - Members and caregivers

- **Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MOC training.**

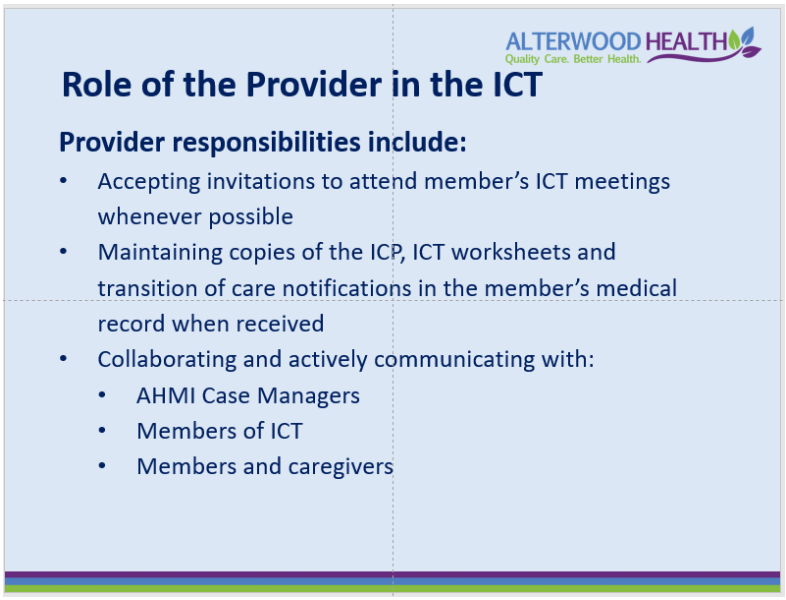
  Providers are notified of the annual training requirement via email or fax communication depending on their preference. The notification explains the importance of the training and the method to complete the training using the website. The fax / email list is maintained as proof of notification for the training. Additionally, the training requirement is highlighted in provider newsletters and in provider meetings. All provider meetings that involve the model of care include a dated and signed attendance sheet.

  Once the training is completed via the website, providers are required to enter their demographic information into a web form which confirms that they have successfully completed the training.

- **Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP Plan will take when the required MOC training has not been completed or is found to be deficient in some way.**

  Any provider that has been identified as not completing the training receives follow up from the provider relations representative for that area. Provider relations maintains the master list of training and follows up with offices that do not complete it in a timely manner. A corrective action plan (CAP) is created for those offices that do not complete the MOC training. The CAP could include alternative methods of the training to meet the requirement.

  Attachment L: Screenshot of Model of Care Training Slide – Role of the Provider in the ICT Team



MOC 4 – MOC Quality Measurement and Performance Improvement

Element A: MOC Quality Performance Improvement Plan

- **Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:**
    - **The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MOC by using specified data sources, performance and outcome measures. The MOC must also describe the frequency of these activities.**
    - **Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process.**
    - **Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B).**
    - **Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the re-measurement plan for goals not achieved.**

The Quality Improvement Program Description (QIPD) identifies the process by which the Plan collects, analyzes, and reports data measuring health outcomes and indices of quality pertaining to D-SNPs special needs beneficiaries. Structure, process, and outcome measures are identified to evaluate the effectiveness of the care management plan and the beneficiaries' health status. Alterwood Advantage uses its data management and reporting to improve care and service for Medicare enrollees, so that clinical outcomes, satisfaction, use, and program costs are closely tracked, measured, and analyzed.

Information is captured from many sources within the D-SNP and is channeled up through the Quality Committee Structure and ultimately to the Board of Directors, who has oversight for the Quality Improvement Program. Participants in the Model of Care coordinate and provide care and are instrumental in determining the impact of care on overall outcomes. The specific measures monitored, and quality improvement projects are outlined in the annual Quality Improvement Work Plan (QIWP). Measures and quality improvement projects are based on the previous year's Quality Improvement Evaluation and annual population assessment. The QIWP is a working document that is updated through the year to reflect additional monitors and initiatives based on newly identified opportunities for improvement, issues, trends or priorities. Quarterly updates to the QIWP specific to the SNP-MOC are overseen by the Clinical Monitoring Oversight Committee and are then reported to the QIC as necessary.

Alterwood Advantage is committed to improving the quality of health care for its beneficiaries. Alterwood Advantage will conduct clinical and non-clinical quality improvement initiatives that

achieve, through ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. The Quality Improvement Committee (QIC) will establish ad hoc workgroups to analyze data, determine root causes, review best practices, plan interventions, develop monitoring and evaluation plans, collect/analyze data and evaluate performance. This continuous quality cycle, using the Plan-Do-Study-Act (PDSA) methodology, will repeat until goals are met. To sustain performance, monitors will be established and incorporated into the QIWP. The QIC is composed of senior leadership and representatives from all areas within the organization. Both clinical and non-clinical members of the QIC provide, oversight, direction and support of the quality improvement program.

Various methods and tools to collect quality processes are employed. The Quality Improvement Department coordinates the collection and analysis of certain data elements and monitors the data elements set forth in the MOC 4 section of this document with internal evaluation and/or auditing tools. Each business owner participates in monitoring and evaluation activities for important aspects of care under their direction. Data is tracked over time and documented using approved and consistent methodologies and processes. Data collection and analysis is ongoing, as needed. Data analysis includes comparing available data to established SNP MOC goals, previous performance and benchmarks. Tools and applications such as geo-access software, call management applications and a suite of reports and data collection records available in the Care Manager system facilitate data analysis. Statistical tools and methods are applied to differentiate special-cause variation from common-cause variation. Root cause analyses are employed to identify opportunities for implementing corrective and improvement action. Pattern and trend analysis are incorporated into quality-of-care investigations to determine the scope of the problem.

In addition to the oversight and performance evaluations conducted within the Alterwood Advantage QI program (see section 2 of Compliance Plan) the following performance metrics will be included in the D-SNP program and utilized in the day-to-day operations:

- The total volume of D-SNP patients who are fully engaged in the CM program:
  - Data sets detailing the current statuses of all cases are available to staff to track day-to-day operations. The data report forms a clinical picture of the Health Plan's most at risk membership
  - Analyses by individual health management process, staff member, health load and productivity assure adequate staffing and workflow
  - Quarterly, results are summarized in narrative form and reported up to the Quality Improvement Committee.
- Utilization metrics:
  - Utilization metrics include but are not limited to data on ED visits for primary care, Ambulatory-Sensitive Acute Inpatient and Skilled Nursing Facility Admissions, average length of stay and readmissions within 30 days in this

vulnerable SNP patient population are run weekly. Authorization records may also be used for more current analysis and trending.
    - Analyses include comparison to internal goals and baselines.
    - Results are summarized quarterly in a narrative form during CMOC meetings.
- Referrals to community resources, ongoing visits to PCP, care integration (PCP + BH providers as indicated):
    - Ongoing visits to PCP are measured to determine members who are due or overdue for a PCP visit.
    - Health Management audit data is used to measure appropriate referrals to community resources.
    - Summary data is presented to the CMOC; individual cases are reviewed with Medical Directors to identify gaps in locating resources for patients
    - Quarterly, these data are included in operational reports
- Gaps in Care:
    - Both health management strategies and formal campaigns have a role in reducing gaps in care. Prospective clinical gaps in care data are available on the Electronic Data Warehouse (EDW) which demonstrates progress towards gaps in care both preventive or outcome goals.
    - Operations managers and staff at every level, review aggregate data and progress towards annual gaps in care goals (Element 2, Goal 6a.) to design additional strategies throughout the year.
    - Monthly reports on gaps in care are reported at all levels of the health plan.
- Care Plan Goals, frequency of touch for acuity, and other process measures:
    - Care plans are generated, using the care management application, prioritized and customized to individual patient for the highest acuity patients with impactable needs.
    - The Chief Clinical Operations Officer (CCOO) /designee reviews the data through clinical documentation audits and automated reports.
    - Alterwood Advantage will perform clinical documentation audits on a random sampling of individual Health Manager's (CM) cases. CMs must achieve 95% compliance with all care plan requirements. Lack of compliance with standards results in a corrective action plan and potentially, disciplinary action. At least one case per CM per quarter is audited by a trained auditor.
    - Audit data is continuously updated and is presented to CMOC quarterly by the clinical auditor. Audit data presented allows for tracking and trending of Health Manager performance by individual health management process and by case status type. Caseload and individual Health Manager productivity is also tracked
    - The beneficiary's ICT, run by the Health Manager, reviews individual patient cases periodically.
    - Data can be analyzed by Health Manager, region, zip code, and acuity, with course correction to workflow, caseload, and individual Health Manager productivity.

- CMS Performance Standards, i.e., Turn-around times for standard (14 days) and expedited (72 hours) organizational determination
    - Reporting out of the authorization system, data is reviewed, analyzed and reported on. Management reviews trending data to ensure compliance with timeliness and CMS standards.
    - This is a proactive report that allows the manager to identify potential time line infractions before they occur. Once identified the managers will address the issue with the assigned staff person and the request for services is determined before the time expires.

The Quality Improvement Committee is made up of the following standing members.

- Chief Medical Officer – Chair
- Chief Executive Officer/President
- Chief Financial Officer
- Medical Director(s)
- Chief Health and Quality Officer
- Chief Marketing Officer
- Chief Operating Officer
- Chief Information Officer
- Vice Business and Legal Affairs
- Compliance Officer
- Manager, Health Management
- Vice President, Medical and Pharmacy Management
- Manager, Quality Improvement
- Manager, Member Services
- Manager, Appeals & Grievances
- Manager, Credentialing

Alterwood Advantage collects all core health plan data, vendor data and other sources into the single consolidated enterprise data warehouse (EDW). The EDW is used to produce internal reports essential to Quality Improvement activities including monitoring model of care activities and health outcomes of members. Data from the warehouse is also sent via secure site to our NCQA certified HEDIS vendor which uses certified software to produce annual MAPD and SNP HEDIS reports. This is monitored by NCQA approved auditors.

Most reports to support day to day operations are available on the EDW where data can be refreshed and monitored frequently to support and oversee processes. Managers and other authorized users are granted access to reports to support their operational area. Having real-time, accessible data allows department staff and managers to promptly identify variations and act to resolve identified issues before they impact beneficiaries, providers and/or overall health plan performance.

Alterwood Advantage provides senior leadership, department managers, clinical supervisors, authorized staff and Quality Improvement Department staff access to data to assist in coordinating high quality care for beneficiaries in the following ways:

- Identifying and prioritizing patient needs and assigning staff members to the members' integrated care plan.
- Identifying specific high-risk patients with particularly difficult level of complexity for daily/weekly case conference review with Medical Directors and/or clinical supervisors
- Monitoring caseloads so staffing levels can be adjusted as needed
- Monitoring timeliness and other indicators to ensure compliance and quality objectives are met consistently and determine when intervention is necessary
- Evaluating trends and analyzing data to identify opportunities of improvement and priorities
- Monitoring processes to ensure they are having desired effects and identify when process improvements may be necessary.
- Comparing scores on key performance metrics against best practice benchmarks and quality goals to monitor progress
- Tracking impact of corrective actions monitoring effectiveness of interventions
- Monitoring compliance with standards, laws and regulations
- Assessing network adequacy and evaluating access to plan services
- Monitoring under and over utilization of services, including preventative services

Business leaders utilize data and reports daily to manage departments, establish priorities and ensure human and technology resources are used optimally to meet beneficiary needs and performance goals. Formal, aggregate reports are reviewed and discussed in the appropriate quality committees on a regular basis. Data and reports are utilized to monitor the quality of care and service provided to our beneficiaries, assess the functionality of established processes, evaluate service delivery levels and impact on health outcomes, ensure beneficiaries' individual needs are being met, gaps in care are being closed and care plan goals are being met.

The reports and subsequent analyses help to monitor and improve areas such as preventive care service delivery, chronic disease management, appropriate utilization of services, continuity of care during care transitions, use of appropriate medication therapy and access and use of primary care and specialty services. Examples of indicators include monitoring HgbA1c levels in members with diabetes, hospital readmission rates, breast cancer screening rates, ambulatory office visits, provider network geo-access analysis and appointment availability surveys. Presentation of reports through the Quality Committee structure promotes communication, collaboration and accountability. Based on findings, action plans are established and result in corrections, updates or modifications to existing processes and procedures, training and education, the creation of new procedures and initiatives, acquisition of new resources or technology, opportunities to modify the Model of Care and implement ad hoc quality improvement activities or targeted improvement efforts such as specific or enhanced outreach campaigns.

CMS STAR measures including HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey information, and the Health Outcomes Survey (HOS) data are reported and tracked regularly through the Stars Committee and then are reported to the QIC. In addition, utilization metrics are also tracked for the D-SNP patient population in the CMOC and the Medical Management Review Committee (MMRC). Goals for all measures are set, based on baseline data patient population. Health management process indicators are also included. Examples of items tracked and reported are:

- Medical and surgical inpatient stays by facility
- Average length of stay
- ED visits by facility and diagnosis
- Prescription utilization by brand, generics, and specialty drugs
- Categories of utilization of services per reporting period
- Preventive Care Service Rates
- Outcome indicators related to Diabetes and Hypertension control
- Medication gaps in care and adherence
- Satisfaction with the health management and utilization management experience
- Satisfaction with the Health Plan and Health Care
- Provider satisfaction with the Health Plan
- Baseline health and functional status and outcomes over time

Alterwood Advantage invests heavily on data collection and analysis of HEDIS measures which assess a large scope of care and service and use a sound, nationally accepted methodology. Alterwood Advantage has designed an internal prospective HEDIS dashboard based on HEDIS methodologies to track month to month performance and trends in between annual HEDIS rate reporting cycles. These reports allow the organization to pinpoint specific areas for intervention, implement timely actions and evaluate impact. Member detail reports provide member and provider specific characteristics for both compliant and non-compliant members to assist with analysis and focus action planning. For example, examining members with diabetes who have A1c levels >9 and the areas those members reside may result in community-based interventions or partnerships to improve care in those areas. Likewise, providers who have the greatest number or percent of members with A1c levels >9 could be targeted for focused education and increased monitoring by on-site chart review.

Use of data and reports with the provider networks will also be used to help educate practitioners on quality measures by providing physician specific data on outcomes through Provider HEDIS Gaps in Care Reports, provider newsletters, communications sent along with the monthly panel report, communications posted on the company website and the provider portal, and decision support through working in ICTs or along with Alterwood Advantage's Medical Director.

Actions to improve the Model of Care may involve changes to policies and procedures, staffing patterns or personnel, physician or facility network, systems of operation or internal/external communication. These topics are monitored and addressed on an as-needed basis by the

responsible manager to expedite the resolution of any barriers or gaps. In addition, all actions will be documented and reviewed in QIC minutes.

Element B: Measurable Goals and Health Outcomes for the MOC

- **Identify and clearly define the SNP's measurable goals and health outcomes and describe how identified measurable goals and health outcomes are communicated throughout the SNP organization. Responses must include but not be limited to, the following:**
  - **Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC Element 1.**
  - **Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.**
  - **Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.**
  - **Ensuring appropriate utilization of services for preventive health and chronic conditions.**

Alterwood Advantage's dual-eligible target population faces key issues identified by CMS and others regarding accessing and integrating care – lack of formalized structures and processes for both beneficiaries and providers to provide comprehensive, integrated care. Better coordination will engage beneficiaries with a usual source of care, leading to efficient utilization of resources and achievement of optimal health outcomes. The following discussion outlines Alterwood Advantage's goals and associated metrics to identify and achieve goals that are relevant to our population.

- **Describe how the SNP establishes methods to assess and track the MOC's impact on the SNP beneficiaries' health outcomes.**

Alterwood Advantage developed a series of goals based on national guidelines (i.e., NCQA/HEDIS, STAR Ratings) and requirements (i.e., provider access) to ensure quality care delivery according to established best practices. Alterwood Advantage supports continuous activities and initiatives to identify and evaluate health and service outcomes recognizing that goal achievement and maintenance requires constant effort. In addition, goals are periodically reassessed as part of the Quality Improvement Evaluation (QIE) regarding the degree and rate of progression toward goals, barriers, relevance to the existing clinical environment and other relevant observations. Local, regional and national benchmarks are used to assist Alterwood Advantage with goal setting and to assess optimal goal achievement. The goals of the Plan's integrated care management are:

- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care and steering members to a more appropriate setting.
- Improving coordination of care through an identified point of contact (e.g., gatekeeper)

- Improving seamless transitions of care across healthcare settings, providers, and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

Alterwood Advantage's measurable goals are established for indicators of care and service based on several sources, including but not limited to:

- NCQA Standards
- CMS standards
- Health Outcome Surveys
- HEDIS measures
- Satisfaction surveys
- Admission/readmission rates
- Completion of beneficiary risk assessments in a timely manner
- Appropriate use of medications
- Provider access and availability metrics
- Internally developed audit and review tools based on established protocols or clinical practice guidelines

Alterwood Advantage will be using the care management system to monitor and track the effectiveness of delivered care and progress toward achieving those goals. The system functionality includes, but is not limited to:

- Health Risk Assessment Tool (HRAT)
- Determination of acuity level and risk stratification
- Web portals to facilitate beneficiary participation in health management activity
- Provider portal to facilitate information continuity and shared health management activity across multiple settings

- **Identify the specific beneficiary health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used.**

  Goal / Focus: Improving access to essential services such as medical, mental health, and social services

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal
Provider Network Adequacy	Geographical Access (Time/Distance) Report / Provider Relations	Meet / exceed CMS network adequacy standards for all regions and provider types	100% for each provider type and geographical area / CMS standards	Quarterly / Immediately & Ongoing
Appointment Availability	Secret Shopper Survey / Provider Relations	Initial visit w/in 90 days	100% / CMS	Quarterly / Immediately & Ongoing
		New enrollee high risk visits w/in 15 days	100% / CMS	Quarterly / Immediately & Ongoing
		Routine appointment w/in 7 days	100% / CMS	Quarterly / Immediately & Ongoing
		Preventive visit w/in 30 days	100% / CMS	Quarterly / Immediately & Ongoing
		Urgent visit w/in same day	100% / CMS	Quarterly / Immediately & Ongoing
		Emergency visit immediately	100% / CMS	Quarterly / Immediately & Ongoing
After Hours Access	After Hours Survey / Provider Relations	After Hours Access / Communication (one of the acceptable after hour communication options is available/functional)	100% / CMS	Quarterly / Immediately & Ongoing

Goal / Focus: Improving coordination of care through an identified point of contact (e.g., gatekeeper)

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal
New enrollee HRA	HRA Completion Report / Health Management System	HRA completion w/in 90 days of enrollment	100% / Internal	Quarterly / Quarterly
Initial PCP visit within 90 days of enrollment	Initial PCP Visit Report / IT	Beneficiaries will have PCP visit within 90 days of enrollment	TBD	Quarterly / Quarterly
HRA Reassessment	HRA Completion Report / Health Management System	HRA reassessment completion w/in 365 days of previous assessment	100% / Internal	Quarterly / Quarterly
Recent PCP Visit	Claims / Health Rules	% of beneficiaries without a PCP visit in the past 6/9/12 months.	5% improvement from baseline	Quarterly / Quarterly

Goal / Focus: Improving seamless transitions of care across healthcare settings, providers, and health services

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal
Discharge Follow-up	DSNP Discharge Audit / Internal DSNP Discharge Case Audit Review Tool (HS/QI)	Outreach attempt within 3 business days from notification of discharge.	90% / Internal	Quarterly / Quarterly
		Care Plans will be reviewed and/or updated within 30 days post discharge	90% / Internal	Quarterly / Quarterly
		Documented communication of Individual Care Plans for beneficiary's post discharge to ICT team within 30 days of discharge.	90% / Internal	Quarterly / Quarterly

		Care Plans updated to include referrals/resource linkages as identified in discharge plan or post discharge assessment.	90% / Internal	Quarterly / Quarterly

Goal / Focus: Improving access to preventive health services

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal
Preventive Service completion rates	Beneficiaries Self Report / CAHPS	Flu Vaccination	TBD	Annually / 1 year
		Pneumococcal Vaccination	TBD	Annually / 1 year
		Tobacco Use Cessation Intervention	TBD	Annually / 1 year
	Colorectal Cancer Screening (COL) Measure / HEDIS	Colorectal Cancer Screening	TBD	Monthly (Prospective Rates) Annually (Final Rates) / 1 year
	Breast Cancer Screening (BCS) Measure / Prospective CY (internal)	Breast Cancer Screening	TBD	Monthly (Prospective Rates) Annually (Final Rates) / 1 year

Goal / Focus: Assuring appropriate utilization of services

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal

CM evaluation and follow-up	CM Case Audits / UMHA Auditor. Key CM Audit Criteria will be scored for this purpose including:	CM Case audits show beneficiaries are evaluated for appropriate utilization of services, gaps are incorporated into Individual Care Plan goals and interventions/referrals and follow-up are appropriate.	95% Overall Audit Score	Quarterly / Quarterly
	Comprehensive Assessment (Appt status)			
	Comprehensive Assessment (ED)			
	Comprehensive Assessment (Health Screen)			
	Comprehensive Assessment (Vaccines)			
	Assessment of community resources			
	Facilitation of Beneficiaries referrals to resources			
	Behavioral Health (PHQ-2) Screen and referral to resources			
	Follow-up calls, referrals, etc. are followed up as planned			
	Education, care coordination services and referrals to outside resources are recorded			
	Resolution to issues are addressed in a timely fashion and the CM plan and goals are modified as needed			

	Documentation of ICT Meeting (offered or occurred)			
	Care Plan Updated in the past 6 months			
	Overall Audit Score for each Health Manager			
Beneficiary Participating in Health Management	Numerator: # of ICPs in UTL Status Denominator: Active DSNP members	Measure the status of all DSNP cases and reduce the rate of beneficiaries in UTL or opt out status	2% improvement from Baseline	Quarterly / NA
	Numerator: # of ICPs in Opt Out Status Denominator: Active DSNP members		2% improvement from Baseline	Quarterly / NA
SNP Care Management	SNP Care Management / STARS Technical Specifications (Internal STARS Report)	Increase rate of beneficiaries who receive initial assessment and reassessment	TBD	Monthly / 1 year
ED Visit Rate (without admission)	ED Visits Report / UMHA Solutions	Beneficiaries with ED visits not resulting in hospital admission will decrease	2% improvement from Baseline	Quarterly / 1 year
Medication Reconciliation Post Discharge	Medication Reconciliation Post Discharge (MRP) Measure / HEDIS	Increase beneficiaries who receive a medication reconciliation within 30 days from discharge from hospital	5% improvement from Baseline	Quarterly / 1 year
Inpatient Days	Inpatient Days per/K	Decrease days spent by beneficiaries in an inpatient setting	2% improvement from Baseline (CY 2019) / Internal	Quarterly / 1 year
Average Length of Stay	Average Length of Stay (Days)	Decrease the average length beneficiaries remain in an inpatient setting	2% improvement from Baseline	Quarterly / 1 year

Readmission Rates	Readmission Rate	Decrease the rate of preventable readmissions to the hospital w/in 30 days	2% improvement from Baseline	Quarterly / 1 year

Goal / Focus: Improving beneficiary health outcomes

Metric / Topic	Measurement Methodology / Data Source	Measurable Objective	Benchmark / Source	Measurement Frequency / Timeframe to meet goal
Diabetes A1c Control	HEDIS CDC A1C control / STARS Technical Specification (inverse of A1C >9 HEDIS CDC sub measure)	Improve glycemic control for beneficiaries with diabetes	TBD	Monthly / 1 year
Controlling blood pressure (CBP)	Controlling blood pressure (CBP) measure / HEDIS	Improve blood pressure control for Beneficiaries with hypertension	TBD	Monthly / 1 year
Med Adherence-Diabetes	Med Adherence-Diabetes / STARS Technical Specifications (Internal STARS Report)	Improve medication adherence rates for beneficiaries with Diabetes	TBD	Monthly / 1 year
Med Adherence-Hypertension	Med Adherence-Hypertension / STARS Technical Specifications (Internal STARS Report)	Improve medication adherence rates for beneficiaries with Hypertension	TBD	Monthly / 1 year
Care for Old Adults	Advance Care Planning	Improve number of beneficiaries who complete advanced care planning	100% / Internal	Monthly / 1 year
	Medication Review	Improve number of beneficiaries who complete a medication review	TBD	Monthly / 1 year
	Functional Status Assessment	Improve number of beneficiaries who complete a functional status assessment	TBD	Monthly / 1 year

	Pain Assessment	Improve number of beneficiaries who complete a pain assessment	TBD	Monthly / 1 year
Beneficiaries satisfaction with Health Care	Beneficiaries Self Report / CAHPS	Improve Health Care satisfaction rating based on CAHPS survey	TBD	Annually / 1 year
Beneficiaries satisfaction with Health Plan	Beneficiaries Self Report / CAHPS	Improve Health Plan satisfaction rating based on CAHPS survey	TBD	Annually / 1 year
Beneficiaries report of getting needed care	Beneficiaries Self Report / CAHPS	Improve positive beneficiary's response related to "getting needed care" on CAHPS survey	TBD	Annually / 1 year
Beneficiaries rating of quality of life	Beneficiaries Self Report / HOS	Establish baseline on beneficiaries rating of quality of life via Health Outcomes Survey	Establish baseline	Annually / 1 year

- **Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.**

Timelines for monitoring and evaluating metrics on the SNP MOC are outlined on self-monitoring and/or auditing tools which are presented during CMOC and/or QIC meetings. Updates to measures set forth in MOC 4 above are provided at least quarterly to the QIC. Interventions to improve SNP MOC metric scores are addressed during CMOC meetings. The goals identified by Alterwood Advantage will be monitored, trended and tracked under the direction of the Quality Committee Structure. Alterwood Advantage will monitor progress towards achieving the goals using various utilization and service-related reports, dashboard reports, detail-level reports, and reports from other committees, including data from member experience surveys and member satisfaction survey data. The frequency of those reports and updates will depend on the nature of the task but will usually be completed from monthly, quarterly, bi-annually or annually, depending on the metric. Data may also be presented month-on-month, quarter-over-quarter, and year-over-year basis as appropriate. The intent of reporting, analysis and comparison is to determine the effectiveness of the goal. A quarterly review of data is conducted on the progress of the goals and presented at the QIC. Findings are summarized and presented at least annually to the Board of Directors.

In addition to the annual Quality Improvement Evaluation of the entire health plan, the plan will conduct a specific evaluation of the SNP-MOC. Using the metrics described above applied

only to D-SNP members, e determines if its Model of Care is meeting the needs of its members. The Quality Department leads the collection of data. The Compliance Department leads in the coordination of the evaluation with an assigned vendor that will complete the annual evaluation. All Departments are responsible for evaluation of their processes and outcomes. The annual SNP-MOC evaluation is presented to the CMOC for review and then to the QIC and BOD for final approval. The evaluation includes a review of performance as well as recommendations for improvement strategies which are then formalized in the QIPD.

- **Explain the specific steps the SNP will take if goals are not met in the expected time frame.**

In the event a goal is not achieved, the Vice President of Quality Management or responsible business leader will perform a detailed analysis to identify barriers to meeting goals. This analysis will lead to an action plan with required resources to address and overcome the barriers. For each needed action, the plan includes specific target completion dates and parties responsible for completion. The QIC will review, provide input and approve the plan as necessary until the desired outcomes have been achieved and the CAP has been closed. If needed, the Quality Improvement Program may also be adjusted to reflect progress or identification of new trends.

The following is an example of a hypothetical situation and how Alterwood Advantage would address the situation. The performance metrics indicate that a beneficiary outreach within 72 hours of discharge is measured at 85%, which is below 100% benchmark. In that case, Alterwood Advantage would perform a detailed analysis taking into consideration the specific needs of dual-eligible special needs population to identify potential drivers of the deficiency. The analysis would be presented at the QIC for further development of potential interventions. A corrective action plan or mitigation plan would be designed which includes timelines, and responsible staff.

If the metrics are not met for three consecutive reporting periods, health services and quality management staff will perform additional cause investigation and analysis to identify the source and contributing factors and a Corrective Action Plan (CAP) will be created under the direction of the Chief Medical Officer. The issue, analysis and the CAP will then be presented to the QIC for input, approval and recommendations and will be presented to the Board of Directors. Depending on the nature and severity of the deficiency, any one or more of the following actions may be taken:

- Individual staff member is placed on a performance review for an identified deficiency. The staff member will be required to correct the deficiency, usually within 30 days. If needed, additional training will be provided, and management and Human Resources will monitor the staff member's performance.

- A Provider is placed on a CAP for an identified deficiency (e.g., Medical record review audit for completeness of documentation and medication list).

- An internal Corrective Action Plan (CAP) is initiated to address a deficiency (e.g., 25 percentile HEDIS rate for appropriate medications for asthma). As part of the development of the quality improvement activity or initiative, a barrier analysis will be conducted, an action plan with timelines will be created, necessary resources will be put in place, and a list of team members will be developed. In addition, interventions will be implemented as needed and progress towards goals will be monitored.

Attachment M: Specific examples of internal CAPs are provided below:

Example of Deficiency	Example of Corrective Action Plan	Example Timeframe
Appointment wait time deficiency identified during Accessibility Study for a large primary care group	Provider group is informed of appointment wait time standards and will be notified of deficiency. The providers in conjunction with Alterwood Advantage will formulate a CAP that includes specified timeframe for correcting deficiency (e.g., 60 days).	Follow up within 3 months and ongoing until the CAP is closed to ensure provider is compliant by conducting quarterly Provider representative visits
An audit reveals that a Health Manager did not update or adjust ICP following inpatient admission for CHF exacerbation for several Beneficiaries	Discuss performance issue with Health Manager, review established policies and procedures, verify understanding of the policies and procedures by Health Manager, provide additional training if needed, and monitor for improvement. If there is no improvement, the Health Manager will be placed on a performance review.	30-day monitoring
A hospital's readmission rate is greater than 2 standard deviations above the mean	Analysis indicates inadequate discharge planning resulting in increased readmission rate. Meet with facility and share the results. A QIP to reduce readmissions is developed in conjunction with hospital management.	3-month
Rate for osteoporosis management falls below 50th percentile	Alterwood Advantage will develop a QIP to improve osteoporosis management	1 year
Beneficiary satisfaction survey falls below 75th percentile	Alterwood Advantage will develop a QIP to improve beneficiary satisfaction	6-months

Element C: Measuring Patient Experience of Care (SNP Member Satisfaction)

- **Describe the specific SNP survey(s) used and the rationale for selection of that tool(s) to**

measure SNP beneficiary satisfaction.

Alterwood Advantage is committed to exceeding members' needs and expectations. To that end, Alterwood Advantage collects member satisfaction data in the following areas for all Medicare D-SNP operations and conducts annual quantitative and qualitative analysis:

Appeals and Grievances (including CTM's) are monitored and analyzed on a quarterly basis. Alterwood Advantage understands that a member who is not happy with the level of service may be less likely to utilize or engage in care management services or visit their provider when needed. Therefore, resolving appeals and grievances in a timely manner is a priority. Monitoring and evaluation includes timeliness or response/resolution indicators and the analysis of the areas of complaint activity. It also includes analyzing the types of complaints to identify opportunities to make processes more beneficiary friendly. Grievance activity is also screened for indication of quality of care or patient safety issues.

Data is reviewed at least quarterly by the Grievance and Appeals Committee which reports to the QIC. The results of Quality-of-Care investigations are also reported to the QIC. Provider specific quality issues are also reviewed in the Credentialing Committee and are considered in the re-credentialing process. Provider quality issues may also be presented during the Provider Advisory Committee.

Alterwood Advantage collects and reports member complaints and appeals by the following reasons:

- Quality of Care
- Enrollment/Disenrollment
- Access to Care
- Pharmacy Access
- Marketing
- Customer Service
- Organization Determinations
- Coverage Determinations
- CMS Issues
- Other

These appeal and grievance types are used to trend reasons for member dissatisfaction. The Appeals & Grievances Committee identifies trends in areas of greatest dissatisfaction. The Committee also identifies potential drivers of that dissatisfaction and reports to QIC for additional corrective action.

The annual **Consumer Assessment of Healthcare Providers and Systems** (**CAHPS) survey** process is coordinated by the Quality Improvement Department and is under the supervision of the Quality Improvement Committee. Alterwood Advantage contracts with a CMS-approved CAHPS survey vendor. The Quality Improvement Department coordinates the survey process

and ensures that it is administered as required. The QIC oversees this process. Results are reported so that D-SNP responses can be analyzed separately to identify any specific opportunities or concerns related to that specific population. When results are available, the Member Experience Committee analyzes the findings and develops an action plan to address deficiencies and opportunities for improvement. The Member Experience Committee includes the Chief Medical Officer, Chief Clinical Operations Officer, Manager of Member Services, Manager of Provider Relations, Manager of Marketing, Vice President of Quality Improvement and the Director of Accreditation. The Quality Improvement Committee (QIC) may direct the addition of ad hoc or focused surveys to further understand the source of dissatisfaction or to evaluate interventions prior to the next formal CAHPS survey.

Alterwood Advantage will contract with an approved, certified vendor to conduct the **Medical Health Outcomes Survey (HOS)**. The Medical Health Outcomes (HOS) survey is administered to a random sample of members from Alterwood Advantage at the beginning (baseline survey) and end (follow-up survey) of a two-year period. Aged and disabled beneficiaries continuously enrolled in the same Medicare health plan for six months are eligible for sampling. A new baseline sample is surveyed annually. For each member who completes a baseline and follow-up survey, a two-year change score is calculated, and the member's physical and mental health statuses are categorized as better, the same or worse than expected, considering risk adjustment factors. HOS results are assigned for each Medicare HMO based on the outcomes of members in that HMO. These HMO-specific results are assigned as percentages of respondents whose health status improved, declined or remained the same.

The Quality Improvement Department coordinates the exchange of data with CMS and the vendor to and ensures required timelines are met. The Quality Department retrieves reports from the HPMS system and shares results with the Executive team and QIC. The Member Experience Committee reviews HOS results at last annually and recommends potential improvement actions to the QIC.

Health Management member experience surveys for the D-SNP population are administered annually to those beneficiaries actively enrolled in the D-SNP plan via the CAHPS Survey. The survey touches on the beneficiary's satisfaction with the health management process, understanding of the process, ability to actively participate in the process and asks for beneficiary feedback in improving the process.

The results of the above survey(s) are integrated into the overall MOC performance improvement plan via quality improvement activities and actions through an organizational work plan. Quarterly and annual reports for each department/functional area are recorded into the QI reporting documentation for review by the QI staff and Quality Improvement Committee. Outcome data is analyzed and trended against the established benchmark targets along with follow up with the appropriate responsible department/functional area for a detailed analysis of the activity and reasons for any benchmark variances.

A summary report is presented and reported to the QIC for discussion of interventions to correct significant problems for both clinical and non-clinical services. Elements, which lend themselves to best practices, are implemented and incorporated into the MOC.

Refer to the Quality Improvement Program Description (QIPD) for detailed information regarding the process by which the Plan collects, analyzes, and reports data measuring health outcomes and indices of quality pertaining to D-SNPs special needs beneficiaries.

- **Explain how the results of SNP member satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.**

Results from the various mechanisms in place to monitor patient experience and satisfaction are utilized to identify opportunities for improvement through the Member Experience Committee. Findings from this data may result in corrective action plans with providers, changes in credentialing/re-credentialing status, process improvements, modifications of policies and procedures, member and provider education and the formation of quality improvement initiatives, changes to the MOC. The Member Experience Committee develops and implement interventions to improve member experience and tracks their progress quarterly with reports to the QIC. The annual QI and SNP MOC evaluations incorporate the findings from member experience data which is the basis for making recommendations to the subsequent year's QIPD and MOC.

Element D: Ongoing Performance Improvement Evaluation of the MOC

- **Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated.**

UMHA has an ongoing performance improvement evaluation mechanism in place to analyze results of the performance measures to improve the Model of Care. For example, the reports and subsequent analyses are designed to improve preventive care, immunization rates in the dually eligible patient population, reducing HgbA1c levels in diabetics, reducing unnecessary readmission to the acute care facility, the use of the ED for primary care, or increasing member use of advanced directives.

Findings from data collection and MOC metrics are discussed within business meetings and within the Quality Improvement Committee Structure. Workgroups and ad hoc quality improvement teams are utilized to further analyze data, determine root causes and propose/implement action plans under oversight of the QIC.

- **Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process.**

Monitors are established or re-evaluated each year and outlined in the Quality Improvement and SNP-MOC Evaluations. While data for these evaluations is compiled annually, data collection is continuous, communicated regularly at various committee meetings, and is stored in the EDW. The frequency of reporting is usually set to be collected monthly or quarterly in order to quickly identify and readily address negative trends. Many reports are available to managers for real-time monitoring such as call volumes, hold times, complaint activity, and admission reports/census. HEDIS prospective reports allow for the monthly monitoring of key indicators. The Stars Committee analyzes data monthly and plans interventions to improve rates that are trending below the national HEDIS mean or goal prior. Prospective HEDIS reporting is one example of how Alterwood Advantage can mobilize data and take action to impact outcomes readily versus waiting for annual HEDIS rates to be published.

HEDIS, CAHPS survey, HOS data will be reported and tracked on an ongoing basis. In addition, utilization metrics are also tracked for the D-SNP patient population. Goals for all measures are set, based on baseline data and national benchmark comparisons for the D-SNP patient population. Examples of items tracked and reported are:

- Medical Condition(s)
- Age and Gender
- Medical and surgical inpatient stays by facility
- Average length of stay
- ER visits by facility and diagnosis
- Physician visits by PCPs and specialists
- Top diseases and conditions
- Pharmacy by brand, generics, and specialty drugs
- Categories of utilization of services per reporting period

Analytics will be used to help strategize improvements and target specific areas. To this end, demographic data using zip code and geo-mapping may be used to pinpoint opportunities for both field-based outreach, and additional creative interventions. Using data analysis and Geo-mapping on diabetic patients who have not had annual retinal screening, for example, could help bring needed services through a community partnership and/or a mobile health-van event.

The Quality Improvement and SNP-MOC evaluations are used in development of the following year's QIPD and any changes to the MOC processes. Barriers, lessons learned, and strengths are documented based on the previous year's results.

- **Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.**

Results are reviewed and presented by the Chief Medical Officer and/or the Chief Clinical Operations Officer at the QIC meetings which is the key vehicle for sharing this information with

key stakeholders. This committee, which reports to the Board of Directors, will issue recommendations to improve the Model of Care and outcomes. Actions to improve the Model of Care may involve changes to its policies and procedures, staffing patterns or personnel, physician or facility network, systems of operation or internal/external communication. Ad hoc workgroups or quality improvement teams may be formed to develop and oversee improvement or corrective action plans on specific areas shown to be in need of improvement. These topics are monitored and addressed on an as needed basis by the responsible manager to expedite the resolution of any barriers or gaps. In addition, all actions will be documented and reviewed in QIC minutes.

The Model of Care will be evaluated on an ongoing basis and summarized annually in the SNP MOC Evaluation for the Quality Improvement Committee and reported to The Board of Directors for approval. The SNP MOC Evaluation will offer recommendations for the subsequent year including barriers, lessons learned, and strengths and any other recommendations as deemed appropriate by UMHAs vendor tasked with completing the annual SNP MOC evaluation. The QIC will utilize the evaluations to organize the subsequent year's strategy as captured in the 1) Model of Care written description, 2) QI Program Description (QIPD) and the 3) QI Annual Work Plan. The Clinical Operations Program Description is also reviewed annually and provides additional details on the Utilization Management and Health Management programs. Documentation of final approvals of the Model of Care and associated documentation is captured in meeting minutes from the QIC and The Board meetings. Model of Care evaluation documents are preserved both electronically, and with hard copies that serve as permanent record of the quality program for a period of at least 7 years as per our record retention policies.
The annual evaluation of past performance about the Model of Care summarizes progress towards goals, and external benchmarks. There is a summary review of all programmatic Model of Care performance metrics. Emphasis is placed on outcome measures, goals and targets set for the year and progress therein. Customer satisfaction measures, including but not limited to complaints and grievances, call center monitoring metrics, customer satisfaction survey data insight as well goals set regarding improvements needed in these areas are also included in the annual evaluation. Implementation of any quality improvement initiatives concerning the SNP MOC are fully described in the annual Quality Improvement and SNP MOC Evaluation. The organization's progress in Stars/HEDIS and outcomes improvement is another area typically showcased in the annual evaluations. Typically, the yearly evaluation celebrates successes but also points the direction to the next year's QIWP, which is detailed, and projects "who will do what by when" regarding the priorities for quality for the coming year, incomplete objectives from the previous year, and anticipated goals, targets for strategic improvements in quality.

The QIWP for the coming year and schedules the various tasks, timeframes and responsible parties necessary to carry out the Quality Program and SNP MOC requirements. The above-mentioned documents are compiled by the Quality and Compliance teams and UMHAs vendor(s). Development of the documents requires significant input and content from vendors and departments throughout Alterwood Advantage, are approved by the Board of Directors,

and provide an important historical overview of the quality program as well as a roadmap for success.

The following is an example of a performance measure evaluated, individually and, for the Model of Care and the written description that preserves the information for evaluation and preservation of historical information:

- The Quality Improvement Program Description (QIPD) includes a narrative on how complaints, appeals and grievances are collected, tracked, analyzed and addressed. Policies and Procedures on these processes are detailed and promulgated throughout the health plan from the corporate level to local markets. Investigation of each individual complaint results in a response to the individual complainant, but additionally is put into context with other complaints. Complaints are tracked, trended and analyzed into specified categories so that systemic improvements can be addressed. It would be quite possible to use complaint and complaint resolution to improve customer service and marry complaint data with other sources of data to improve service. A service center might notice complaints about telephonic access, and notice, in analyzing data for a given quarter that call center statistics validate an outlier data point on response time for a given week, that coincides with a concomitant increase in complaints. Managers were able to fit an "assignable cause" to the outlier data point (an interactive voice response outreach (IVR) campaign conducted without an appropriate match to increase staffing during the campaign). An action plan to bolster staff during planned IVR campaigns brings the average speed of answer back down under industry standard of less than 30 seconds and call abandonment rates to less than 5%. This process not only results in improved call center statistics, but also returns complaint levels to previous lower levels.

As mentioned, these annual documents are reviewed and approved annually by the QIC, and reported up, through those individuals to the Board of Directors. They are available to all regulatory agencies, accrediting bodies, and onsite auditors upon request.

Element E: Dissemination of SNP Quality Performance Related to MOC

- **Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A.**

The below table summarizes roles and responsibilities of individuals involved in the timely communication of performance updates.

ALTERWOODAdvantage Senior Leadership	Role in Communicating Performance Updates
President/CEO	-Communicates performance updates to the Board of Directors -Relays feedback and direction from the Board of Directors to management staff, QIC

	-Along with executive leadership, determines organizational priorities and resource allocation
Chief Medical Officer MD	-Communicates performance updates to members of the QIC, subcommittee chairpersons -Communicates findings to direct reports and staff in Health Services, Quality Improvement -Communicates performance through interaction with providers and vendors
Chief Health and Quality Officer	-This role is responsible for the operational components of the Health Services Model of Care Program. She/he conducts analysis, evaluations and works side-by-side with the medical director in developing new initiatives/programs. - Reports findings from health services activities to PAC, QIC, Medical Review Committee. - Overseeing the entire Quality Improvement program. She/he communicates with various stakeholders to strategize, initiative quality improvement initiatives and corrective action plans - Reports findings to Quality Improvement committees and/or subcommittees
Chief Marketing Officer	-Responsible for the development and approval of member and provider communications.
VP, Business and Regulatory Affairs	-Communicates and provides education to all levels of staff regarding compliance and regulatory standards -Chairs the Compliance Committee which receives reports from QIC -Communicates to Board of Directors -Tracks and follows up identified areas of deficiency -Note: some compliance metrics are also used in the Quality Program such as timeframes for appeal and grievance resolution, network standards, etc.
Enrollment, Claims Administration, and Member Service	Role in Communicating Performance Updates
Appeals and Grievances Manager	-Chairs the Grievance and Appeals Committee -Provides reports to leadership and QIC regarding Grievance and Appeal activity and trends -Responsible for reporting related to customer service phone access and service levels to QIC and leadership team.
Member Enrollment Manager	-Responsible for all the Membership Accounting functions including enrollment/disenrollment processing which is used in the development of reports and metrics to communicate quality findings.
Member Fulfillment Management	-Responsible for all member communications such as enrollment packet, ANOC/EOC, other regulatory and/or supplemental member information mailings when applicable.
Claims Analyst	-Responsible for claims adjudication which is required for the development of reports and metrics to communicate quality findings.

Member Services Representatives	-Provide members with information, including how to access information on the quality improvement program.
Network Development and Maintenance	Role in Communicating Performance Updates
Provider Services Representatives	-Communicate with providers regarding activities related to quality initiatives -Perform new provider orientation which includes information on the quality program and clinical practice guideline resources -Provide provider education and distribute “talking points” and ad hoc communications linked to quality initiatives
Provider Credentialing Specialists	-Communicate findings from credentialing activities to the Medical Director and the Credentialing Committee
Health and Quality Management	**Role in Communicating Performance Updates**
Medical Director MD	-Communicates with QI team, credentialing team, peer reviewers, Credentialing Committee and Provider Advisory Committee regarding quality-of-care investigations -Chairs the Credentialing Committee and communicates findings/receives feedback to the QIC. -Communicates on daily basis and serves as a resource to health services staff in evaluating appropriateness of care and care coordination activities.
Quality and STARs Director	-Chairs the Operational Oversight Monitoring Committee which reports to and receives feedback from the QIC -This role is responsible for communication of quality standards, distribution and updates to the QIPD and QIWP -Communicates findings from quality monitoring and evaluation activities to relevant business owner or Quality committee. -Maintains documentation from meetings, workgroups and corrective action plans
Health Operations Manager	-Representative on several Quality Improvement Committees -Communicates results of audit activities to staff to improve care planning and care coordination activities -Responsible for preparing and presenting reports to Quality Committees
Health Managers	-This role is responsible for the day-to-day management of care management activities for the Plan, assessment, planning, facilitation and advocacy for an individual’s health needs which all play a role in the delivery of the SNP Model of Care. -Engage both member and the family / caregiver when applicable
Special Needs Coordinators/Social Workers	-Contact members pre-screened by HRAs as members with special needs to assess if the member requires special services. –Communicates with providers to ensure that members are receiving appropriate access. - Engage both the member and the family when applicable. Refer to community services groups for additional supports and services.

Utilization Management RN	-This role is responsible for the day-to-day management of utilization management activities for the Plan, such as prior authorization, concurrent review, retrospective review, which all play a role in the delivery of the SNP Model of Care. -Communicate with Medical Directors on a day-to-day basis about the appropriateness of care and discharge planning.
Health Management Coordinators/Assistants	-Clinical Operations Coordinators/Assistants work in conjunction with Health Mangers to contact members to coordinate health care services and facilitate appointment scheduling.
Quality Improvement RN	-This role includes data collection and performing or coordinating member outreach communication activities such as mailings, newsletters and phone reminders for preventive care or other key services related to improvement initiatives. As well as monitoring and evaluation activities as outlined in the QI Work Plan, coordinates QI projects and supports the QI Program.
Operational Effectiveness and Learning Management Supervisor	- This role assists in developing and distributing internal staff communications on SNP performance, developing and distributing and SNP performance into the annual training materials.

- **Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.**

Performance results are reviewed and presented at the Model of Care Oversight Committee quarterly and workgroup chairpersons, the Chief Medical Officer, Medical Director, Chief Health and Quality Officer at the QIC meetings which is the key vehicle for sharing this information with key stakeholders. The Quality Improvement Department also facilitates the dissemination of quality performance to stakeholders through a variety of mechanisms such as the website and member and provider newsletters.

Performance data is reported from the QIC to the Compliance Committee and the Board of Directors. Feedback and direction provided by the Board of Directors is communicated back through the Alterwood Advantage leadership team and Quality committee structure through the Chief Executive Officer and VP Business and Regulatory Affairs Officer.

Performance results are also communicated to the relevant QI subcommittees which include practicing network physicians. These committees meet and exchange information at least quarterly. Providers are also informed of performance results by fax or mail, along with the monthly panel report distribution, at provider meetings and via the provider newsletter. Annual CAHPS survey results and other formal QI study results are posted on the company's website. The provider newsletter or fax communication is used to alert providers that this information is available. Key stakeholders, including vendor representatives, are provided

information about performance results during routine vendor oversight and operational meetings which occur at least quarterly. The Quality Improvement Department is responsible for ensuring communications are made in a timely manner to key stake holders. This is accomplished by having a QI representative on all QI committees, workgroups, subcommittees, vendor meetings. The QI department also facilitates the communication of performance results and quality improvement initiatives to staff and managers through email, training alerts and participation in departmental staff meetings and stand-up meetings. Information about the Quality Improvement Program and how to obtain additional information is posted on the company's website for members. Information about quality initiatives and performance results may also be published in the member newsletter.

The Quality Improvement Committee will receive quarterly reports on the MOC metrics through the Model of Care Oversight Committee and conduct a formal evaluation of the Model of Care at least annually. All data analysis and assessments will be performed and reported in electronic format and stored for ease of access to all QIC and Board Members. The personnel responsible for monitoring and evaluating the Model of Care effectiveness serve the health plan on the Quality Improvement Committee. The Quality Improvement Committee is comprised of experienced personnel who have responsibility and authority to make decisions that impact the MOC program and its effectiveness. Results of the evaluation and periodic assessments will be made by this Committee and reported up to the Board of Directors. The health plan President will be involved in all aspects of the MOC review and will be involved in major decisions regarding policy, resources, interventions and overall direction.

Members receive information on changes, performance results, improvements, updates and ad hoc alerts on the MOC in the following formats and schedules:

- Member Newsletter (twice annually)
- Email / Mail (as needed)
- During ICT meetings (as needed)

Staff communication on progress, performance results and improvements, updates and ad hoc alerts on the MOC in the following formats and schedules:

- During Medical Management staff and team meetings (ongoing)
- All-Staff meetings
- Email (as needed)
- Staff training and education sessions (as needed)
- SharePoint sites (ongoing)

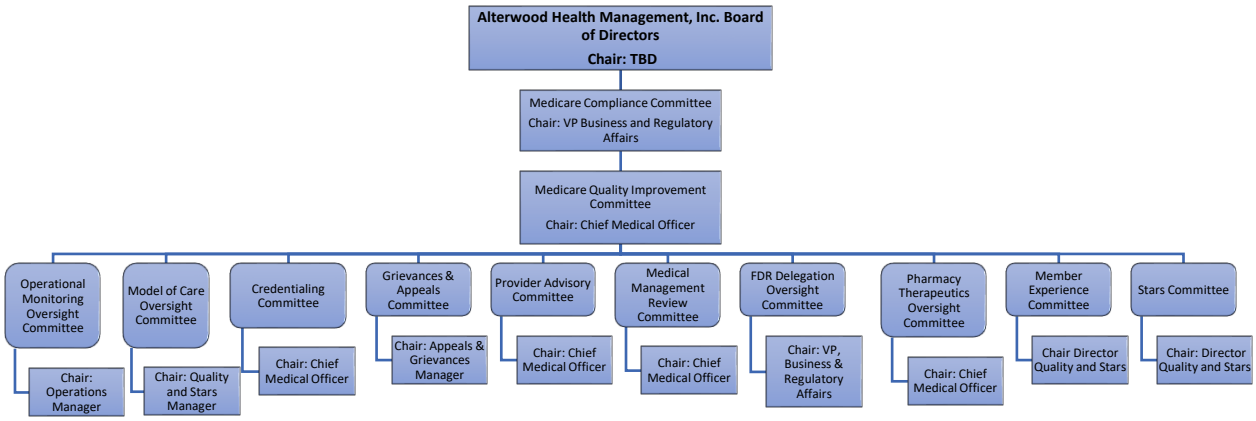
The annual Model of Care Program Evaluation will be conducted by the end of the third quarter for the previous year to allow for the availability of HEDIS and CAHPS data. Input into the annual review flows from the front-line level upwards through the quality infrastructure and ultimately, to the Board of Directors. This evaluation is developed by a vendor that is monitored by the Compliance Department with significant input from the Chief Medical Officer,

Chief Health and Quality Officer and other members of the leadership team and quality subcommittee chairpersons. It will be reviewed and approved by the QIC, prior to forwarding it to the Compliance Committee and Board of Directors. The members of the Quality Improvement Committee will assess the model of care after reviewing the outcomes from many different sources. Those include financial data, clinical data, beneficiary satisfaction and overall outcomes. Alterwood Advantage will also annually review the adequacy of the network to make certain the needs of the beneficiaries are being met.

As such, data, processes and developments concerning the Model of Care are reviewed continuously via ongoing discussion, dialogue and debate. Alterwood Advantage may also work with an external vendor to evaluates its MOC.

The committee structure for quality described in the QIPD permits a free exchange of information from the top down and from the bottom up, all in the best interest of the member and his/her family. The Board of Directors sets the strategic plan for the organization regarding quality and quality improvement strategies. Every level of the organization has responsibilities for quality improvement, regardless of role. The organization responds by carrying out that mandate: collecting data, analyzing it, designing and implementing various tactics to carry out the overall strategic plan for quality improvement, and ultimately improving outcomes in measurable ways set out by the Board.

Attachment N: Organization Chart of the Committee Structure



Attachment O: Sample Quality Improvement Committee Agenda

ALTERWOOD ADVANTAGE
Quality Care. Better Health.

Medicare QIC 2nd Quarter 2022

Agenda Items		Assigned To	Approval Needed	Target Completion Date
I.	Call to Order	CMO		
II.	Q1 Minutes Approval	CMO		
III.	Old Business a. See Action List	CHAIR		
IV.	Corrective Action Plans (CAPs) a. Report Open CAPS b. Self-Report Issues	Compliance Officer		
V.	STARS Sub-Committee a. Stars Prospective Report b. Stars Oppurtunities & Iniatives c. Part D STARs Report	STARS Manager		
VI.	Model of Care Oversight Committee a. HOS update b. SNP-Moc Update c. CCIP Update d. COC Update	Manager Quality		
VII.	Member Experience Committee a. CAHPS update b.	Member Services Director		
VIII.	FDR Committee a. Behavioral Health Vendor b. PBM Vendor c. Dental Vendor d. Eye Care Vendor	Compliance		
IX.	Provider Advisory Committee			
X.	P & T Committee			

Other stakeholders need access to the data, outcomes and results. This may include our clients, consumers and the public at large. NCQA required metrics are submitted according to CMS requirements for D-SNP plans and are publicly available. This transparency is important not only to our beneficiaries but to the public at large as these data, strategies and results taken together demonstrate our accountability for implementing and maintaining a high-quality Model of Care program.

Alterwood Advantage is committed to ensuring compliance with its D-SNP Model of Care.