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Introduction

AllCare Health is a physician-led organization, striving to be a leader in providing better healthcare and services for the people of southern Oregon. For more than 30 years, our integrated network of professionals has delivered healthcare at the right time and the right place, while controlling costs for both patients and taxpayers. Our brand is based on the foundational ideas of care, coverage, and compassion. AllCare Health and its subsidiary companies are designated “Benefit Companies” by the state of Oregon. AllCare Health has also achieved the Certified B Corporation status from the non-profit B Lab®. These designations are a public recognition of both our history and our present culture of stewardship — a crucial step to formalize our ongoing commitment to our communities. Our team and integrated network of healthcare providers are fully committed to improving physician-led, member-focused healthcare for our more than 71,875 current members and potential new members — today, tomorrow, and beyond.

Current lines of business and membership as of January 2025

Medicare AllCare Advantage Membership: 2,842

AllCare Advantage/AllCare Health Plan, Inc. is the only locally owned Medicare Advantage (HMO) Plan for Medicare-eligible beneficiaries in southern Oregon. AllCare Advantage’s service area covers Jackson, Josephine, Curry, and southern Douglas counties.

Medicaid AllCare Coordinated Care Organization (CCO) Membership: 69,033

AllCare CCO, a Medicaid MCO, provides Medicaid enrollees in southern Oregon with easy access to comprehensive, coordinated care. AllCare CCO’s service area covers Jackson, Josephine, Curry, and southern Douglas counties.

AllCare Practice Operations

Practice Operations offers clinics affordable access to electronic health records, revenue cycle management, and Management Services Organization (MSO) services. With a strong community presence in the Rogue Valley of southern Oregon, we deliver high-quality, responsive support tailored to the needs of our provider offices.

Our experienced team, with decades of medical and technical expertise, is dedicated to helping practices enhance operations and improve patient satisfaction. By providing comprehensive solutions such as EHRs, practice management, training, and responsive support, we aim to reduce costs, streamline resources, and empower practices to thrive.

AllCare Independent Physician Association

Established in 1994 as formally Mid Rogue Independent Physician Association (IPA), now AllCare IPA, we are a local network of independent and employed healthcare providers, including doctors, podiatrists, nurse practitioners, ophthalmologists, and behavioral health professionals in southern Oregon. AllCare IPA represents 63 independent providers in private practice, one Federally Qualified Health Center (FQHC), and eight employed shareholders throughout our service area.

AllCare Health currently serves Jackson, Josephine, and Curry counties and the communities of Glendale and Azalea in southern Douglas County.



Purpose Statement:

Working together with our communities to improve the health and well-being of everyone.

We see ourselves as part of our communities – believing that a thorough understanding of our communities helps us better coordinate care. We believe that healthy communities benefit our employees, patients, members, providers, and stakeholders. Our ability to be responsible stewards and grow the company allows us to invest in our communities.

Model of Care

MOC 1: Description of Overall SNP Population

MOC 1 Element A: Description of Overall SNP Population)

MOC 1 Element A Factor 1: Determine, verify, and track eligibility

AllCare has processes and policies in place for identifying, verifying, and tracking SNP enrollees to ensure eligibility for appropriate care coordination services. The plan receives Medicare Advantage enrollment applications directly from beneficiaries, through sales agents, through CMS's Online Enrollment Center (OEC), and through CMS's approved default enrollment option as per 42 CFR § 422.66(2). In addition, monthly Medicare Advantage eligibility files are received from CMS via Reveleer's Voyager Application. Enrollment staff verify enrollee eligibility through a review of the Medicare Advantage application against MMIS, the State Medicaid system, and MARx, the Medicare Advantage Prescription Drug System, to validate dual enrollment and ensure all information in the internal systems match. AllCare Health will retain a copy of the eligibility verification in the Beneficiary's file. The following steps are taken initially and to redetermine, verify, and track eligibility:

1. Verify Beneficiary's current Medicaid status via MMIS and Medicare eligibility via MARx.
 - a. Once this information is verified, staff will document in the appropriate system then continue with the eligibility process outlined in the ENR-CS-100-Enrollment Eligibility Policy.
 - b. If staff are unable to verify dual eligibility the beneficiary will be contacted. If staff are unable to reach the Beneficiary, it will be documented in the appropriate system with all outreach attempts and outcomes.
2. AllCare Health will pend the application if unable to obtain the appropriate proof of Medicaid eligibility, per the ENR-CS-101-Enrollment Application Processing Policy.
 - a. AllCare will send a letter within the required time frames as stated in the ENR-CS-101-Enrollment Application Processing Policy.
3. AllCare Health will submit completed enrollment applications to CMS via the Voyager system. Before the file is submitted for enrollment to CMS, the enrollment goes through a final check against the MARx system using a Batch Eligibility Query (BEQ) file. Enrollments that pass the BEQ check are submitted to Medicare. Enrollments that fail the BEQ check are pended for review, following the ENR-CS-101-Enrollment Application Processing Policy.
4. Verification of dually eligible members is at least as often as the State Medicaid conducts redetermination of Medicaid eligibility. AllCare Health utilizes files from the State, which reflect the Medicaid status of the Dual SNP members. Each week our system auto merges records between our Medicare Advantage plan and our State Medicaid CCO for members who are on both. The 834 eligibility files are received for CCO members from the Oregon Health Authority via secure file transfer. These

files contain new or changed Eligibility records for AllCare CCO members. The files are converted and placed in a folder, which is securely uploaded into our internal eligibility system by the Medicaid Enrollment Administrator. Once all the records have been uploaded, they are reviewed for errors. Once all errors have been processed, the records are then posted to the internal eligibility system. This process is repeated daily if there are 834 Eligibility files to process.

5. On a monthly basis, all SNP members' Medicaid eligibility is verified with the state Medicaid agency. Members identified as not meeting the SNP eligibility requirements are notified via letter and are given a grace period of 90 days, starting the first of the following month, to regain Medicaid eligibility, or they will be disenrolled from the SNP. Prior to disenrollment, the Enrollment Specialist reviews each member identified as losing their Medicaid eligibility by querying the state Medicaid system. The member will either be disenrolled for loss of SNP eligibility after the grace period or take the necessary action for reinstatement. If AllCare Health is alerted that a member enrolled in the SNP no longer qualifies for Medicaid status, staff provide a three-month deeming period for the member to provide confirmation of continued eligibility for the special needs status. The deeming period begins the first of the month following the month in which AllCare Health received information that the member no longer qualifies for the Dual SNP and ends on the last day of the third month.

AllCare's Disenrollment Process for Loss of Dual Status notification:

1. An initial letter is sent to the member or the member's legal representative within ten days of receipt of the monthly Dual SNP membership comparison report from the State indicating members that have lost Dual SNP status.
2. At the end of the three-month grace period, if no response is received from the member or legal representative, a final letter is sent within one business day following the last day of the period of deemed continued eligibility. The disenrollment notice to the member and the transaction to CMS shall be sent within three business days following the last day of the period of deemed continued eligibility; however, in no case shall the disenrollment notice to the member be sent after the transaction is submitted to CMS.
3. AllCare Health submits a disenrollment to CMS within two business days following the last day of the period of deemed continued eligibility for an effective date of the first of the month following the last day of the period of deemed continued eligibility. If at any point during this process the member provides proof of their dually eligible status the disenrollment process is cancelled.
4. Once CMS has confirmed the disenrollment and notified AllCare Health via the Transaction reply report (TRR), the applicable system is updated, and the disenrollment confirmation letter is sent to the member. AllCare Health will not retroactively terminate members due to retroactive Medicaid termination. If during any time within the three-month deeming period, AllCare Health confirms the member regained his/her Medicaid

eligibility, AllCare Health will send the disenrollment cancellation letter to the member within ten calendar days of receipt of confirmation or regained Medicaid eligibility.

a. Notice Requirements:

- i. Request for Additional Information: To obtain information to complete the enrollment request, AllCare Health must contact the individual to request the information within ten calendar days of receipt of the enrollment request. The request may be written or verbal but in either case the request must be made within ten calendar days.
- ii. Combination Acknowledgement and Confirmation Notice: A notice acknowledging and confirming an enrollee/member enrollment. This notice is sent within seven calendar days of the availability of the Transaction Reply Report (TRR).
- iii. Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs: A notice confirming the premium, deductible, and copay amounts for the DSNP. This notice is sent with the Combination Acknowledgement and Confirmation Notice.

Members with eligibility on both a Medicare Advantage plan and the CCO are identified through the above processes and linked through a master member index number.

MOC 1 Element A Factor 2: Describe the health status and health disparities of target population

Oregon is a geographically diverse state: marked by volcanoes, abundant bodies of water, dense evergreen, and mixed forests, as well as high deserts and semi-arid shrublands. It is also extremely rural with the concentration of the population living in cities concentrated within the Willamette Valley and along the interstate highway on the Western side of the state. Given the mountainous geography and rural nature, transportation, internet connectivity, and availability of services can be an issue for many of the population.

According to the 2023 United States census estimates, Oregon had a population of 4,233,358, which is a 10.5% increase over the 2010 census. Additionally, 14.9% of Oregon's Population are of Hispanic or Latino origin (of any race). Most current data available at CMS.gov indicates there are approximately 154,100 "dually eligible" enrollees in Oregon, of which 56,300 are partial and 97,800 are full Medicare-Medicaid eligible.

AllCare Health has been administering a Medicare Advantage program for 20 years. We have a long-standing presence in our market as both a Medicare Advantage and a Medicaid payer. AllCare Health had processes in place for many years before it offered an SNP to coordinate care to provide a seamless process for those members who are enrolled into both its Medicare and Medicaid programs.

As of January 2025, AllCare had 69,033 members covered on AllCare CCO (Medicaid) and had 2,842 members covered on AllCare Advantage (Medicare Advantage). All 2,276 of our AllCare Advantage plan members are fully dually eligible members (Medicare and Medicaid [Oregon Health Plan]) with AllCare CCO as a secondary payer. 447 AllCare Advantage

members were a mixture of partial dually eligibles (401) and full dually eligibles (46) with Medicaid coverage from a different source. 3,498 AllCare CCO members were dually eligible but were not enrolled in AllCare's Medicare Advantage Plan.

	AllCare CCO	AllCare Medicare Advantage	Other Medicaid	Other Medicare
AllCare Health CCO	69,033	2,276		3,498
AllCare Medicare Advantage	2,277	118	447	

Therefore, we anticipate having more than 3,000 members in our Special Needs Plan across our service areas of Jackson, Josephine, Southern Douglas, and Curry counties. These counties are bordered on the West by the Pacific Ocean, on the South by the Siskiyou Mountain Range and on the East by the Cascade Mountain Range. Jackson county has the highest population of approximately 221,000, followed by Josephine 88,000, and then Curry County at 23,000 according to county statistics for each area based on the 2023 estimated US Census data.

Many of AllCare's members, due to the rural nature of our service area, face significant access challenges to medical facilities, including urgent care, dental services, and many medical specialists. In some parts of our service area, access to these services is extremely limited. Round-trip distances can easily reach 400 miles, and for highly specialized care, they can extend to 600 miles or more.

To address these challenges, AllCare has developed a robust Non-Emergent Medical Transportation (NEMT) program. This program ensures that our members receive exceptional transportation services, including efforts to accommodate same-day ride requests whenever possible. (For more details, please refer to the transportation section in the following Element Factor 1.)

There are five Hospitals in our three Oregon county service area (a. – e.) and one in a neighboring county (f.):

- a. Curry General Hospital, Gold Beach – Critical Access Hospital.
- b. Providence Medford Medical Center, Medford.
- c. Asante Three Rivers Hospital, Grants Pass.
- d. Asante Rogue Regional Medical Center, Medford – Rural Referral Center. Rural referral centers are hospitals located in a rural area (with a few exceptions) in which at least 50% of Medicare patients are referrals, and 60% of Medicare patients live at least 25 miles away.
- e. Asante Ashland Community Hospital, Ashland.
- f. Sutter Coast Hospital, Crescent City, CA.

AllCare Health developed a detailed description of our population using data collected from a variety of sources, including, but not limited to, the following:

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

AllCare Health uses information from our own internal systems to evaluate specific membership characteristics and then supplements this data with state statistics to provide a comprehensive assessment of the population we serve. A comparison between our data and data from other sources has allowed us to evaluate our membership and determine if there are variances with the generally available Medicare data for our region. Our extensive experience managing dually eligible members in our area has allowed insight and specific data on our current members providing baseline information, until area-specific data is available. We used data from our case management process and information gathered directly from our case managers to determine additional needs of the population. Once we have experience as a DSNP we will be able to replace this initial review with information and reports specific to the population.

AllCare Health currently operates a Medicare Advantage plan in four counties, Jackson, Josephine, and Curry and two towns in Southern Douglas County. All potential DSNP members are low-income members living in rural areas with limited access to services depending on the specific County in which they live:

The AllCare Health target population includes individuals in very remote areas. According to the 2020 US Census:

- Jackson County has a population density of 80 inhabitants per square mile.
- Josephine County has a population density of 54 inhabitants per square mile.
- Curry County has a population density of 14 inhabitants per square mile.

The U.S. average is 94 people per square mile with areas with <10 considered a County with Extreme Access considerations.

Maintaining a healthy environment is essential for helping people live longer and for enhancing their quality of life. The rural and agricultural nature of our counties lends itself to certain environmental factors that can have a significant impact on health. Some of these include air quality issues due to seasonal forest fires and allergens, infrastructure issues, insect and pest outbreaks and increased algal blooms due to warming waters.

Public transportation is limited and can be a barrier to accessing the health care services needed in much of our service area. AllCare CCO does boast a vigorous Non-Emergent Medical Transportation service benefit (exclusive to AllCare CCO).

AllCare Health's 2023 Community Health Assessments of Jackson and Josephine Counties as well as Curry County identified the following key themes as the biggest social factors affecting health in our service area. (Additional details on social determinants of health affecting our target population can be found in MOC 1 Element A Factor 4.)

- Cost of Living
- Lack of Affordable Housing
- Homelessness
- Access to Care
- Affordable Health Care
- Lack of Behavioral Health Services
- Dental and Oral Health
- Food and Nutrition
- Child Care
- Provider Shortage
- Environmental Risks
- Public Safety
- Community Building
- Poverty
- Substance Use
- Transportation
- Discrimination

It was also found that a sizable percentage of members in Josephine County tend to have a lower health literacy level compared to other Medicare members. In both counties white, non-Hispanic is the predominant Race/Ethnicity.

MOC 1 Element A Factor 3: Identify population demographics

Race and Ethnicity information has been obtained from AllCare Health's current dually eligible membership (2,276):

Race	Respondents	% of Respondents
Other White	1692	74.34%
Declined	306	13.44%
Western European	65	2.86%
Unknown	58	2.55%
American Indian	30	1.32%
Other Hispanic or Latino	23	1.01%
Other Asian	15	0.66%
Eastern European	12	0.53%
Hispanic or Latino Mexican	12	0.53%
Other	12	0.53%
Multiple Racial or Ethnic Identity	10	0.44%
Other African/African	8	0.35%
Other Pacific Islander	6	0.26%
Biracial or Multiracial	5	0.22%
Filipino/a	4	0.18%
Native Hawaiian	4	0.18%
African American	3	0.13%
Chinese	2	0.09%
Hispanic or Latino Central American	2	0.09%
Slavic	2	0.09%
Asian Indian	1	0.04%
Hispanic or Latino South American	1	0.04%
Indigenous Mexican, Central American or South American	1	0.04%
Laotian	1	0.04%
Middle Eastern	1	0.04%
Total	2276	100.00%

Ethnicity	Respondents	% of Respondents
Other	881	38.71%
Hispanic	607	26.67%
Not Hispanic	578	25.40%
Declined	180	7.91%
Unknown	30	1.32%
Total	2276	100.00%

Race/Ethnicity	Respondents	% of Respondents
Hispanic/Latino(a), any race	81	8.4
African American or Black, non-Hispanic	8	0.8
American Indian or Alaskan Native, non-Hispanic	14	1.4
Asian, non-Hispanic	4	0.4
Native Hawaiian or Other Pacific Islander, non-Hispanic	5	0.5
White, non-Hispanic	825	85.1
Other, non-Hispanic	4	0.4
Multiple races	29	3.0
Total	970	

Chronic Condition	Dually Eligible Members	%
Diabetes	863	35
Depressive, bipolar, and paranoid	619	25
COPD	522	21
Fibrosis of lung and other lung disorder	611	24
Morbid obesity	377	15
Vascular disease	423	17
Congestive heart failure	399	16
Heart arrhythmias	329	13
Drug/alcohol dependence	325	13

Chronic Conditions	Dually eligible Members	Percent of Dually eligible Members
Diabetes	719	36%
COPD	629	32%
Depression Disorders	400	20%
Vascular Disease	353	18%
Substance Use Disorder	316	16%
Heart Failure	293	15%
Obesity	277	14%
Kidney Disease	269	14%
Heart Arrhythmias	265	13%
Cancer	226	11%

When looking at the AllCare Health Medicare Advantage HCC data for these individuals the top 10 HCC conditions are Diabetes, COPD, Depression Disorders, Vascular Disease, Substance Use Disorder, Heart Failure, Obesity, Kidney Disease, Heart Arrhythmias, and Cancer. We have identified that Diabetes (35 % co-morbid rate) is the highest co-morbid condition noted in the target population.

Josephine, Curry, Douglas, and Jackson Counties have a high rate of premature age adjusted mortality for Oregon when compared to the State of Oregon. According to the National Institute of Health on Minority Health and Health Disparities, the state of Oregon premature age adjusted mortality rate of deaths per 100,000 (2019-2021) was at 340, with Curry County at 531, Douglas County at 506, Josephine County at 470, and Jackson County at 368.

Premature Age-Adjusted Mortality for AllCare's Service Area	
All Races (includes Hispanic/Latino) Both Sexes, Ages <75, 2019-2021	
	Premature Age-Adjusted Mortality Rate Deaths per 100,000
United States	390
Oregon	340
Curry County	531
Douglas County	506
Jackson County	368
Josephine County	470

Source: National Institute of Health on Minority Health and Health Disparities

AllCare Health served 2,842 individual dually eligible members through its Medicare Advantage plan in January 2025. 62% were Female and 37% Male. There were 129 members under age 34 and 70 over age 85.

Average Dually Eligible Members by Age Group and Gender 2025			
Age Group	Male	Female	Total
00-34	73	56	129
35-44	75	79	154
45-54	85	131	216
55-59	81	116	197
60-64	113	173	286
65-69	314	520	834
70-74	104	229	333
75-79	63	143	206
80-84	18	52	70
85-99	16	54	70
Total	942	1,553	2,495

The average age trended higher from 2018 to 2021 whereas there has not been a meaningful change in the median age. The percentage under 65 slowly decreased from 47% to 38%.

Year	Average Age		% Under 65
2018	61.9	65.3	47%
2019	62.6	65.8	44%
2020	63.2	65.7	43%
2021	63.9	66.1	38%

MOC 1 Element A Factor 4: Define the unique characteristics of the SNP population by plan type

AllCare Health will cover full dually eligibles. While AllCare has experience coordinating care between Medicare and Medicaid, gaps in care often occur due to transportation, Medicaid benefits that are only covered through the state, and the need of many members for long-term services and support.

SNP members qualify for Medicare because they are either aged and/or disabled. Approximately 38% of our SNP population is disabled per the Social Security Administration (SSA) definition. Disabilities approved by the SSA and for the receipt of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) can be physical or mental health in nature. Disability limits the member from having gainful employment for at least 12 months. Many of our members, 65 and older, may also have a disability as well.

Of the 2,842 dually eligible members enrolled in AllCare Health's Medicare Advantage plan in January 2025, 62% were female. Their dual status, including eligibility for Medicaid, which has

specific income criteria, makes them among the poorest in the general population. Being low income is a challenge for these members and can create certain barriers that will impact their health, such as affordable housing, transportation, and food insecurity.

Our service area includes rural counties with higher than state averages of living at or below the poverty line. According to the US Census Bureau, Oregon's statewide average of people living in poverty in 2023 was 12.2%. In Curry County the percentage is 15.8%, Josephine County sits at 15.1% while Jackson County's poverty rate is at 12.6 %.

While all Oregonians are rent burdened with an average rental requiring 32.6% of their income, this gap becomes more profound for those considered low income or extremely low income. According to Oregon Housing and Community Services, approximately 242,000 households fall into the low income or extremely low-income categories, yet Oregon only offers approximately 113,000 housing units that are both affordable and available to them, resulting in a deficit of 128,000 units for these households. For housing to be considered affordable, a household must not spend more than 30% of their income on housing costs.

Another way to understand this gap is that for every unit affordable to a low-income household, there are 4.2 families in need of such housing. The lack of affordable options forces people to accept housing beyond their financial means, leading to a cost burden, financial instability, and, in some cases, homelessness.

The Mortality rate is higher than the state average in all our counties of coverage with Josephine and Curry being in the highest mortality rate while Jackson is roughly in the middle when all health factors are measured. The mortality rates due to opioid overdose has decreased, according to the Oregon Health Authority from 1,416 deaths in 2023 to 392 in 2024, according to the report released in October of 2024. Incidents of non-fatal overdoses experienced increases in 2023 but began dropping substantially by the summer of 2024, according to the OHA, despite initial increases in 2023 and the start of 2024.

Oregon housing is 22.1% higher on average than the rest of the US with the seventh highest cost of living in the US. In Oregon, sheltered homelessness increased 24% between January 2023 and January 2024, according to a new report by Portland State University's Homelessness Research and Action Collaborative (HRAC). This appears to be the largest increase since detailed statewide reporting started in 2007. In 2024, the number of year-round shelter beds increased significantly — 2,455 beds were added statewide, resulting in a 32% increase in the number of available beds for a total of 10,408. Most of those shelter bed capacity increases occurred in Oregon's metropolitan areas* but not in Josephine nor Curry County where shelter beds decreased post overturning the Ninth Circuit's ruling by Scotus. The same is largely true in Jackson County as well except for Medford where shelter beds and affordable housing increased by 67 shelter beds and 133 rapid rehousing units.

Health Risk Assessment data for AllCare Health's Medicare Advantage dually eligibles throughout 2024 indicate activities of daily living (ADLs), finances, transportation and stress are the biggest barriers that interfere with members' ability to get the care they need.

Public transportation access is an important service to maintain health. Not only does taking public transportation provide additional opportunities for exercise, but the presence of public transportation also makes it easier for individuals and families without private transportation options to access goods and services, especially those with disabilities. Public transportation is highly variable in the three counties in the AllCare Health service area. Members living in larger cities in the three counties have better access to public transportation than those living in rural areas.

Transportation options and limited public transit for residents in some of our rural regions contributed to a lack of access to nutritious food and food insecurity. Roughly 13% of Oregon residents report concerns of hunger and lack of regular access to adequate food. Based on studies by organizations like Rural Hunger who study food availability in rural regions, 9 out of 10 counties where people experience the highest rates of hunger are rural. While many may qualify for the Supplemental Nutritional Assistance Program, cuts to the program were made post pandemic and more are expected in the coming months. For those who rely on home delivery, the services are harder to access due to a lack of delivery volunteers in our most rural communities.

Our region lacks affordable housing for those with low to moderate incomes with the average rent in Oregon set at \$1,800 per month. Housing assistance through subsidized programs have a 2.5-year wait list, according to the philanthropic data research group, “USA Facts.” For those AllCare members who are homeless moving up the list requires weekly check-in and tracking which is difficult for the unhoused who lack cell phone services and must rely on wi-fi and public access to internet.

MOC 1 Element B: Subpopulation- Most Vulnerable Enrollees

MOC 1 Element B Factor 1: Define the most vulnerable enrollees

AllCare Health’s Intensive Care Coordination Program (ICCP) is a comprehensive evidence-based care coordination program to support the treatment and management of AllCare Health’s Medicare Advantage members. Through the ICCP, vulnerable populations are identified to direct resources towards the members with the greatest need for case management services. In general, this includes individuals who have high health care needs, are identified as aged and/or blind, have limited mobility, are disabled, have multiple chronic conditions, suffer from mental illness, have chemical dependency, deal with complex medical needs, receive Medicaid-funded long-term care or long-term services and supports, or experience health disparities, such as cultural and linguistic needs.

AllCare Health uses multiple tools to help identify, stratify, and coordinate care for these members, including information from programs such as PointClickCare, MedOptimize and many internal platforms pulling data sets together into several Power BI dashboards in tandem with our claims data. Our care coordination staff monitor reports derived from these tools on a routine basis and reach out to members and their provider team for screening and assessment regarding integrated care plans. Referrals into the program are accepted by the member, the member’s representative, a provider, other medical personnel serving the member, or

the member's long-term care/service supports case manager. At a minimum, case managers review available data during annual assessments/reassessments for status changes and transitions of care.

Using the experience derived from our ICCP program, our stratification process, and data from our members on both our Medicare and Medicaid program, we have identified a subset of our SNP target population that requires additional services and specialized programs to assist in management of their special needs. We consider these individuals our "most vulnerable population." We have defined this population as members exhibiting all the following:

- Members with comorbidities, including diabetes.
- Members that are female.
- Members that are under the age of 65 and by SSA's definition disabled.

Every quarter, staff review updated Intensive Care Coordination Reports to identify these particularly vulnerable members. Other methods to identify such members, including claims data, hospital, and other service utilization reports, pharmacy claims, provider reports, diagnostic data, and the Interdisciplinary Care Team (ICT) communication/identification.

MOC 1 Element B Factor 2: Identify demographic characteristics of the most vulnerable enrollees

By December of 2023, there were 660 dually eligible members that met the criteria of our most vulnerable or the highest risk level. 63% are female and 37% are male, with the average age for female and male are 68 and 65 respectively. The total diabetic chronic condition population average age is 67. Of these members 62.7% have some form of disability, and 16.9% being identified as having Long Term Services and Supports. Sixty-seven percent of these most vulnerable live in Josephine County, and 32% live in Jackson County, and Douglas and Curry Counties have less than 1% each. Seventy-two percent of the population identify as white, 20% did not answer / declined/unknown, 2.3% Hispanic/Latino, and 2.1% American Indian/Alaskan Native. Ninety-seven percent preferred language was English with Spanish at 2.4%.

Seventy-seven percent of members identified in this cohort had at least one other condition besides Diabetes with the most prevalent chronic conditions being COPD, Chronic Kidney Disease, Vascular Disease, Major Depressive, Bipolar, and Paranoid Disorders. The average number of prescriptions per person was 17.0 - with prescriptions for cardiovascular disease (Hypertension & Lipid Irregularity) and Antidepressants most common in addition to Diabetic drugs.

Age

The average age of AllCare Health's most vulnerable is 67. Sixty-three percent of these individuals are on Medicare due to some form of disability. People with disabilities tend to be in poorer health and to use health care at a significantly higher rate than people who do not have disabilities. They also experience a higher prevalence of secondary conditions and use preventive services at a lower rate than others. Moreover, people with disabilities are affected disproportionately by barriers to care. These barriers include health care provider stereotypes

about disability, lack of appropriate training, and a lack of accessible medical facilities and examination equipment, sign language interpreters, and individualized accommodations.

Gender

All cohort members are female. It is important to women's health that they receive regular screening for breast and cervical cancer and osteoporosis in particular. Research has also identified that women are less likely to obtain the necessary screening for cardiovascular disease than men.

Ethnicity

As previously mentioned, most members are white - 85% White, 8.4% Hispanic followed by 1.4% American Indian/Alaskan Native. From the "Racial and Ethnic Disparities in Health Care in Medicare Advantage" report released in 2016 by the CMS Office of Minority Health, some health disparities exist for Black and Hispanic populations. Utilizing CAHPS/HEDIS data collected in 2014, the Office identified that Black and Hispanic populations had significantly lower results compared to Whites for some access, preventive care, and health outcomes. For access to care, these included getting needed care, including from specialists, getting appointments and care quickly and getting prescription drugs. Significantly lower rates for preventive care were observed for annual flu vaccine and colorectal cancer screening. Important health outcome rates such as control of blood sugar and blood pressure were also lower.

Language barriers

For non-English speakers, language can be a communication roadblock and have a negative impact on quality care and health outcomes. Information gathered from State enrollment files for the 2,227 AllCare CCO members on the AllCare Medicare Advantage Plan revealed that English was the primary language for 64% percent of members, with the next highest Spanish, at 24%. Language barriers can impede access and lead to miscommunications and breakdowns in care. To ensure meaningful linguistically appropriate communication our DEI Department includes a Meaningful Language Access work group whose purpose is to provide effective, understandable, and culturally and linguistically appropriate materials that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of our members. The work group has four priorities: uphold the CLAS Standards; partner with the community to develop policies and procedures to ensure cultural and linguistic appropriateness; establish goals and accountabilities for all AllCare staff; and evaluate and monitor the impacts on health equity and outcomes to inform service delivery. Care Coordination uses a health education program that supplies appropriate health literacy material and videos for members. In addition, the DEI Department hosts multiple Meaningful Language Access training courses that include discussion on the CLAS Standards for all staff.

In response to identified gaps regarding language access in our service area, AllCare has developed a robust 64-hour Health Care Interpreter training program, which is offered up

to two times per year to qualified individuals in our service area, as well as the state. We are also one of the only testing centers in Oregon. As a result of these endeavors, the number of certified interpreters in our service area has increased from 3 in 2017 to more than 400 available to work in our service area. AllCare currently contracts with more than 20 local State Qualified Health Care Interpreters to meet the current needs of our member population including Spanish and ASL (including one certified in Spanish sign language). In addition to this, AllCare contracts with a Language Service Vendor that has more than 300 languages available on demand to meet our current member population's needs.

AllCare won the "2019 Language Access Champion" award from the National Council for Healthcare Interpretation.

Health literacy

Patients with poor health literacy make more medication errors. They are less able to follow treatment instructions, are less successful in navigating the health care system, and are at higher risk for hospitalization. To address disparities in health literacy, member literature is written at a sixth-grade reading level to make it as easy to understand as possible. Primary Care Clinics have care coordinators who collaborate with members to ensure they understand their appointments, what was discussed, and their medications. AllCare Health care coordinators and care managers are available for members who may need more assistance in understanding the literature they receive.

Socioeconomic status

All DSNP members are dually eligible for Medicare and Medicaid. Not being able to afford the essentials, such as food, clothing, transportation, and housing creates a social deficit and can lead to behavioral health problems, such as depression. Not being able to purchase fresh fruits and vegetables due to price and buying high-caloric and processed foods instead can result in poor control of chronic diseases, such as diabetes and CHF. Dually eligible members may need assistance understanding the coverage of services under their Medicaid plan and have concerns about additional costs for healthcare visits, medications or testing supplies, and may miss medical appointments or preventive care. To address this, AllCare Health has progressively invested in understanding the social determinants affecting members and works collaboratively with community partners to increase access to affordable housing and improve nutritional options.

Other

2024 HRA data indicates that transportation and ADLs are a major concern for these members. These factors can have an impact on member's physical and emotional health and ability to follow their doctor's treatment plan. Members who live alone may require assistance with additional long-term care supports and services such as delivered meals, help with household chores and identification of social supports in the community. Members without transportation may have difficulty making appointments for preventive and routine care.

People with certain disabilities experience specific health disparities and additional unique problems in accessing health care and services. If these problems can be resolved, crosscutting solutions hold the potential to improve health care for the broader disability community. For example:

Women with significant disabilities are likely to have fewer Pap tests and mammograms than women who do not have disabilities, and they have less knowledge and awareness of risk factors for cardiovascular disease and participate in less preventive screening for this disease compared with women without disabilities.

Adults who are deaf or who experience significant hearing problems were three times as likely to report fair or poor health compared with those who did not have hearing impairments. American Sign Language (ASL) is the primary language for many people who are deaf, yet interpreters frequently are not provided during medical visits. Consequently, people who are deaf have significant difficulty communicating effectively with their health care providers and receiving health care information and instructions.

Adults with developmental disabilities are at risk for hearing and vision difficulties, cardiovascular disease, obesity, seizures, mental health and behavioral problems, poor oral health, and poor general fitness. Young adults with developmental disabilities often encounter significant problems when they attempt to make the transition from coordinated childhood medical care to adult services. Problems include primary care physicians who are not trained to provide needed care, and insurance coverage that does not adequately compensate health care providers for the time required to provide care and care coordination.

People who experience significant vision loss are more likely to have heart disease and hypertension, experience a greater prevalence of obesity, and smoke more than the general population. Health care providers rarely supply printed health care instructions, educational materials, and information such as directions for taking prescription medications in accessible formats, and people who are blind or have vision impairments also appear to be excluded systematically from receiving high-quality diabetes education. Access to vision rehabilitation services also can be limited.

MOC 1 Element B Factor 3: Establish correlation between demographic characteristics and clinical requirements

Characteristics of our most vulnerable members include but are not limited to multiple chronic conditions, diagnosis of a disability, frail conditions, social isolation e.g., lacking or having limited access to support systems in the community, and having challenges to accessing care due to language or cultural barriers. AllCare Health has an established policy and procedure that facilitates the identification of these members, especially those who are at risk or vulnerable, who may benefit from services provided by community organizations. The coordination process refers and links members into helpful community programs and resources that address special needs, including, but not limited, to economic, legal, housing, psychosocial and medical services, as appropriate for the member, which are not standard

Medicaid or Medicare benefits. These services are integrated into the member's individualized care plan and may be coordinated with the assistance of community health centers, protective and legal services, state agencies to establish Medicaid eligibility, translation services, and church-based food pantries.

In addition, age, disability status, language, health literacy, and poor socioeconomic status can potentially impact the ability of these members to manage their chronic conditions and results in poor health outcomes in this population. While English is overwhelmingly the highest spoken/understood language, Spanish is prevalent among our members and communities. Chronic conditions are complex and often confusing. Multiple medications further complicate each situation. In addition, Diabetes often results in functional impairments. We can coordinate a home assessment and offer the use of community resources and/or coordinate services offered by Medicaid if the member is a dually eligible member to assist those with functional impairments requiring additional help. Supplemental benefits, offered as part of our plan, provide additional services such as dental, vision, transportation, physical fitness, and/or over the counter medications. Cognitive issues, when present, add to the complexity of a member and significantly impact all domains of care, including physical, functional, psychological, and social. We screen each member through questions in our HRA to identify these issues. This population may not be conducive to change or effective management of the debilitating or progressive condition they are experiencing. If, during interactions or when assessing a member during the HRA process, cognitive issues are identified, the Case Owner would coordinate with the provider if a more intensive exam were needed, recommend a home assessment, and work closely with care givers to help the member and minimize complications and injuries that may be exacerbated by the level of impairment.

Special Services and Benefits for these most vulnerable

AllCare Health will offer these members a few specialty services and benefits designed to meet their additional healthcare needs.

Evidenced-based Diabetes Self-Management Program

AllCare Health employs an Intensive Care Coordination team that is trained in the management of whole-person care. This member-centric care model utilizes an interdisciplinary care team approach. This approach meets members where they are in their healthcare continuum. The following disciplines are utilized collaboratively; RN and LPN case managers, social workers, intensive care coordinators, and Community Resource Specialists (traditional and certified health workers). RN case managers are trained in chronic care management and understand the disease processes of both Type 1 and Type 2 Diabetes. They will be able to assist the diabetic member in the formation of achievable, realistic goals in the self-management of their disease in the areas of diet, medication adherence, monitoring blood glucose levels, foot checks, immunizations, eye exams, and keeping appointments with their PCP. Additionally, the Intensive Care Coordination team supports social determinants of health and behavioral health management.

Nurse Advice Line through Fonemed

Available to answer member health questions 24 hours a day, 7 days a week. Especially trained and licensed registered nurses evaluate patient symptoms, offer medical advice based on the gold-standard Schmitt Thompson protocols and document encounters in secure systems to manage protected health information.

Dietician services

AllCare Health's interdisciplinary care team (ICT) provides education to members about healthy nutrition. AllCare Health dedicated dietician provides targeted nutrition education to support and assist the members in making dietary changes with ongoing adherence to recommended dietary requirements. Nutritional support is medically necessary in diabetic populations where dietary adjustment plays a central and therapeutic role.

Member Portal

The Member Portal is a wellness platform provided by HealthTrio, designed to enhance member engagement and support. Through this portal, members can conveniently access their benefits information, member cards, and make changes to their primary care provider or dental plan. Additionally, members can send secure messages to the customer care team at their convenience. The portal also allows for document uploads and secure submission of a Health Risk Survey.

Asante Lifeline

Provides a personal help button to wear around your wrist or neck. When emergency medical help is needed, a button can be pushed, and a Lifeline representative will be notified immediately. Lifeline response experts have instant access to the member's health profile, can quickly assess the situation, and send help fast.

Rebuilding Together Rogue Valley

Rebuilding Together Rogue Valley's (RTRV) Safe-at-Home program has been developed to help low-income seniors and persons with disabilities safely "age-in-place" as long as possible in their current homes. Preventing falls and improving accessibility will save lives, save dollars, and address the housing crisis in Southern Oregon by helping keep this vulnerable demographic from needing public housing or becoming homeless. RTRV provides in-home safety assessments, repairs homes, builds ramps, installs safety equipment and bathroom safety devices.

Transportation Services

AllCare Health provides Non-Emergent Medical Transportation (NEMT) services through ReadyRide for members enrolled in AllCare CCO. To ensure consistent access for our members, AllCare requires ReadyRide to exclusively serve its members, alleviating the financial strain of offering transportation services to outside customers, which could otherwise reduce availability, especially for same-day rides.

As part of the Medicaid benefit, transportation is arranged through locally contracted providers at no cost to the member when medically necessary, with no copay or limits on usage. This service covers transportation to and from Medicaid and Medicare-covered services for SNP members.

For members with their own means of transportation, AllCare also offers a mileage reimbursement program. This program reimburses eligible SNP members for certain travel expenses incurred while traveling to and from covered appointments.

Vision Benefit

In addition to Medicare-covered vision services, SNP members are eligible for limited vision coverage, including routine eye exams and an eyewear allowance.

Oral Health Services

Members have access to preventive and restorative oral health services through their Medicaid program.

Hearing Services

SNP members may have limited hearing aid benefits, including exams and hearing aids provided through their Medicaid program.

Medication Therapy Management

All SNP members that meet eligibility for our Medication Therapy Management (MTMP) program are offered at least one annual comprehensive medication review with a specially trained pharmacist. AllCare Health contracts with MTMCare to provide these services to AllCare Advantage members. Through MTMCare, specially trained Pharmacists are identified to deliver these services. Services include comprehensive medication review, targeted medication recommendations for prescribers, and drug plan information.

Value Based Insurance Plan

AllCare Health engages in the Value Based Insurance Design (VBID) program through CMS. Our program allows all D-SNP members to fill their prescriptions without any cost share. In addition, AllCare partners with our MTM program to encourage eligible members to complete a comprehensive medication review with an MTM pharmacist. Once completed, the member is eligible for a gift card and may be eligible for additional gift cards when they fill extended day prescriptions for hypertension or hyperlipidemia medications. Supplemental benefits included into the D-SNP plan are Fall Prevention and Meal Benefit. Fall Prevention includes fall prevention services through certified and contracted professionals. We cover in-home safety assessments and bathroom safety devices. The Meal Benefit is unlimited; 30 meals in 30 days after each SNF and inpatient discharge.

Case Management for Special Needs

All SNP members are enrolled in case management. In addition, for a small subset of members with specific conditions, members may be enrolled in more specialized case management

programs, which include home visits. The member's Case Manager or provider will refer the member for the services. In addition, members may receive the following interventions as indicated by their Individualized Care Plan (ICP):

- Additional assessments.
- Condition-specific assessment and monitoring.
- Coordination of multiple services, such as home health, PT, OT, wound care, DME, specialty visits, etc.
- Coordination of care with multiple external entities (i.e., Department of Social Services, Medicaid, etc.).
- Surveillance for potential status changes such as ER visits, hospitalizations, and SNF stays.

Social Workers and/or Case Managers

Conduct county-specific research to identify and connect members with the resources in their community to meet their individual needs. These can range from assistance for homelessness, home modifications such as ramps, resources for identified food scarcity, financial assistance, support groups, in-home supportive services, transportation, addiction and dependency counseling and services, etc.

Language Access

AllCare Health provides free aids and services to those with disabilities to communicate effectively, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). AllCare Health provides free language services to members whose primary language is not English, such as qualified interpreters and information written in other languages. Most of AllCare's written materials have been translated into Spanish and the DEI department coordinates translation for other languages and formats as needed. In an effort to provide effective communication to our Limited English Proficient (LEP) members and enhance accessibility, AllCare established two dedicated language access lines:

- General Language Access Line: This allows members to request an interpreter in their preferred language. Calls connect to an interpreter first, who then connects to AllCare's front desk.
- Spanish Language Access Line: Recognizing that Spanish is our most in-demand language among our LEP members, this line connects callers directly to a Spanish-speaking interpreter. After this, the call is routed to our office for further assistance.

MOC 1 Element B Factor 4: Establish relationships with community partners

Since 2016, AllCare Health has funded more than 682 Community Benefit Organizations (CBOs) through Health-Related Services (HRS). These investments include low-income housing programs and housing supports, local school programs, school-based health clinics, programs for low-income seniors, trauma informed and Adverse Childhood Experiences (ACES) training, youth programs, maternal and child health programs, nutritional supports,

community centers, peer support services, behavioral health programs, public health agencies, and community service organizations such as United Way and Rotary, among others. AllCare Health takes part in a collaborative Community Health Assessment and Community Health Improvement Plan that strengthens grass-root relationships with multiple community partners, Regional Health Equity Coalitions (RHECs), Community Advisory Councils (CAC), Continuum of Care, and social service agencies. (Please also note the mention of our community partners in Factor 3.)

At the community level, AllCare Health engages with community partners to develop a regional Community Health Assessment (CHA) to identify leading barriers to health and prioritize health needs in the communities we serve. Using this assessment, a Community Health Improvement Plan (CHP) is developed to frame goals and measurable outcomes related to improving community health in key areas identified in the CHA.

AllCare Health also has a robust Community Engagement Plan designed to foster two-way communication between AllCare Health and the community, so that we can provide preventive health and Social Determinants of Health and Equity (E) support and education. This continual feedback from the community serves to improve health outcomes, removes barriers, and ensures the delivery of services needed for our most vulnerable members.

We fund community benefit organizations in our region through an internal team of SDOH-E subject matter experts. This team knowledge expands across the following focus areas: housing, environmental sustainability, nutrition, education and early learning, interpersonal violence, trauma informed approaches to care and service, care coordination, health equity, diversity, inclusion, and physical/oral/behavioral health. Additionally, AllCare has three Community Advisory Councils, one in each of our counties, who are provided with a budget to fund community organizations and projects. This funding is focused on innovative health interventions, /prevention programs, and to strengthen or build sustainability and capacity in existing, effective community programs. All this work is done through a well-developed equity lens, which is informed by both best practices and the evolving needs of our community customers.

The clinical team also coordinates with other case managers who may be involved with the member, including long term services and supports (LTSS) case managers/service coordinators if the member is a dually eligible member or may qualify for Medicaid benefits, and to deliver needed services to our most vulnerable members. This coordination may take place electronically, through verbal contact, or as part of the ICT. During our interactions with the member, we ask for information on other programs the member may be enrolled in or be receiving benefits through. Community-based organizations and local social service offices are also engaged, when appropriate, to help address member's financial resource and housing needs. The member's case manager may assist the member by contacting the LTSS case manager/service coordinator regularly to coordinate benefits to comprehensively meet the member's medical and non-medical needs. Comprehensive coordination of Medicare and Medicaid benefits, as well as non-medical (social/environmental) support, enables members to receive the best care in the most appropriate setting while maintaining as much independence

as possible. When a member has any of the triggers for possible inclusion in a LTSS program, referrals may be made, or discussion with the member and/or provider occurs, to assist in coordination. Outreach to providers and working closely with the member as part of our case management program helps the member coordinate needed care. If the member is not a dually eligible member, community resources are essential to bridge the gap between needs and what Medicare would cover. Below is a list of frequently used resources in the community:

PATIENT CENTERED PRIMARY CARE HOME

If the members' primary care provider clinic is designated as a Patient Centered Primary Care Home (PCPCH), case management and care coordination processes are coordinated with the PCPCH. The care management team supports the PCPCH by approving and helping to arrange covered benefit service provisions as well as any additional identified services. This includes collaborating with Department of Human Service (DHS) agencies for needed community-based services. When the PCPCH assumes additional care management activities, SNP care coordination staff continue to monitor services.

COMMUNITY MENTAL HEALTH PROGRAM

AllCare Health has agreements with the Local Mental Health Authorities (LMHA) (Jackson County Mental Health, Options for Southern Oregon, and ADAPT/Curry County Mental Health), to provide crisis intervention and crisis management services. For all other mental health services in Jackson and Josephine counties, AllCare Health contracts with Options for Southern Oregon. In Curry County, we contract for all mental health services with Adapt.

COMMUNITY HEALTH CENTERS

AllCare Health contracts with Community Health Centers (CHC or Federally Qualified Health Clinics) to ensure the necessary access to CHC nurses and social workers for its members. CHC social workers provide face-to-face health navigation services to members and participate in ICTs, contributing information obtained from working closely with members. This partnership is critical to meet the various needs of members that frequently are not identified until a case manager is in the member's home.

SENIOR AND DISABILITY SERVICES

AllCare Health has Memorandum of Understanding's (MOUs) with Jackson, Josephine, Douglas, and Curry counties that address the need for improved person-centered care and alignment of services between the local Area Agency on Aging, Rogue Valley Council of Governments (RVCOG), and local county programs for Senior and Disability Services. The MOU outlines the roles and responsibilities of the CCO and the APD/AAA as it relates to serving Medicaid members in their homes, and in long-term care facilities. Roles and responsibilities focus on the following:

- a. Prioritization of high-needs members with long-term services and support.
- b. Person-centered individualized care plans for coordinated and aligned care, focusing on member needs, health equity, language and disability access, health literacy and promoting wellness and better health outcomes.

- c. Transitional care practices including care transitions or changes in health status or level of services, ensuring discharges are monitored and follow-up care is received.
- d. Member engagement and preferences in long-term care, in home and community-based settings.
- e. Establishing member care teams.

Inherent to each area of focus is definition of data sharing activities, referral practices, risk assessment and screening, person-centeredness, collaboration and communication, team meetings, and shared accountabilities. These MOUs have been in place since 2012 and were then updated every three years or more often if needed. AllCare Health will document and submit by August of each year an update of coordination activities with Type B AAA or State APD district offices within our Service Area. The Oregon Health Authority (OHA) is responsible for enrollment to the Oregon Health Plan (Medicaid) for those not served through Senior and Disability Services. OHA has case managers working with physical health fee-for-service SNP members, addressing barriers to care as well as assisting the member in accessing needed community resources.

DEPARTMENT OF HUMAN SERVICES (DHS)

AllCare Health funds a registered nurse in the Public Health department in Josephine County who provides needed health services to clients of DHS Child Welfare and Self Sufficiency Field Offices as well as other public health programs. AllCare Health also regularly engages and coordinates with all three of our regional Child Welfare Offices for Systems of Care and Wraparound work. We partner with DHS Child Welfare on our quality incentive measure to obtain assessments for children in DHS custody. Lastly, coordination of intensive behavioral health services occurs for our shared members and families who are in behavioral rehabilitative services (BRS). Staff located at these offices can help members who may be eligible for childcare assistance, cash assistance helping those escape domestic violence as well as food benefits such as SNAP.

DEVELOPMENTAL DISABILITIES DEPARTMENT

Each county has a developmental disabilities (DD) department within their county health department providing support for children and adults with intellectual and developmental disabilities. Supports may include case management, support for families, access to supported housing, jobs, and transportation as well as residential services in the member's own home or in a group or adult foster home setting. A case manager may be an integral part of successful care coordination for members engaged in the DD services.

AllCare Health provides physical, behavioral, and oral health for our Medicaid members with Intellectual and Developmental Disabilities (I/DD) as well as care coordination planning particularly upon transition from hospital and long-term care facilities to community-based programs and residential facilities. AllCare Health works closely with local I/DD programs and brokerages to remove barriers for non-covered medical services and SDOH-E by utilizing health-related services when a need is identified. Needs may be identified by the member,

family, medical provider, or other entities working with the member. In addition, AllCare Health supports The Linkage Project, that is connected to OHSU and the Oregon Office on Disability and Health, and this program is for adults with intellectual and developmental disabilities (I/DD) who have unmet preventive health needs. The Linkage Project Team from the Oregon Office on Disability and Health helps in three ways:

- They ask people in the project questions about their preventive health needs.
- They help people learn about healthy behaviors, going to the doctor, going to the dentist, getting screening tests, and getting mental health counseling.
- They help people find preventive health care and other health supports in their community.

The Linkage Project is a 10-state Centers for Disease Control and Prevention (CDC) project in collaboration with Oregon Developmental Disability Services (ODDS). The project has been completed over four years. It started in Southwest Oregon but is now open to all case management entities across the state that are interested in working with the Linkage Project Team. The Oregon Office on Disability and Health (OODH) Linkage Project Team is seeking referrals for individuals who may benefit from Linkage Project activities. AllCare Health has partnered with The Linkage team Care Coordinators to ensure that vulnerable members receive appropriate supports and services. AllCare Population Health leadership works directly with The Linkage Project to provide education on how AllCare can support members and have developed streamlined referral pathways to access services and care coordinators. The Linkage Project Team works with participants over a 3-month period to provide education about preventive health care as well as individualized linkages to care and programs that can help address their unmet needs. Our Linkage Team can assist participants in English and Spanish.

The program is interdisciplinary and includes the involvement of nurse care coordinators, behavioral health clinicians, community health workers, and the Linkage Care Coordinators. The partnership has helped identify members who may struggle with access in the community and has promoted and encouraged the engagement of local resources and agencies. Outcomes have included increased dental care, increased access to preventive health screenings, tobacco cessation, alcohol and drug cessation, and ensured members have opportunities to engage in accessible spaces or opportunities for physical activity and outdoor recreation. AllCare Health regularly engages and coordinates with local I/DD programs and brokerages for Systems of Care and Wraparound work.

CONNECT OREGON

Connect Oregon is a coordinated care network consisting of healthcare, government, nonprofit, and other organizations. These network partners use Unite Us' application, a Community Information Exchange (CIE), to securely identify and deliver services that address the needs of individuals within their communities through a no-wrong-door approach. Unite Us receives resource data from 211 info and provides a non-English mode to assist for screening and document accessibility for Spanish speaking individuals. Additionally, Unite Us enables

secure, meaningful information sharing across sectors using Health Information Trust Alliance (HITRUST), SOC (Service Organization Control) 2 Type 2, and National Institute of Information and Communications Technology (NIST) certifications. This CIE follows Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and the Family Educational Rights and Privacy Act (FERPA) regulations. Access and permissions satisfy HIPAA/NIST standards by having user-level roles and permissions and Business Associate Agreement (BAA) when applicable.

AllCare continues to be a regional leader in the utilization and adoption of the Unite Us platform. AllCare provides unlimited Unite Us user licensing costs for providers. This allows all providers and staff to have full access to the platform free of charge within AllCare's service area. This platform is free for non-profits and Federally Qualified Health Centers (FQHCs). Unite Us enables AllCare Health, providers, and community partners to send and receive electronic referrals to address health and social needs that improve health across communities. In 2024, AllCare hosted multiple Unite Us training onsite and via secure online platforms for community partners, healthcare providers, and staff to increase platform utilization, referrals plus access to care and SDOH-E services. Individuals being served through Unite Us has increased 41% over the last 12 months.

HOUSING ORGANIZATIONS

AllCare Health provides grant funding to local housing agencies and programs that offer transitional and permanent affordable housing to the homeless across our service area. Affordable housing has been a priority of AllCare Health since 2015, as adopted in our current CHIP. AllCare Health participates in "Operation Welcome Home". This is a collaborative project in Josephine County to increase capacity, effectively coordinate efforts, identify veterans, and receive technical assistance as a community to ensure the right resources are being offered to meet the need for supportive housing. Other examples of programs funded by AllCare Health include:

- Rogue Retreat, which is funded on a PMPM basis for our Medicaid members in need of transitional and supportive housing.
- Mid Rogue Foundation's Foundry Village is the first tiny house transitional community for those affected by homelessness in Josephine County, Oregon. They also have "Evan's Place", a state-of-the-art transitional home designed to provide comfortable and affordable housing for low-income seniors over 55 years of age.
- The Salvation Army's "Hope House" is a drug and alcohol-free transitional living facility that accommodates single men, single women and families. Living facilities include individual rooms and dorms for single men and women.
- Brookings CORE Response is set to transform a local motel into 18 affordable housing units for veterans.
- CASA "Riviera Mobile Park Cooperative Preservation" is a 103-space manufactured dwelling park in Grants Pass. This resident mobile home park target population is homeowners who are at or below 80% of the Area Median Income, with 76% of park

residents aged 62+, 19% are veterans, and 33% are disabled.

- “Hearts with a Mission”, which provides temporary housing for homeless teens for whom foster care is not an option.
- “Welcome Home Oregon” has multiple housing units that provide housing for post-carceral individuals.

COMMUNITY RESOURCE SPECIALISTS

In addition to our care coordination, integrated health care, and funding to address the social determinants of health, AllCare Health maintains a strong peer support program particularly to address certain chronic conditions as well as support for Medicaid members in their efforts to maintain a healthy lifestyle. Most of our Community Resource Specialists (Traditional Health Workers (THWs)) are individuals who have life experience and are better able to offer peer support for those in times of transition or seeking opportunities to improve one’s health. AllCare Health members can access a wide array of Peer Support Services through our subcontracted Mental Health and contracted substance use disorder (SUD) treatment providers. Members can engage in Peer Run Organizations, Drop-in Centers or Clubhouse that are supported by our Mental Health agencies. AllCare Health has directly funded Peer Support Organizations, including Compass House, Foundations for Recovery, and a developing Recovery Café.

AMERICAN INDIAN/ALASKAN NATIVE

Portions of AllCare Health’s service areas overlap with the service area of three federally recognized tribes: the Cow Creek Band of Umpqua Tribe of Indians, the Coquille Indian Tribe, and the Confederated tribes of Coos, Lower Umpqua, and Siuslaw Indians. AllCare Health’s Behavioral Health contractor (Options for Southern Oregon) in Jackson and Josephine counties holds an MOU for coordination of care and access to services, warm handoffs, and patient release of information with the Cow Creek Band of Umpqua Indians who have AllCare Health members primarily in the Douglas County areas served by AllCare Health. The Coquille Indian Tribe and the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians have been offered by Options for Southern Oregon to negotiate formal MOUs with AllCare Health and, to date, have declined. However, AllCare Health’s behavioral health contractors do provide care coordination, patient release of information, and crisis services to members of these tribes on an individual basis. In addition, AllCare Health currently holds contracts with United Indian Health Services in Curry County. There are no tribal health clinics in Jackson or Josephine counties.

AllCare Health’s DEI Department (Diversity, Equity, and Inclusion) continuously engages with Native American-based organizations locally and statewide to bring training to AllCare Health staff and support specific needs. We host at AllCare Health’s headquarters the Southern Oregon Education Service District (SOESD) Culture and Family Nights every month. This partnership with the SOESD has given us the opportunity to support Native American and Alaska Native youth in Jackson and Josephine Counties. By addressing their unique educational and cultural needs, the program helps students achieve high academic standards.

AllCare is engaging the Department of Veteran Affairs Native American Health and Wellness program to develop best practices with the local FQHCs on providing culturally appropriate care.

AllCare Health provides funding and staff support for the following programs, which are examples of an extensive list of other social services we support through funding as well as staff resources to the following programs:

- Tobacco Cessation programs are available to all members with targeted outreach grouped for the unhoused and members engaged in SUD and/or behavioral health services. Multiple AllCare Health staff participate on community executive boards, committees both on a local and state level, stakeholder meetings and attend outside agency staff meetings to discuss AllCare Health specific members or community needs.
- AllCare Health supports community events by allowing staff to participate in 8 hours of volunteer work each year within the community. As a result, multiple community events have been able to continue annually throughout multiple counties.

MOC 2: Care Coordination

MOC 2 Element A: SNP Staff Structure

MOC 2 Element A Factor 1: Define administrative staff roles and responsibilities

AllCare Health, Inc. is the parent corporation, which owns AllCare Independent Physician Association, Inc., AllCare Health Plan, Inc., and AllCare CCO, Inc. AllCare CCO, Inc. (CCO) is a coordinated care organization, which contracts with the State of Oregon to provide health and related services to individuals eligible for Medicaid health benefits under the Oregon Health Plan. AllCare Health Plan, Inc. (Plan) contracts with the Centers for Medicare & Medicaid Services (CMS) to provide health and related services to individuals eligible for health benefits through Medicare Advantage plans. Within the corporate structure, the Chief Executive Officer oversees the Corporation and reports directly to the Board of Governors. The CEO oversees the Chief Compliance Officer, Chief Operating Officer, Chief Information Officer, Chief Financial Officer, Chief Strategy & Innovation Officer, Chief Human Resources Officer, and Chief Medical Officer as well as several other vice presidents. AllCare Health has an internal dedicated Medicare sales team, as well as dedicated enrollment and marketing staff. The Population Health Department is comprised of two care coordination teams, one team serves the Medicaid members, while the intensive care coordination program (ICCP) provides services to predominantly Medicare Advantage and dually eligible-eligible members. Each care coordination team maintains a separate interdisciplinary team receiving support from other plan departments such as Quality Improvement/Management, Benefit (Utilization) Management, Pharmacy, Customer Care Services, Provider Services and Claims. For this report, the terms Population Health and Care Coordination are used interchangeably.

See Appendix for AllCare Health Leadership Organization Chart.

Administrative Oversight

CHIEF EXECUTIVE OFFICER (CEO)

The Chief Executive Officer has the senior level executive responsibility and reports directly to the governing board. The Chief Executive Officer provides leadership for all aspects of the company's operations with an emphasis on long-term goals, growth, and a focus on a reasonable medical loss ratio. The CEO is responsible for providing strategic and operational leadership for the company working closely with the Board of Governors and the Executive Leadership team.

CHIEF OPERATING OFFICER (COO)

The Chief Operating Officer (COO) reports directly to the CEO. This position remained vacant for several years and is now in the process of being filled. Its responsibilities have yet to be clearly defined.

CHIEF MEDICAL OFFICER (CMO)

The Chief Medical Officer provides clinical leadership system-wide. This position oversees the Credentialing Department and peer review activities associated with the credentialing

process. The CMO or his/her designee recommends practitioners to the Credentialing Committee and other committees as appropriate for review and approval. The CMO or his/her designee ensures and provides oversight for the provider use of clinical practice guidelines within the scope of physician practice oversight. The CMO provides clinical oversight for authorizations and conducts medical chart reviews as indicated. The CMO or his/her designee conducts and/or observes ICT meetings on a non-scheduled basis to ensure that all medical, pharmacological, oral, behavioral health and other service needs are being met for the SNP population. The CMO must be a board-certified Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO).

CHIEF FINANCIAL OFFICER (CFO) – CURRENTLY UNFILLED

The Chief Financial Officer (CFO) reports directly to the CEO. During the interim, the CFO's responsibilities are shared by the VP, Controller & Financial Regulator and the VP, Financial Planning & Analysis, who collectively oversee the organization's financial health, ensuring stability, compliance, and strategic oversight. They manage budgets, cash flow, and financial planning while maintaining internal controls and accurate reporting. Risk management remains a key focus, as they monitor liabilities and implement cost-control initiatives to enhance efficiency. They ensure regulatory compliance, oversee audits, and manage banking relationships to maintain financial integrity. Additionally, they provide financial insights that support executive decision-making, aligning operational needs with long-term financial strategy to ensure the organization's continued stability and growth.

CHIEF COMPLIANCE OFFICER (CCO)

Provides direction and oversight of Compliance and Quality programs. Defines the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and first-tier, downstream, and related entities. Monitors the CMS Complaints Tracking Module (CTM). Identifies and assesses areas of compliance risk. Communicates the importance of the Compliance program to management and employees. Maintains interdepartmental communication on compliance matters. Oversees activities related to the development, implementation, and maintenance of the privacy policies in accordance with applicable Federal and State laws. Responsible for addressing privacy issues, investigating all privacy incidents and breaches, determining steps to mitigate risk, and summarizing and reporting findings. Participates in the development of and conducts training on HIPAA privacy.

CHIEF STRATEGY & INNOVATION OFFICER (CSIO)

Under the direct supervision of the Chief Executive Officer, the Chief Strategy and Innovation Officer (CSIO) is responsible for overseeing the Medicare Advantage line of business, ensuring its financial viability, and submitting required bids, reports, and data requests. Additionally, the CSIO oversees the Customer Care, Enrollment, Brand & Creative Services, and Marketing departments, driving a member-centric approach to operations, engagement, and service delivery. This role ensures that all initiatives align with strategic goals, enhance the member experience, and strengthen the organization's market presence.

CHIEF INFORMATION OFFICER (CIO)

The Chief Information Officer (CIO) develops, plans, and implements an information technology (IT) strategy that meets the company's business needs, delivers an optimal return on investment, and maintains the highest level of security for company operations. The CIO collaborates with members of the executive leadership team to identify ways IT can assist the company in achieving business and financial goals. This position ensures compliance with government regulations that apply to systems operations.

SENIOR VP OF CLINICAL OPERATIONS

The Senior VP of Clinical Operations is responsible for the development and implementation of benefit design and utilization management for medical, behavioral health, and pharmacy and all aspects of pharmacy services. This position provides operational oversight to ensure that plan benefits and utilization activities are aligned with the Quality Improvement Program and under physician review when appropriate, including identification of areas/cases for quality review, analyzing data for trends including over and under-utilization, ensuring regulatory compliance of the utilization management process, and annual review of utilization management criteria.

SR. VP, PROVIDER SERVICE

Ensures the development and maintenance of an adequate, high-performing provider network that supports member access to care and aligns with organizational goals. This includes addressing provider adequacy, fostering strong relationships to enhance engagement and satisfaction, driving quality improvement initiatives, and advancing value-based care models. By collaborating across departments, the SVP integrates provider services with clinical and financial objectives, monitors network performance and promotes strategies to optimize member outcomes and achieve organizational success. Key outcomes include network adequacy, provider satisfaction, and the achievement of quality and financial targets.

VP, HUMAN RESOURCES (VP, HR)

The VP, Human Resources is responsible for developing and executing human resource strategy in support of the overall business plan and strategic direction of the organization, specifically in the areas of employment law, succession planning, talent management and acquisition, change management, organizational and performance management, training and development, and compensation. The VP, Human Resources provides strategic leadership and guidance by articulating HR needs and plans to the CEO, the executive leadership team, shareholders, and the board of governors, as well as guiding labor and employee relations.

VP OF POPULATION HEALTH

The VP of Population Health is responsible for the design, development, implementation, and analysis of the Disease Management Programs for chronic conditions as well as working with the Quality Improvement staff on initiatives that promote health/wellness/prevention. The QIC has oversight responsibility of all Disease Management activities and initiatives conducted

for the Health Plan members. The CMO has overall physician-oversight responsibility for the Disease Management Program development/activities in Health Plan programs.

The disease management programs strive to improve and standardize processes of care, improve chronic condition management, improve member compliance with treatment, perception of their quality of life, sustain improvements made, and decrease medical utilization while not compromising quality of care.

Care Coordination (CC) Case Manager is designed to meet the needs of a population defined as having potential needs above that of the general population. All staff designated as CC support staff participate in interdisciplinary care meetings and seminars that focus on customer service, communication and listening skills, motivational interviewing, knowledge of State and Federal guidelines and rule changes, patient benefit information, internal referral/prior authorization processes, and available community resources. The Care Coordination Team has the potential to bridge services to best meet the needs of those members with special health care needs and chronic conditions.

Administrative Functions

Enrollment and Eligibility Verification

Enrollment Specialists and Enrollment Supervisors are responsible for the following:

- Verify Medicare and Medicaid eligibility.
- Process enrollments and voluntary and involuntary disenrollments according to CMS guidelines and within CMS required timeframes.
- Maintain an internal member database and ensure data accuracy by conducting reconciliation with CMS (TRR - Transaction Reply Report and MMR- Monthly Membership Report) and State Medicaid files.
- AllCare CSIO is ultimately responsible for these functions.

Customer Care

Customer Care Representatives and Customer Care Supervisors are responsible for the following:

- Handle inbound/outbound call center activities.
- Verify Eligibility and member benefits.
- Answer member inquiries.
- Provide information on benefits and services.
- Resolve customer issues and complaints.
- Assist with account management, including member account changes (e.g., Primary Care Provider, Dental Plan, etc.).
- AllCare CSIO is ultimately responsible for these functions.

Claims

Claims Specialists are responsible for the following:

- Process claims for contracted and non-contracted providers.
- Assess payment accuracy and conducts recoveries of overpayment.
- AllCare V.P. Claims Admin. & Business Services is ultimately responsible for these functions.

Appeals and Grievances (A&G)

A&G Coordinators are responsible for the following:

- Intake and resolution of member grievances.
- Coordinates with the Quality Management department in the resolution of member quality of care complaints.
- Intake of reconsiderations and coordination with the Chief Medical Officer/Medical Directors department for resolution.
- Intake for appeals processing.
- AllCare's Director of Quality is ultimately responsible for these functions.

Provider Services and Provider Engagement Team

The Provider Engagement Team is responsible for the following:

- Ensure the provider network meets adequacy standards, addressing gaps in access across specialties and geographic areas.
- Build and maintain strong relationships with providers to enhance engagement, satisfaction, and collaboration.
- Lead efforts to improve provider performance, care quality, and alignment with value-based care models.
- Collaborate across departments to integrate provider services with clinical, financial, and operational objectives.
- Monitor network performance to identify gaps and implement strategies to optimize access and outcomes.
- Act as a primary point of contact for provider offices, ensuring seamless communication and addressing needs.
- Implement initiatives to improve provider satisfaction and reduce administrative burdens.
- Track key performance metrics and provide actionable insights to enhance provider efficiency and outcomes.

Credentialing

The Credentialing Manager is responsible for the following:

- Credentialing and recredentialing providers.
- AllCare Associate Medical Director is responsible for these functions.

Marketing, Sales & Communications

The Marketing Director is responsible for the following:

- Develop communication articles and materials for distribution to stakeholders.
- Develop and distribute plan-specific member & provider educational materials.
- Develop marketing materials.
- Reach out to CCO Members who are new to Medicare and are not enrolled in any fee-for-service Medicare plan and Members not enrolled into AllCare CCO, at least once every calendar year.
- AllCare CSIO is ultimately responsible for these functions.

Finance

The finance team is responsible for the following:

- Collect and analyze financial data to support operations.
- Develop and manage the financial budget and conduct appropriate planning, including actuarial projections.
- Ensure regulatory compliance.
- Oversee audits.
- Manage risk management program.
- Monitor HCC risk adjustment process.
- Reports to the Finance Committee and to the Board of Governors.

Training

VP of Compliance and the Director of Quality are responsible for the following:

- Assess and identify individual and group quality and compliance training needs for employees and contracted staff through key business indicators and develop various training curricula, materials, and aids.
- Coordinate quality and compliance training efforts to meet training demands through peer shadowing, classroom classes and online presence.
- Oversee the auditing of employee teams and contracted staff results and identify gaps in quality and compliance training and implement improvements in training programs.
- AllCare Quality Director is ultimately responsible for this function.

Regulatory & Compliance

VP of Compliance is responsible for the following:

- Assure statutory and regulatory compliance.
- Ensure compliance with HIPAA and Medicare guidelines.
- Manage and implement the Compliance Program.
- Monitor Fraud, Waste and Abuse.
- Provide reports to CMS.
- AllCare CCO is ultimately responsible for this function.

MOC 2 Element A Factor 2: Identify clinical staff roles and responsibilities

The AllCare Health Intensive Care Coordination Program (ICCP) is a comprehensive evidence-based care coordination program to support treatment and management of quality of life for members of AllCare Health's Medicare Advantage plans, including members who are dually eligible. The ICCP team operates within both federal and state regulatory requirements to provide the best possible utilization of member benefits to support health and quality of life.

The ICCP team is made up of both licensed/certified staff and unlicensed staff. Licensed practitioners include Registered Nurses, Licensed Practical Nurses, Respiratory Therapists, and Social Workers. These individuals can serve as Case Owners and coordinate the care plan for identified members. Unlicensed roles include Intensive Care Coordinators who can also function as Case Owners and Community Resource Specialists. Unlicensed Intensive Care Coordinators are Case Owners for Social Determinants of Health and Equity (SDOH-E) focused cases and consult licensed Case Owners for mental health and physical health concerns. Non-licensed staff serve a supporting role and assist the Case Owner and the member in conducting the plan of care. The ICCP team is part of an overall Care Coordination team within AllCare Health's Population Health Department. Another care coordination team focused on Oregon Medicaid members enrolled in the AllCare Health Medicaid Coordinated Care Organization also resides within the Population Health Department and serves as backup to the ICCP team. The ICCP utilizes and works in collaboration with other branches of AllCare Health, including, but not limited to, Benefit (Utilization) Management, Customer Care, Information Technology, Behavioral Health, and Claims and Billing.

AllCare Health will leverage the ICCP team and processes to support its SNP Model of Care. All staff positions that call for an applicable license or other credentials are verified and validated prior to hire by the AllCare Human Resources department.

Population Health Department

Within AllCare Health, Care Coordinators act as guides with accountability for overseeing the community-level team processes and take the lead on cross system/agency collaborations and the pooling of resources. The Care Coordinator acts as one point of entry to a full-service system utilizing resources to ensure all patient care needs are met efficiently and affordably. The term care coordinator is applied to all licensed and unlicensed staff who participate in a member's care coordination efforts. Case managers help monitor the patient and collaborate with physicians to change treatment plans when needed.

The titles of "Case Manager" and "Care Coordinator" are often used interchangeable by AllCare Health. These terms apply to both licensed and unlicensed staff who have the primary responsibility for initiating and overseeing the entirety of the member care plan. This includes Nurses, Social Workers, Respiratory Therapists, Intensive Care Coordinators, or Health Coaches, depending on the member's needs.

Licensed staff are involved in all decisions related to risk stratification, treatment plan goals and member self-management protocols.

Vice President of Population Health

This position is responsible for oversight and monitoring, assessing, planning, implementing, and evaluating all aspects of department programs and for ensuring their financial viability, quality of service, and efficient and effective operations. This position ensures compliance with CMS and Oregon Health Authority (OHA) requirements and deliverables.

Director of Care Coordination Program

This position is responsible for assessing, planning, implementing, and evaluating all aspects of department programs and for ensuring their financial viability, quality of service, and efficient and effective operations. Provides supervisory oversight to the Care Coordination Supervisors, implementation, monitoring and assessment of care coordination programs, involvement with metrics, and assistance with quality improvement concerns.

Care Coordination Supervisor

This position is responsible for providing supervisory oversight to the Care Coordination Team as it works with members receiving care from local agencies, hospital systems, and community partners and for providing program support to the Care Coordination Director or Vice President. Duties includes, but are not limited to, regular chart reviews, compliance monitoring, case assignments, training and reporting analysis.

Care Management – License RN/LPN

This position is responsible for providing the overall assessment and management of the member plan of care to achieve member-defined goals. This includes aspects of chronic disease management, coordination with community providers, and member engagement. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office.

Case Manager – License LCSW

This position is responsible for providing the overall assessment and management of the member plan of care to achieve member-defined goals. This includes aspects of behavioral health and substance use disorder management and addressing social determinants of health. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office.

Social Support Care Coordinator – License MSW

This position is responsible for delivering evidence-based wellness promotion and self-care management solutions. The process shall include assessment, planning, implementation, coordination, and request for services required to meet member's health care needs. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office. This position is a licensed MSW.

Respiratory Therapy Case Manager – License RT

This position is responsible for providing the overall assessment and management of the member plan of care to achieve member-defined goals for those members with a primary respiratory concern. This is targeted towards the specific management of members with respiratory conditions in need of education, training, motivation, self-management, advocating, and compliance support. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office.

Transitions Coordination Nurse (includes Goals of Care) – License RN/LPN

This position is responsible for coordinating behavioral, medical, social, and oral health care needs during transitions from one health care setting to another, or from home, to or from a healthcare setting, to ensure the best quality of care, decreased risk for patient safety issues, and highest level of independence for members. Additionally, this position is responsible for providing support and education to members about chronic disease management, and Advance Care Planning resources and how to access them. This role aids members to establish goals during periods of health transition such as receiving a terminal diagnosis. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office.

Intensive Care Coordinator

This position is responsible for identifying social determinants of health barriers, assisting in navigating the community-based network of services, providing benefit education, facilitating communication between the member and their providers, and assisting in member development of a self-management plan. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office. This position may include licensed or unlicensed personnel.

Community Resource Specialist

This position assists members in their communities to access physical, oral, and behavioral health services by building trusting relationships. This enables the Community Resource Specialist to serve as a liaison linking intermediaries between the member, numerous services, and the community, improving quality and cultural competence for services being rendered. This improves capacity by increasing health literacy, knowledge, and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. The setting for the delivery of service may include telephonic, home setting, provider offices, community partner locations, and in-person at the AllCare Health office. This position includes both Traditional Health Workers (THWs) and Community Health Workers (CHWs).

Positions that are part of the clinical team but reside in other departments include:

Pharmacists

A team of pharmacists provide drug information consultations, pharmacy utilization review and benefit management oversight, and participate regularly with the care coordination team during ICTs and various other meetings. This position requires appropriate licensure, which is monitored by the AllCare Human Resources Department.

Medical Directors

The team of medical directors provides the overall clinical oversight of operations and plan management, including appropriate use of clinical practice guidelines and integration of care transition protocols. The medical directors participate regularly with the care coordination team during ICTs and various other meetings, including benefit (utilization) review and quality oversight that regularly reviews and analyzes data for appropriate and timely health care services. This position requires current state M.D. or D.O. licensure.

Behavioral Health

Staff within AllCare Health work with members to support their behavioral and social determinants of health needs but do not provide direct patient care. Members are referred outside the organization for formal counseling. This team includes licensed and unlicensed staff.

Integral aspects of AllCare Health Care Coordination strategies include:

Assessments: AllCare Health's Care Coordination team assists members in completing the Health Risk Assessment (HRA), and other appropriate health assessments as warranted, requested, or recommended. Ongoing reassessment is performed with modification to the individualized plan of care (ICP) and completing a new HRA when indicated.

Case Manager (CM) and or Care Coordinator: Members enrolled in Care Coordination services receive an assigned case manager (CM) or Care Coordinator who is primarily responsible for coordinating with the member in the development and management of the individualized care plan (ICP) and sharing the ICP with the member's medical care team. The CM works closely with the care coordination team to meet member identified needs and goals. The member may choose another CM or Care Coordinator at any time as they desire.

Individualized Care Plan (ICP): The ICP is developed by the CM in collaboration with the member, the member's caregiver, family, or representative if indicated by the member, and member's providers. The ICP includes the member's preferences, personal health goals, the services needed to meet the member's special needs, and the member's preferred providers who are also included in the interdisciplinary care team (ICT). The ICP outlines and guides coordination for the appropriate care delivery between multiple providers. With the member's consent, the ICP is shared with and reviewed by the member's primary care provider and any other providers authorized to be involved in the member's care. CMs are responsible for ensuring that ICT providers are following the ICP and are communicating appropriately and accurately with one another.

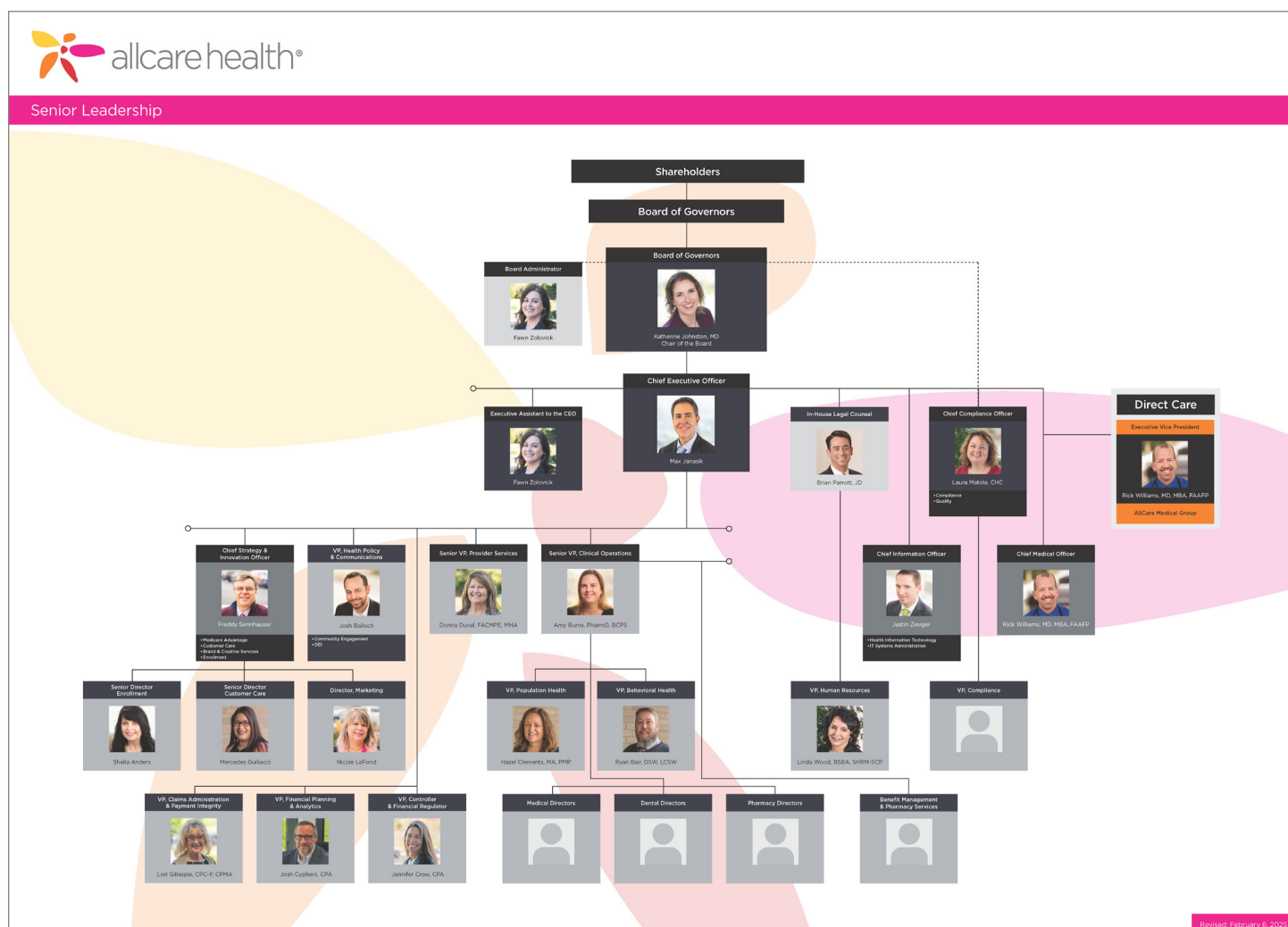
Interdisciplinary Care Team (ICT): The ICT is comprised of the AllCare Health care coordination team to include the CM, medical directors, pharmacy, dental, and utilization management departments, as well as the member and member's caregiver or family as preferred, medical providers, and community partners as appropriate. The ICT assists with reviewing and monitoring the ICP and member progress and navigating barriers to goals and successful outcomes.

AllCare has structured committees to provide additional oversight and recommendations on Model of Care performance, utilization patterns of health services, care transition protocol effectiveness and adoption and implementation of appropriate clinical practice guidelines. These committees report their findings through the Quality Improvement Committee (QIC) and to the Board of Governors. The Chief Medical Officer is a member of the Quality Improvement Committee, Utilization Management Committee, and MOC Steering Committee. Findings during evaluation of the MOC are reported to the QIC, and improvement strategy recommendations from the committee are brought back to the SNP care coordination department leadership for operational consideration.

MOC 2 Element A Factor 3: Provide organization chart

AllCare Health develops, reviews, approves, and maintains role-based job descriptions for every employee. These job descriptions create the foundation for all training, guidance, supervision, monitoring, and feedback regarding employee performance. Job descriptions include roles and responsibilities, reporting structure, education, and licensing requirements, as well as the skills and competencies necessary to effectively perform in the position. Initial orientation and training include a detailed review of the individual's job description. Annual performance evaluations include an assessment of the employee's performance compared to expectations delineated in the job description. The organizational chart on the previous page summarizes how AllCare Health integrates administrative and operational oversight with clinical care coordination for members.

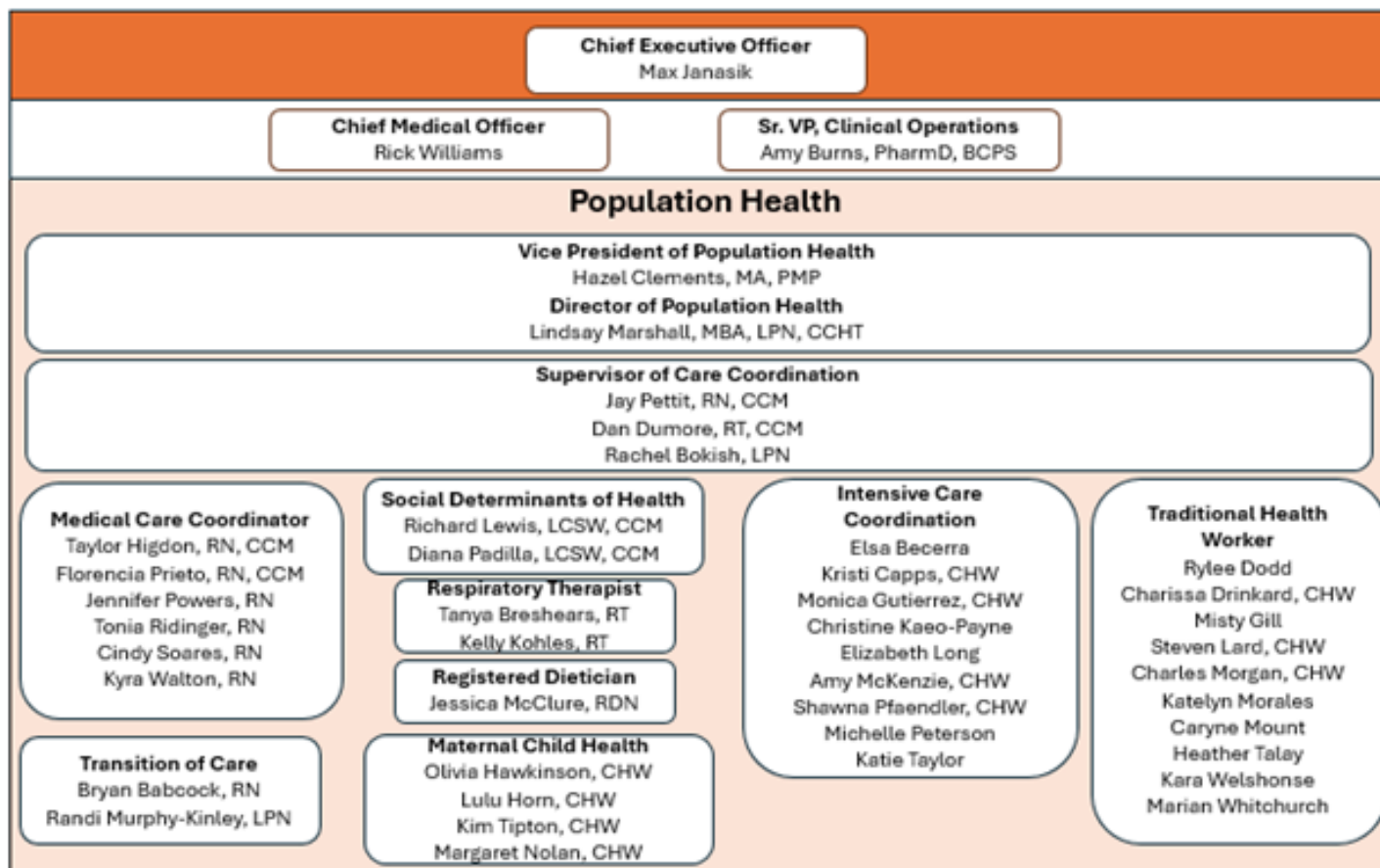
See appendix for larger version



Revised: February 6, 2025

As previously mentioned, the Population Health Department consists of two care coordination teams. These teams are trained in all processes and serve as backups for each other, creating a depth of resources for the organization that will accommodate any changes and ensure consistent ongoing support for the SNP members.

See appendix for larger version



MOC 2 Element A Factor 4: Specify contingency plans

To ensure ongoing continuity of staff functions, AllCare has developed a BCDR (Business Continuity and Disaster Recovery) plan that outlines preparation and activation procedures for any Emergency Performance Interruptions (EPIs), and issued Presidential major disaster or emergency declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services.

AllCare and its delegated vendors have policies and procedures in place in case of emergency and for climate related issues. AllCare is committed to ensuring the continuity of critical business functions under any circumstances, including disaster, crisis, emergency, or other unplanned events. Business continuity plans exist for each critical functional area. They address four primary areas of need: loss of personnel, infrastructure, facilities, and information technology. The management in each functional area creates and maintains mission essential functions for their area and reviews this plan at least annually.

Care Coordination's Disaster Recovery and Business Continuity Plan Policy addresses how essential functions are provided to members during a major or minor disruptive event. The procedure includes how Care Coordination mission-essential functions will be conducted.

AllCare's Business Contingency Plan provides guidelines to follow before, during and after an event, such as a disaster, which may have impacted business operations. AllCare has processes in place to ensure adequate numbers of clinical and non-clinical staff are available to provide Care Coordination services. Clinical and non-clinical staff do not all work in one location and are able to provide back-up to other staff if needed. Care Coordination administrative and oversight staff can work remotely and have the skills to perform normal workday functions offsite in the event they are not able to come into the office due to weather, outages or other disruptions. They can log into their respective electronic system from home, respond to voicemail and emails coordinating with providers and community partners to assist the member.

- If staff are unable to work in the office, designated staff will use laptop computers with remote connectivity (our own encrypted VPN tunnel) to perform care coordination services.
- At a minimum, the following staff will be assigned for remote work:
 1. One Community Resource Specialist.
 2. One Behavioral Health Care Manager (LCSW).
 3. One Clinical Care Manager (RN).
- All remote staff must have access to internet for remote connectivity to AllCare systems and other online verification tools, as well as printing capability and telephone service for contact with members and/or caregivers, providers, delegated vendor(s), and information services.

AllCare also looks to the contracted provider network to be available for members' urgent needs. This includes vendors of equipment, specifically vendors contracted to support respiratory needs. Emergency contact lists are available for these key vendors. Additionally,

all hospitals, long-term care facilities, and community-based health departments are required to have established contingency plans per licensure. Contracted providers maintain consistent availability of service call lines to assist with medical issues that arise during emergencies on a 24 hour, 7 days per week basis. Facilities are required to maintain appropriate levels of staff to provide care and assessment.

Annually, the system and processes are tested to identify that the IT 'fail-over site' is functioning properly. The report is presented to the Board of Governors and the Executive Leadership Team.

MOC 2 Element A Factors 5 & 6: Describe MOC staff training and maintaining training records

Initial and annual refresher training is provided by the AllCare Care Coordination leadership team on the MOC for applicable internal and contracted employees who are responsible and/or involved with the MOC. Employees are identified for the required training through their direct involvement in the MOC, their job descriptions, by their assigned department and by their management. Other employees, such as those who interact with members and providers, may be required to take the training as well.

Training may be provided in any of the following ways:

- Computer Based Training (CBT) and education internally through our current software vendor (internal training and tracking site for all CBT training modules).
- In person and through printed material.
- During staff meetings.
- Power Point presentation via secure online webinars.

The training includes but is not limited to the following topics:

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

Power Point slides of the AllCare Staff training on the SNP MOC can be found in MOC 3 Element C Factor 1.

Initial Training

AllCare Health employees receive MOC training during new employee orientation through the AllCare Health CBT System soon after hire. Training has been organized into a bundled

educational campaign that is a well-rounded training approach containing written policy and procedures, visual/auditory presentation on the MOC via power point, and a knowledge verification check for efficiency of information sharing. The power point presentation includes elements on the importance of the SNP member's health care needs and preferences for health services, care coordination, and transition protocols, and the employee's role in the MOC. Our system verifies and keeps record of employee participation in the campaign bundle upon their electronic attestation denoting completion of the requirement.

When trainings are conducted in person, attendance is documented in the form of meeting minutes and a sign-in sheet with signed attestation statements. Upon completion, this information is given to the Care Coordination leadership team who uploads the information into an electronic file within the AllCare network computer drives to ensure a complete record of each staff person's training attendance, testing, and attestation. When trainings are conducted via secure online platform, attendance is documented in the form of meeting minutes and a sign-in sheet verified by conducting a verbal roll call by management. Management uploads the information into an electronic file to ensure a complete record of each staff person's training, attendance, testing, and attestation.

Contracted entities receive MOC training through Provider Network Services at the time of initial contract and annually thereafter. Trainings may be conducted electronically via secure online platform, webinars or computer-based training, in-person, through the provider portal, or through printed materials. Evidence of training attendance and attestation of completion is stored securely within the AllCare network computer drives.

Annual Training

Annually, management is alerted via email notification of the staff members who need to complete this required training. When staff members log in to the CBT System, the assigned MOC training course is listed on the staff member's required learning list. An interactive CBT module is the preferred initial and annual training approach. The training includes knowledge checks throughout the course to ensure comprehension. Tracking of the completion of the training occurs via the system. All completed training is tracked in each employee's record of completed training. Management is responsible for ensuring employees complete the training and can monitor the training compliance through the electronic training records. At the end of this section is a series of screen shots copied from the CBT to demonstrate the content and format of the training. A participation list is generated from the system for every employee who has completed the training. In addition, each employee receives an electronic verification when the training is completed. Management is responsible for monitoring and confirming the completion of the training and taking any action if they identify employees who are not compliant per AllCare Health's Employee Disciplinary Action Policy.

When annual trainings are conducted in-person by the Care Coordination leadership team, attendance is documented in the form of meeting minutes with a sign-in sheet and signed attestation statements. This information is the responsibility of the Care Coordination leadership team who files the information electronically into the AllCare network computer

drives to ensure a complete record of each staff person's training attendance, testing and attestation. When trainings are conducted via secure online platform, attendance is documented in the form of meeting minutes and a sign-in sheet verified by conducting a verbal roll call by management. Leadership uploads the information into an electronic file within the AllCare network computer drives to ensure a complete record of each staff person's training, attendance, testing, and attestation.

The Care Coordination leadership team monitors their staff to ensure all who are required to take the training complete it timely. The annual training is not optional and must be completed by the deadline set by management. The CBT System sends multiple reminder notices to management prior to the training due date. Shortly after the training deadline has passed, the director obtains attestations from managers indicating that all required staff have completed the training timely. The training is also included in the new hire orientation agenda.

A report is generated by the manager(s) that aggregates both the in-person and CBT training attestations. This is provided to the Director who can take action if there are employees who have not completed training. The report has information such as: name, employee ID, department, registration date, completed date, and manager contact information. Each manager can generate a team report to track this information on an ongoing basis.

Clinical teams receive an intensified training that connects the MOC to their role in the organization. This more detailed training is based on roles and responsibilities during new staff orientation. Additionally, ongoing training is provided to all applicable staff to communicate changes or reinforce processes as needed. Training and education are offered in a variety of ways, including:

- Group training classes on systems, protocols, and policies
- Independent training through online technology
- Conferences to review and answer more detailed questions on protocols, processes, and best practices.
- Shadow existing clinical staff.

Contracted entities that directly interact with SNP members are provided the training digitally upon contract signature and annually thereafter. Trainings may be conducted electronically via secure online webinars or computer-based training, in-person, through the provider portal, or through printed materials. Evidence of training attendance and attestation of completion is stored securely within the AllCare network computer drives.

MOC 2 Element A Factor 7: Address incomplete or deficient training

Every AllCare Health staff member and contracted entity with SNP MOC Program responsibilities is required to participate in the SNP MOC Program Training. All trainings are given with a specified date of completion. Population Health leadership is responsible and held accountable for the oversight and assurance of the mandatory SNP MOC Program Training implementation, completion, and compliance. Managers are responsible for reviewing the record of their employees for compliance with this requirement and reporting to their director

any staff who have not completed training, signed the training attestation or staff who have not received training completion certificates. This direct oversight and accountability ensure all staff will have met and understand the SNP MOC Program Training requirements. Staff who do not meet the requirements set forth by the Population Health Staff and Provider Training policies and procedures may be remediated for disciplinary action. This includes re-education, training and/or one-on-one instruction. If an employee does not complete training as required, deficiency of training will be addressed and documented during staff annual evaluation and/or disciplinary action will be coordinated with the HR Department. The Director and the management team monitor the completion of the training. We expect minimal challenges to exist due to the effective way training and tracking is performed. However, we do anticipate that resource constraints, the current work from home environment, and increased sick days may challenge our ability to ensure all staff complete the training. If a manager identifies staff who have not completed training or if staff do not attest timely, the manager escalates to the next level of leadership for prompt attention. Management escalation continues until all required staff have completed the training. Leadership is engaged as needed to ensure training is completed timely and to initiate disciplinary action if necessary. Disciplinary action may include performance improvement plans up to dismissal. The Care Coordination team works closely with the Human Resources Department for all disciplinary corrective actions. All efforts will be made to ensure compliance.

Additional challenges that may occur with the training include missing the deadline assigned to complete the training. Actions that may occur if this training deadline is missed include scheduling time during the workday to complete the training, assigning a new date for training to be completed, assessing why the training has not been completed, and disciplinary action as part of our performance management process per AllCare Health's Employee Disciplinary Action policy.

Contracted entities who demonstrate non-compliance with MOC training will be contacted by Provider Network Services for remediation. The applicable language in the contract will be reiterated and all efforts will be made to ensure compliance. If continued non-compliance is identified, this will be referred to AllCare Health's Chief Compliance Officer for further outreach. The disciplinary action may include a corrective action plan and if necessary, potentially escalate to loss of contract.

MOC 2 Element B: Health Risk Assessment Tool (HRA)

MOC 2 Element B Factor 1 & 2: Conduct initial and annual HRA assessments & Use of HRA Information to develop the ICP

Throughout this section of the SNP MOC, we refer to the HRAT as the HRA.

On a weekly basis, the AllCare Health Care Coordination leadership team reviews a data dashboard that tracks both newly enrolled and currently enrolled members. This data dashboard includes enrollment dates and the status of each member's HRA, highlighting whether the HRA is current, overdue, or missing. An initial HRA is sent to each SNP member upon enrollment. This HRA is a proprietary tool that evaluates their medical, functional,

cognitive, psychosocial, and mental health needs and is distributed through standard mail by the enrollment department. If there is no response to the mailed HRA within 30 days of enrollment as noted by the weekly enrollment list, then two mixed modalities (e.g., paper digital or verbal), on different days, and at different times and should be in the members preferred method of communication and language. Outreaches are attempted by the care coordination team within the following 14 calendar days and are documented within the AllCare Health Care Management System. Completed paper HRAs are scanned into the AllCare Care Management System within one business day of receipt and are transcribed by care coordination staff into the Care Management System within two business days. HRA results are evaluated by clinical staff for evaluation, stratification, and appropriate case assignment within one business day of receipt of HRA transcription within the electronic Care Management System. Member stratification for appropriate case assignment occurs utilizing AllCare Health's Care Management pathways. After determining the member's appropriate care management pathway, AllCare Health care coordination management evaluates the suitable mix and intensity of care coordination services and activities within the designated pathway based on the member's initial identified medical, functional, cognitive, psychosocial, and mental health needs. The four pathways include Risk Management, Wellness, Complex Population Health, and Behavioral Health. Once the appropriate pathway is identified, care coordination management assigns the member to an appropriate care coordinator within three business days using the electronic Care Management System, often followed up with an email notification by management to the care coordinator at the time of case assignment. The member is initially assigned to a care coordinator in referred status, while awaiting to be assessed by the care coordinator who will assign an acuity level to the member upon initial member contact and assessment to help identify and determine the level and frequency of outreach necessary to meet the member's needs. An automated initial care plan is started upon this assignment, which also initiates a Program Welcome Call, tasked to occur within one business day of case assignment by management.

Care coordinators use the results of the HRA to guide the creation of the member individualized care plan (ICP) within three business days of case assignment. The ICP is comprised of goals, interventions, tasks, problems, barriers, and outcomes. The problems are specific to identify issues based on the member's answer to a particular question within the HRA. The intervention is targeted to address the associated problem, and the task accompanies the intervention. Care coordinators then work with the member to identify member-led appropriate short and/or long-term goals, which is reflected within the ICP. Any urgent issue that requires immediate attention, depending on the nature of the issue, is referred to the appropriate individual for urgent intervention to be acted on within one (1) business day of notification. All information is documented per protocol resulting in the development of an ICP that can be shared and disseminated to the interdisciplinary care team (ICT). Upon completion of the HRA process, an HRA summary and Individualized Care Plan is generated. This information is shared with the member, members representative, the member's PCP, other providers, and community supports as appropriate, at the start of care coordination

services, with any change in member's health status, and at least every 90 days. It may also be sent to other possible ICT participants (not an exhaustive list), such as:

- Specialist.
- External case managers.
- Social workers.
- Mid-level providers, such as nurse practitioners.
- Pharmacists.
- Health educators.
- Behavioral health providers.
- Medical director.

The composition of the ICT will be individualized according to the beneficiary's medical, functional, cognitive, psychosocial, and mental health needs to further enhance the quality of care and elicit additional information and member engagement. Any identified barriers and additional data from the member's Medicaid plan, historical claims and information from other electronic records are also used to develop the ICP. The ICP is created with the member and their support system with additional supports by the Case Owner, using a trauma-informed, culturally responsive, and linguistically appropriate approach.

Members are sent a reassessment HRA near the end of each calendar year as part of the annual reassessment process. A reassessment HRA is also completed upon identification of a change in member's health status. Completion of the reassessment HRA helps to identify member progress in stated health goals or may show decline in health status. Member non-responses to the HRA or inaccessibility of the member to complete the HRA are also documented and may influence adjustments to the initial plan of care, including developing new strategies for outreach and engagement. Members may be further assessed for their desire and readiness to engage in health management, their level of Activities of Daily Living (ADL) function, community living skill ability, fall risk, smoking risk, behavioral risk, and/or use of urgent or emergent care. Like the initial assessment, risk factors and barriers identified through the HRA are addressed through goals, interventions, and a plan for follow-up. Care Coordinators work directly with the member to achieve goals outlined in the ICP. The ICP is revised to address new barriers, risks or changes in health status identified in the HRA. The ICP is updated to include new treatment and care intervention needs, linkage with resources, specialty support, and/or referrals to support services. All timelines for the above actions are the same as the timelines for the initial HRA and ICP steps.

The HRA is a comprehensive and standardized tool, which contains proprietary clinical content designed to identify the specialized needs of each member. The HRA includes information about their health habits and behaviors, health needs, health history, as well as changes in health status. The HRA can be delivered telephonically with a care coordinator or self-completed on a paper form. Components of the HRA include assessment of current medical, psychosocial, dental, functional, cognitive, and mental health needs or previous history.

SNP members receive the initial HRA immediately upon enrollment through standard mail by the enrollment department, along with a mailing, which includes a Member Handbook that provides a brief introduction into the program and directions on how to obtain more information. This information is also available online at the AllCare Health public website.

For those members who return a mailed-out HRA with identified needs, the case is assigned by care coordination management within three business days of HRA evaluation to a Care Coordinator who will outreach to the member by telephone to share information related to the member's HRA results and offer care coordination services. Intervention alerts are created in the Care Management System to track calls and flag members for follow-up. An HRA dashboard is monitored by the Population Health leadership team weekly. AllCare ensures an initial HRA is conducted within 90 days by Care Coordination leadership who reviews the dashboard and tracks and prioritizes members for telephonic outreach if 30 days have elapsed without a response to the mailed-out HRA. Upon a successful contact, all telephone numbers and member address information are validated and updated as appropriate. If the maximum number of contact attempts has been made and the outreach remains unsuccessful over a period of 30 days, the member's status is recorded as "Unable to Reach" (UTR) due to maximum attempts. If the outreach is unsuccessful because the member's phone number is invalid, the member's status is also recorded as "Unable to Reach" (UTR) due to invalid phone number. All attempts are made to obtain a valid phone number, including, but not limited to contacting their assigned PCP or other identified participants in their care. Members whom the program is unable to contact after three (3) outreach attempts, (e.g., paper digital or verbal), (have invalid telephonic information or decline HRA activities, will receive a system generated ICP covering overarching program goals, which include completion of the HRA, use of 24/7 nurse advice services, and claims identified gaps in care and conditions. This ICP is mailed to the member's address of record, which includes information and a request for outreach to the program for enrollment into care coordination services and HRA completion. A member's health plan coverage is not contingent upon their engagement in care coordination services or completion of the HRA.

Community Resource Specialists attempt to reach out to members who are identified as high risk. This could include home visits or meeting members during provider office visits. However, if the member is reached by phone and declines to complete the survey, the member's status is recorded as "Opt-Out". In the event the member is reached but wishes not to take part in the care coordination program, the member's status is recorded as declined and marked as 'Do Not Call.'

All currently enrolled members who remain enrolled in the special needs plan will have an annual HRA within 365 days or less, of last HRA date. Similarly, to the initial assessment, the annual HRA can be delivered telephonically with a care coordinator or self-completed on a paper form but starts with a mailed request. Components of the HRA include assessment of current medical, psychosocial, oral, functional, cognitive, and mental health needs or previous history.

The same process for the initial HRA applies for the annual HRA as well. If a member was previously marked as 'Do Not Call', they will still receive a mailed-out HRA at annual reassessment.

Through the course of care coordination, a need to complete an HRA outside of the initial and annual reassessment process may be identified. This could be because of a care transition such as discharge from a hospitalization, a triggering health care event, or a change in health status. When this occurs, the assigned Care Coordinator will reach out to the member within three calendar days of event notification to complete a reassessment HRA. If they successfully reach the member, a member of the care coordination team will complete the HRA within the Care Management System within one business day of reassessment HRA completion. In the case of a care transition, a transition of care nurse will be assigned to the member's case by care coordination management within one business day of event notification.

Care Coordinators use the results of the HRA to guide the creation of the member's individualized care plan (ICP), which is developed within three business days of the member's consent and enrollment into care coordination services. The ICP is comprised of goals, interventions, tasks, , barriers, and outcomes. The barriers are specific to identified issues based on the member's answer to a particular question within the HRA. The intervention is targeted to address the associated problem, and the task accompanies the intervention. Care Coordinators then work with the member to identify member-led appropriate short and/or long-term goals. Any urgent issue that requires immediate attention, depending on the nature of the issue, is referred to the appropriate individual for urgent intervention to be acted on within one business day of notification. All information is documented per protocol resulting in the development of an ICP that can be shared and disseminated to the interdisciplinary care team (ICT). Upon completion of the HRA process, an HRA summary and ICP is generated. This information is shared with the member, the members representative, the member's PCP, other providers, and community supports as appropriate, at the start of care coordination services, with any change in member's health status, and every 90 days. It may also be sent to other possible ICT participants (not an exhaustive list), such as:

- Specialist.
- External case managers.
- Social workers.
- Mid-level providers, such as nurse practitioners.
- Pharmacists.
- Health educators.
- Behavioral health providers.
- Medical director.
- Discharge planner.

The composition of the ICT will be individualized according to the beneficiary's medical, functional, cognitive, psychosocial, and mental health needs to further enhance the quality of care and elicit additional information and member engagement. Any identified barriers and additional data from the member's Medicaid plan, historical claims and information from other

electronic records are used to develop the ICP. The ICP is created with the member and their support system with additional supports by the Care Coordinator, using a trauma-informed, culturally responsive and linguistically appropriate approach.

MOC 2 Element B Factor 3: Disseminate HRA information to ICT

AllCare Health requires that all information identified in the HRA, through the initial assessment, annual reassessment, and triggering event or health status change reassessment, be integrated, and addressed in the ICP. The ICP is then shared with the member and consented support systems as well as the member's confirmed primary care provider (PCP) and LTSS case manager, as applicable, upon initiation of care coordination services, with any change in health status, and at least every 90 days. The ICP, located in the Care Management System, clearly documents member needs, stated goals, clinical guidelines in use, actions to be completed, who will complete them and establish the timeframe for completion. The ICP is then emailed to the internal ICT and stored securely and accessibly within the AllCare Health computer network drives at least one day prior to the scheduled weekly ICT meetings in an organized and succinct SBAR (Situation, Background, Assessment, Recommendation) format by the care coordination management team. This ICP is also faxed or telephonically communicated to the external ICT members by the Care Coordinator at least one day prior to the scheduled weekly ICT meetings. The internal ICT can further access additional member information from the Care Management System. Information identified in the HRA is also communicated through direct discussions in-person/telephonic/virtually, between the Care Coordinator and the member, during ICT meetings, through telephonic outreach, and written communication to members and providers through letters and/or fax.

All communications are documented in the Care Management System by the Care Coordinator for access and sharing across the ICT. Care Coordinators work to assure that all required ICT members attend meetings and are engaged in identifying solutions to address needs identified by the HRA. Care Coordinators document all relevant information into the system to support up-to-date member status, ICT participation, and ICP adjustments within one business day of weekly ICT meeting completion.

Member clinical status, HRA results, and other clinical data is shared during the weekly ICT meetings. The ICP is updated within one business day based on ICT discussion and includes interventions and goals, and the associated timeframes. The updated ICP may be shared with the member/caregiver face-to-face, verbally by phone, or sent via mail.

A health status change or care transition will initiate a re-assessment HRA outside of the initial and annual re-assessment process. As described in MOC 2 Factor 2 above the organization has processes in place for enrollees that cannot or do not want to be contacted or complete the HRA.

For members, member representative/caregivers who are unable to be contacted after multiple attempts or refuse to complete a HRA or other assessment, the Care Coordinator will document the refusal in the Care Management System. The Care Coordinator and/or

Care Coordination team will collect available information to inform the ICP, such as claims, pharmacy or other information. Members who are unable to be contacted or refuse to engage in the HRA or ICP process will be monitored for changes in condition. If a change in condition resulting in a care transition occurs, the Care Coordination team will attempt to contact the member/caregiver to conduct the HRA or other appropriate assessment and incorporate the findings into the ICP. Updated information will be communicated to the appropriate ICT participants via the communication methods described above.

MOC 2 Element B Factor 4: Explain HRA methodology and communication plan

Needs identified through the HRA, and predictive modeling process often include gaps in established care protocols, including potential medication non-adherence and the need for visits to primary care or specialty care indicated for their optimal condition management. The HRA, when performed, is designed to identify barriers or safety risks that require follow-up for additional evaluation and coordination of care and services. Upon completion of the HRA, the ICP is created or updated within three business days.

The HRA also identifies, regardless of diagnosis, members who may have needs for care coordination and additional evaluation, for example, positive screen for depression on the Patient Health Questionnaire-2 (PHQ2), food and housing insecurity, emotional or physical abuse, worsening health status, barriers to care, ancillary equipment needs, and other concerns amenable to intervention and/or recent emergency department visits. Upon evaluation of identified needs, members can be referred into care coordination for more intensive intervention. Care Coordinators ensure customized support, which may include assistance with arranging transportation or medication review, help scheduling and coordinating appointments, and assistance obtaining prior authorizations or durable medical equipment. Once a member's needs have been adequately addressed, they can be deescalated to a less intensive acuity or transitioned to self-management. Reviewing, analyzing, and stratifying the HRA results assists AllCare in ensuring members with the greatest needs are addressed as expeditiously as possible. AllCare Health uses four Care Management pathways to stratify and identify the most supportive and appropriate care coordination strategy that will best meet each member's unique needs to target and improve health outcomes.

The results of the HRA and member stratification are documented within the ICP by the Care Coordinator who also discusses the results with the member and member's representative or caregiver and shares the results with the member's PCP and member through a follow-up letter upon initiation of the ICP. The frequency of contact with the member is driven by the member's risk segment, acuity, and vulnerabilities identified upon completion of the HRA. Care Coordinators use the results of the HRA to guide the creation of the member ICP, which is available to the internal ICT in the Care Management System, and made available to the external ICT, provider network, and other SNP personnel involved with overseeing the plan of care via mail/fax/telephone/face-to-face interactions.

Care Coordinators, who may be Nurses, Social Workers, Respiratory Therapists, Intensive Care

Coordinators, or Health Coaches, depending on the member's concerns, work with members to understand and address their needs. When eligible, members may be enrolled in special care pathways to focus on medication adherence, care visit compliance (ensuring follow-up with appropriate specialists), biometric monitoring, or readmission avoidance if they have recently been discharged from the hospital.

Clinical staff and care coordination management review every member's HRA results for evaluation, risk stratification, and appropriate case assignment within one business day of HRA completion, as documented in the electronic Care Management System. During the member risk stratification process, the AllCare Health care coordination team collaborates with community providers to ensure care coordination approaches can meet the unique needs of each member in every population. This occurs utilizing AllCare Health's Care Management pathways, which help to further determine the member's health risk and special needs. After determining the member's appropriate pathway, AllCare Health care coordination management evaluates the suitable mix and intensity of care coordination services and activities within the designated pathway based on the member's initial identified medical, functional, cognitive, psychosocial, and mental health needs. The four pathways include Risk Management, Wellness, Complex Population Health, and Behavioral Health. Once the appropriate pathway is identified, Care Coordination management assigns the member to an appropriate Care Coordinator within three business days using the electronic Care Management System, often followed up with an email notification by management to the Care Coordinator at the time of case assignment. The member is assigned to a Care Coordinator in referred status, while awaiting to be assessed by the Care Coordinator who will assign an acuity level to the member upon successful initial member contact to help identify and determine the level and frequency of outreach necessary to meet the member's needs. An automated initial care plan is started upon this assignment, which also triggers a Program Welcome Call, tasked to occur within one business day of case assignment.

AllCare Health's approach includes four Care Management Pathways:

1. **Risk Management:** Members Opting Out of services, or are Unable to Reach, for: either HRA completion or participation in Care Coordination services.
2. **Wellness:** No identified health care risks, special needs, or conditions requiring treatment or management.
3. **Complex Population Health:** One physical chronic disease, two or more co-occurring physical chronic diseases, co-occurring physical and behavioral health chronic disease, or meeting the qualifications of the identified "most vulnerable".
4. **Behavioral Health:** Mental Health, Substance Use Disorder (SUD), Behavioral Health Dual Diagnosis.

Each AllCare Health Care Management pathway is designed to incorporate standardized care management strategies, evidenced-based activities, and clinical practice guidelines that guide the delivery and intensity of services provided according to the member's identified

risk segment, specialized needs, and personal preferences. The intensity of services provided is in accordance with how often and what type of service delivery is required to meet the member's specific needs and health care goals.

In the event that a member or member representative cannot be reached for HRA completion by a Care Coordinator, or does not return a paper HRA, they will be designated to the Risk Management pathway (after the appropriate amount of outreach attempts) where they will receive ongoing monitoring and support year-round by the benefit (utilization) management and care coordination teams through claims data review and utilization analysis to identify gaps in care or inappropriate or over-utilization of services that may indicate a change in the member's health status or identify a triggering event. If these are identified, the care coordination management team assigns the member a care coordinator within three business days of event notification. The care coordinator will reach out to the member to offer services within one business day of case assignment.

When completing the HRA, if a member is found to have no needs for resources or if they decline services, they will often be designated by care coordination management to the Wellness Pathway for self-management with ownership of the ICP delegated to the member's PCP with review by AllCare Health as needed with changes in health status or identified triggering events and at least annually. Members will be monitored by care coordination management through claims data to ensure they receive an ICT meeting with their PCP or other participants of the member's ICT at least annually.

When completing the HRA, if a member is found to have current needs for resources or services, they will be stratified by clinical staff along two designated pathways: Complex Population Health or Behavioral Health. During the member stratification process, the AllCare Health care coordination team collaborates with community providers to ensure care coordination approaches can meet the unique needs of each member in every population. AllCare Health's Care Management Pathways help to further determine the member's health risk and special needs. After the HRA results are evaluated by care coordination management, the management team further identifies the suitable mix and intensity of care coordination services and activities needed based on the member's initial identified social, behavioral, and medical needs, thereby determining the member's appropriate stratification along one of the four AllCare Health Care Management pathways. The member is then assigned to a Care Coordinator by the care coordination management team within three business days of stratification.

AllCare Health Care Management Pathways

Risk Management Pathway

The Risk management pathway is aimed at monitoring and supporting members declining the HRA or care coordination services, especially if there has been an indicator that a member has a complex or chronic health condition. This pathway is managed by the AllCare Health Care Coordination team, including management, who regularly review member data and local

healthcare system reporting to identify gaps in care, or an inappropriate or over-utilization of services that may indicate a change in the member's health status or a triggering event. If these are identified, the care coordination management team assigns the member a Care Coordinator within three business days of event notification. The Care Coordinator will reach out to the member within one business day of case assignment to offer services and provide assessments and education if accepted. The CM will collaborate with the member's primary care provider to provide a member update and enlist support with member engagement.

Wellness Pathway

The Wellness pathway is aimed at members whose assessment results do not indicate the member has any specific health risks, special needs, or conditions requiring treatment or management. Members who fit within this pathway are managed by the care of their PCP to provide support related to accessing preventive services and helping them stay current with their preventative care. Members in the Wellness pathway receive an annual HRA as an ongoing risk assessment, and a Member Handbook with access to the AllCare Health website. Members along this pathway may at times end up in the Risk Management pathway in instances where pertinent member data is discovered, requiring follow-up from care coordination.

Complex Population Health Pathways

These pathways are aimed at the most vulnerable members with chronic, complex, and/or costly health conditions in need of care management. Depending on the member's condition, they may fit into one of three pathways: One physical chronic disease, two or more co-occurring physical chronic diseases, or co-occurring physical and behavioral health chronic disease. Each of the three pathways is further delineated into two levels.

One Physical Chronic Disease

This pathway is aimed at members who have been diagnosed with one physical chronic disease. These members are assigned to a physical chronic disease management case manager (CM). The CM performs an assessment and reviews the results for clinically significant signs and symptoms according to evidenced-based guidelines and collaborates with the member's PCP. Based on the assessment results, the members follow one of two intensity care management levels: managed and unmanaged.

- **Level 1: Managed Conditions:** Members in this level have one chronic disease that is being well managed by the member and their medical providers. The assigned CM provides regular contact with the member:
 - o Monitoring and ensuring compliance with the evidence-based disease management, medication, and treatment plans in place.
 - o Monitoring the medical team's compliance with evidence-based chronic disease management guidelines.
 - o Providing reminders to members of provider visits, tests, and immunizations.
 - o Assisting members with accessing specialty providers and social support services

when indicated.

- o Providing members with educational materials regarding disease management self-care.
- o Facilitating transition of care episodes related to their chronic condition.
- o Monitoring for signs or symptoms of any deterioration of their health condition and reporting concerns and health status changes to the member's primary care provider.
- **Level 2: Unmanaged Condition:** Members in this level have a chronic condition that is not well managed, with chronic condition signs and symptoms that are not under control, and/or whose condition has resulted in one or more hospitalizations related to the condition. Including all the above aspects from level one, contact between the member and CM increases in frequency. The CM facilitates ICT meetings to address increased needs.

Co-Occurring Physical Chronic Disease

This pathway is aimed at members who have been diagnosed with multiple chronic diseases or conditions. These members are assigned a physical chronic disease management CM. The CM performs an assessment and reviews the results for clinically significant signs and symptoms according to evidence-based guidelines and collaborates with the member's primary care provider. Based on the assessment results, the member follows one of two intensity care management levels: managed and unmanaged.

- **Level 1: Managed Conditions:** This level is for all members with complex or costly health conditions. Those whose conditions are well managed remain in this level and have a CM to help them continue to manage their conditions. The CM assists with social service supports and conducts face-to-face assessments, ICP development, and follow-up as determined by the member's health condition and preferences.
- **Level 2 - Unmanaged Conditions:** If the member's health requires it, all aspects of care management interventions in level one are intensified, including increased contact frequency. Specific care management activities and services provided include care system navigation, health education and motivational interviewing, and care coordination, as well as self-management plan development and medication reconciliation activities when applicable. Members appropriate for this pathway electing not to follow it are referred to the Risk Management pathway.

Co-Occurring Physical and Behavioral Health Chronic Disease

This pathway is aimed at members who have one or more physical chronic disease along with a mental health diagnosis and need assistance due to the co-occurring conditions. Based on the severity of their needs, members in this pathway follow one of two levels:

- **Level 1:** Members in this level have a chronic physical disease along with a mental health diagnosis and have experienced one hospitalization for one or both conditions or are identified as high utilizers. The member is assigned a CM and follows the ICP process. If the member's condition(s) worsens, the member moves to Level 2.

- **Level 2:** Members in this level have a chronic physical disease along with a mental health diagnosis or one chronic disease and serious mental illness (SMI), and they have experienced one hospitalization for any one of the conditions or are identified as high utilizers in more than one area. In addition to the assigned CM, the member is assigned a Social Support Care Coordinator within Behavioral Health. The team collaborates to assist the member to ensure compliance with appropriate follow-up care, services, and treatments. The CM continues with social supports and services via the ICP and ICT processes.

Behavioral Health Pathways

The Behavioral Health pathways are aimed at the most vulnerable members afflicted with mental health issues, substance use disorders, and behavioral health dual diagnoses. These members are assigned a mental health or social support care coordinator. The care coordinator performs an assessment and reviews the results for clinically significant signs and symptoms according to evidenced-based guidelines and collaborates with the member's primary care provider and other participating mental health providers. Based on the assessment results, the member follows one of three behavioral health pathways: Mental Health, Substance Use Disorder, or Behavioral Health Dual Diagnosis.

Mental Health Pathway

This pathway is aimed at members with a serious and persistent mental illness (SPMI) diagnosis or other mental illness identified through utilization data review or by referrals and are triaged into one of two levels of care management. These members are assigned a mental health or social support care coordinator to provide technical support, provider network service access coordination, and member service utilization notification and reporting. Members following this pathway receive care navigation, health coaching, care coordination, case management, and condition management services.

- **Level 1:** Members in this level are those who have a mental illness but do not require continuous mental health services or psychiatric medications. If the member's mental health condition diminishes, the member is immediately referred to the Level 2 pathway. If the condition improves, the member returns to the level 1 Mental Health pathway.
- **Level 2:** Members in this level are those who are identified as having a serious and persistent mental illness (SPMI) as specified within the ICD-10 code and DSMVI-TR/DSM 5 and require continuous mental health services or psychiatric medication adjustments. In addition to mental health care coordination services, members in level 2 are supported by the care coordination team with care navigation assistance for accessing preventive care, engagement with their behavioral health provider, and/or additional services if identified as a need through the HRA.

Substance Use Disorder Pathway

This pathway is aimed at members experiencing substance use disorders identified through utilization data or referrals. Care management strategies include selecting a SUD treatment provider to arrange the start date of treatment, assisting the member with any identified

transportation needs, making referrals required for physician or pharmacy use while in treatment, and conduct follow-up care navigation and care coordination services. These members are assigned to a mental health or social support care coordinator and are triaged through one of two levels of care management.

- **Level 1:** Members at this level are those who are entering treatment for the first time. The care coordinator, in collaboration with the member's treatment coordinator, follows the member during his/her treatment to ensure treatment needs are met. The care coordinator obtains the discharge summary and works with the member to set up the services and supports that are recommended by the treatment team for the navigation of care services.
- **Level 2:** Members at this level are those who are experiencing relapse(s) after treatment. The care coordinator, in collaboration with any treatment coordination provider, either through the county, tribe, or through the treatment provider, follows the member during his/her additional rounds of treatment and ensures that his/her treatment needs are met by providing care navigation and care coordination services. The care coordinator and treatment coordinator discuss the member's progress during treatment.

Behavioral Health Dual Diagnosis Pathway

This pathway is aimed at members who are struggling with substance use disorder along with a serious and persistent mental health (SPMI) diagnosis. These members are assigned a mental health or social support care coordinator. These members follow one of two levels of care management.

- **Level 1:** Members in this level are those who are entering dual diagnosis treatment for the first time needing coordination of the substance use disorder treatment, mental health treatment, and other services. The care coordinator, in collaboration with the member's treatment coordinator, follows the member during his/her treatment to ensure treatment needs are met. The care coordinator obtains the discharge summary from the dual diagnosis treatment center and works with the member and the member's ICT to implement the member's care plan, including arranging and coordinating services and supports recommended in the discharge summary for both substance use disorder and mental health follow-up through providing care navigation and care coordination services. Care coordinator contact frequency continues based on ICT recommendations. More frequent contact is provided if needed or requested by the member.
- **Level 2:** Members in this level are those who are experiencing relapse(s) after dual diagnosis treatment in either their substance use disorder treatment or their mental health treatment. Relapse for substance use disorder means the resumption of use of their substance of choice or another substance. Relapse for mental health is when members fail to follow their psychiatric medication therapy and/or their outpatient services care plan. The care coordinator follows the member during his/her second round of treatment and, in collaboration with the member's treatment coordinator and the member's mental health provider, ensures that his/her treatment needs are met

through providing care coordination services. The care coordinator, treatment coordinator, and mental health provider discuss the member's progress during treatment. The member stratification and HRA results are documented in the ICP within the electronic Care Management System by the Care Coordinator, who also discusses the results with the member and member's representative or caregiver and shares the results with the member's PCP and member through a follow-up letter upon initiation of the ICP. The frequency of contact with the member is driven by the member's risk segment, acuity, and vulnerabilities identified upon completion of the HRA. Care Coordinators use the results of the HRA to guide the creation of the member ICP, which is available to the internal ICT in the Care Management System, and made available to the external ICT, provider network, and other SNP personnel involved with overseeing the plan of care via mail/fax/telephone/face-to-face interactions. Additionally, Care Coordinators are responsible for further member stratification by evaluating and assigning an acuity to all their members. AllCare Health uses an acuity system of 1-4, which determines the level of intensity and frequency of outreach efforts necessary to meet the member's unique needs. The tiering process establishes the intensity of involvement required to meet the needs of the member. Care Coordinators must routinely reevaluate member acuity status and update it as appropriate.

Acuity Level	Description
1	Member has most needs in place and is low risk. Member may need 1-2 calls total from Care Coordination, i.e., DME or new PCP.
2	Member is low to moderate risk and needs support from Care Coordination every 4-6 weeks.
3	Member is moderate risk and needs support from Care Coordination every 2-4 weeks.
4	Member is high risk and needs weekly support from Care Coordination to manage health.

In addition, AllCare Health uses claims data and advanced predictive modeling to determine risk scores for the following:

- Identification of beneficiaries who qualify as "most vulnerable".
- Future high dollar expense (i.e., members listed for possible future organ transplant).
- Behavioral health risk.
- Chronic condition risk.
- Gaps in care risks.
- Mortality risks.
- Admission risks.
- Social determinants of health risks.

Depending on the identified needs and goals of the member, care management activities can include all the following strategies:

Systems of Care Navigation

Providing culturally and linguistically appropriate services (CLAS) to empower members to understand and exercise their rights, and assisting with accessing affordable and appropriate health care, behavioral support, social services, and resources in a timely manner.

Health Education and Motivational Interviewing

Providing opportunities and resources for members to maintain optimal health through motivational interviewing and educational training in living a healthy lifestyle to include fitness, nutrition, tobacco cessation, and setting and achieving personal wellness goals. Health education is provided through Healthwise printable educational resources available within the Care Management System, referrals to wellness programs, direct personal coaching from clinical professionals, and may include member incentives for health care compliance.

Care Coordination

Care Coordination is the bridging of healthcare gaps to deliver coordinated care to improve disease outcomes while containing overall health costs. This deliberate organization of member care activities includes sharing information among all the participants involved with the member to achieve safer and more effective care. This means that the member's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care across multiple providers and organizations. Care Coordination is member-centric to ensure that each member's rights and preferences are honored with the aim to promote improved member self-management.

MOC 2 Element C: Face-to-Face Encounter

MOC 2 Element C Factor 1: Detail face-to-face encounter essentials

AllCare Health has policies and procedures in place to describe the expectation for a face-to-face encounter between a SNP Member and their Care Team within the first 12 months of enrollment and at least annually, as feasible with the enrollee's consent. A face-to-face encounter includes an interaction with the member's PCP (primary care provider), other contracted providers, Long Term Services and Supports (LTSS) staff, ICT, or care coordination staff. This may include in-person or visual real-time telehealth encounters. The purpose of a face-to-face or virtual encounter is to establish and build relationships, maximize the assessment process using all available senses (visual, tactile, auditory, and smell), review HRA results and develop an ICP. The intended outcome of a face-to-face or virtual encounter is fostering a relationship and agreement of the goals of care. Members are informed of the importance of establishing care with their PCP upon enrollment and having preventive care visits on at least an annual basis; this is achieved through the member handbook, the AllCare website, new member welcome packets, and during Care Coordination interaction. Consent

for a virtual visit is obtained during the interaction with the Provider's office when the virtual visit is offered.

For members who have not had a face-to-face encounter with their PCP or other participating members of their ICT, as identified through internal reports, all reasonable attempts will be made by the Care Coordination team to contact the member to encourage their annual visit. The Care Coordination team will make the initial outreach attempt to the member within three business days of notification that the member is overdue for a face-to-face encounter with a member of their ICT, as indicated by regular (at least quarterly) member data monitoring by the Population Health management team. Instances where members refuse a face-to-face encounter with a member of their ICT, or if the member cannot be contacted and becomes an "Unable to Reach" designee, will be clearly documented by the care coordination team within the member's ICP in the electronic Care Management System aligned with the "Unable-to-Reach" documentation procedure and timeline as previously outlined. This information is readily available to the internal ICT in the Care Management System, and made available to the external ICT, provider network, and other SNP personnel involved with overseeing the plan of care via mail/fax/telephone/face-to-face interactions.

MOC 2 Element C Factor 2: Describe qualified personnel

AllCare Health recognizes the value in the human connection between our members and the Care Coordination team. Human connection via face-to-face encounters maximizes verbal and non-verbal communication that is not accessible through telephonic or electronic means. There are instances when a virtual or telehealth visit is an appropriate approach. Examples of this include, member preference, impact of public health emergency, access to out of area specialty care, and others.

AllCare considers in person, real time, and virtual PCP visits as a qualified face to face visit. The relationship between a member and their PCP is an essential foundation in the care management process. Upon enrollment, members are made aware of the importance of visiting with their PCP or other care providers and are encouraged to do so. Member's primary care providers (physicians, nurse practitioners, or physician assistants) are expected to engage with SNP members at least annually for preventive care measures and health maintenance, which is experienced in a face-to-face encounter or via a telehealth visit.

A member's consent to participate in virtual/telehealth visits is obtained during the interaction with the provider's office when the virtual visit is offered. If a member prefers a face-to-face/in-person visit, the provider is expected to accommodate the preference if it is feasible and safe to do so. AllCare also considers a virtual visit from a Care Coordination team member as qualified. If it is determined to be beneficial, Member/Caregiver consent will be obtained and documented prior to the virtual interaction. All member visits with care coordination staff, whether in-person or virtual, are documented within the Electronic Care Management System within one business day.

Specialty, ancillary, and community-based providers often participate in SNP members' care,

ICP development and are participants in the ICT. Specialty providers may include physicians, nurse practitioners, physician assistants, or other providers in behavioral health or medical specialties. Ancillary providers may include home health services, health educators, durable medical equipment specialists, spiritual care practitioners, and others. Community-based providers may include team members involved in Long-Term Services and Supports (LTSS), community resource centers, and others. Face-to-face and virtual encounters with these providers are a layer of additional support in the care management process and plan.

In instances when the member has not had a face-to-face encounter with their PCP or other participating members of their ICT, all reasonable attempts will be made by the care coordination team to contact the member to encourage their annual PCP visit, or they may be encouraged to have a face-to-face encounter with either a licensed or unlicensed DSNP care coordination staff member. The care coordination team will make the initial outreach attempt to the member within three business days of notification that the member is overdue for a face-to-face encounter with a member of their ICT, as indicated by regular (at least quarterly) member data monitoring by the care coordination management team. Instances where members refuse a face-to-face encounter with a member of their ICT, or if the member cannot be contacted and becomes an “Unable to Reach” designee, will be clearly documented by the care coordination team within the member’s ICP in the electronic Care Management System aligned with the “Unable-to-Reach” documentation procedure and timeline as previously outlined. This information is readily available to the internal ICT in the Care Management System and made available to the external ICT, provider network, and other SNP personnel involved with overseeing the plan of care via mail/fax/telephone/face-to-face interactions.

All virtual face-to-face encounters must ensure that the platform used meets health information and personally identifiable information of Medicare enrollees under requirements at 42 CFR 422.118 and 422.504.

MOC 2 Element C Factor 3: Verify qualifying encounters

The AllCare Health Care Coordination team, in collaboration with IT and Claims, collects encounter data through claims to verify that a face-to-face or virtual visit was conducted. Data validation is part of the quality oversight process. AllCare Health has policies and procedures in place to describe the process details. As part of the MOC quality measurement activities, visit history is monitored on a quarterly basis and reported annually in the MOC evaluation. The purpose of monitoring this data on a quarterly basis is to identify members who may need extra Care Coordination assistance to schedule a visit or address barriers to access. AllCare Health also monitors internal data for face-to-face interactions on a quarterly basis, through a monitoring data dashboard.

If a qualified face-to-face encounter has not been identified for a member, the Care Coordination team will outreach to the member for scheduling with the internal ICT team or their PCP within three business days of notification that the member is due for a face-to-face encounter. For members who are not accessing primary care services, the Care Coordination

team can assist to assess for barriers and develop a plan to address those barriers (e.g., Need for home visit, transportation, and language access issues).

MOC 2 Element C Factor 4: Specify clinical functions and assessments

The following describes examples of some clinical, psychosocial and assessment functions that may be included, but not limited to, during face-to-face or virtual visits:

1. Primary or Specialty Care Visits: To assess and initiate or maintain physical or behavioral health interventions/goals (e.g., Preventive, chronic care).
2. Health Risk Assessment: Members may prefer to complete an HRA via in-person or virtual visits. An appropriate Care Coordination team member is assigned to conduct the HRA.
3. Care Coordination: There may be times when a face-to-face or virtual visit may be appropriate to effectively support care planning (e.g., medication reconciliation, home safety assessment).
4. Care Transition Process: Various care team staff or ICT participants may use face-to-face or virtual visits to support members experiencing a care transition (e.g., acute, skilled nursing or palliative/hospice care).
5. Health Education: An appropriate ICT participant may provide face-to-face or virtual visits to provide or reinforce health education.

MOC 2 Element C Factor 5: Address identified health concerns

When health or wellness concerns are identified during the face-to-face or virtual/telehealth visits, the ICT participant (e.g., PCP) or Care Coordination team member will discuss the concern with the member and member's authorized representative or caregiver and share recommendations/options to address the concern. It is the responsibility of the ICT participant or Care Coordination team member to provide the information and education on potential care risks and benefits. This includes using alternative formats or interpreter services to ensure the member/authorized caregiver understands the information.

Additional educational information is provided to members by the Care Coordination team via the Healthwise educational program when readily identified and is documented by the Care Coordinator within the Electronic Care Management System within one business day. This intervention is included in the ICP and shared with the member's ICT. This information is readily available to the internal ICT in the Care Management System and made available to the external ICT, provider network, and other SNP personnel involved with overseeing the plan of care via mail/fax/telephone/face-to-face interactions.

MOC 2 Element C Factor 6: Conduct care coordination activities

Member needs identified from the face-to-face encounters will be added to the ICP by the Care Coordination team and discussed with the ICT. The Care Coordination team will work

closely with the member and member's PCP to make sure that necessary referrals, procedures, and tests are ordered and completed as recommended. Any reasons impacting completion will be documented within the electronic Care Management System within one business day of notification. In cases of member non-compliance, reasonable attempts will be made by the Care Coordinator to reach the member and address any barriers or additional issues, as outlined in previous sections above.

MOC 2 Element D: Individualized Care Plan (ICP)

MOC 2 Element D Factor 1: Describe essential components of the ICP

AllCare Health's s person-centered approach focuses on the member's strengths, needs, and preferences and develops individual goals and interventions in collaboration with the member and caregivers that are reflected within the ICP. To support the member safely, in the least restrictive setting of choice, Care Coordinators work with the member and member's authorized representative or caregiver to develop an ICP that identifies barriers that prevent the member from managing their current conditions and determines interventions to promote and maintain self-sufficiency. Data sources include but are not limited to the HRA, assessments, face-to-face encounters, medical records, claims data, and information obtained from the Health Information Exchange (HIE) or community partners, and through the Community Information Exchange (CIE).

The ICP, an interdisciplinary and collaborative individualized plan of care, includes member-led goals and objectives, timeframes for reassessment and interventions, identification of barriers, role of a caregiver, and reflects the member's personal healthcare needs and preferences, including timeframes for completion. The plan also includes a description of the services specifically tailored to the beneficiary's needs and preferences and an ongoing evaluation of identified goals and whether they are met/not met. The care plan is developed with the member, their representative or caregivers, and other supports with input from the providers involved in the care of the member.

The essential components of the ICP may include any of the following areas and review questions:

- Member's right to decline participation.
- Current health status.
- Clinical history and medication history.
- Ability to perform activities of daily living (ADLs).
- Mental health status and cognitive function.
- Life planning activities.
- Cultural and linguistic needs, healthcare preferences and limitations.
- Caregiver resources.
- Case management plan with long- and short-term goals.
- Follow-up schedule.
- Barriers identified.
- Self-management plan.

- Assessing progress.
- Care transition needs.

After completion, the ICP will include:

Prioritized Goals

- Both short-term and long-term goals are determined with the member and are specific, measurable, attainable, realistic, and timely. Care Coordinators routinely assess progress toward goals and if goals are not met, a review is performed and contact with the member is made to discuss what is inhibiting the documented goal attainment as there may be various barriers such as the member's condition may have stabilized and/or perhaps the member feels they have attained the goal, or they want to change their goal. The Care Management System provides real-time information on goals met and not met, as well as progress towards completion. The Care Coordinator assesses whether the initially established goals are realistic and if modifications are necessary. This is part of the reassessment process when updating a member's ICP. Barriers and progress to goal completion are addressed at the ICT to find solutions.

Identification of Barriers

- Identification of barriers to meeting goals and person-centered recommended solutions for each barrier, including language, cultural/spiritual preferences, literacy (general and health), functional impairments, sensory and/or cognitive impairments, motivation, health disparities, access (geographic location, transportation), and lack of family, caregiver, and/or informal supports.

Needed Resources and Services

- Resources to be utilized, including an appropriate level of care and any services specifically tailored to the member's needs.

Interventions

- Interventions based on the member's identified problems, strengths, resources, barriers, and agreed upon goals.

Self-Management Plans and Personal Health Preferences

- Self-management plans created to support members in managing their health, including specific technology supports, tools, and disease management/health education.
- Identification of member's anticipated treatment and health outcomes.

Collaborations and Timeframes

- Collaboration with ICT, including involvement of family, caregivers, providers, and other formal and informal supports.
- Schedule for ongoing communication with the member and ICT, based on acuity, needs, preferences, and agreed upon goals.
- Timeframes and interim outcomes that create points in time for which achievement towards goals is measured, including the specific way progress is demonstrated.

Education

- Education provided to the member, member representative, family/caregiver, including written materials, telephonic or in person education, health coaching, and referral to other available information, such as that found on the member/caregiver portals or through community organizations and advocacy groups (e.g., Alzheimer's Association, Brain Injury Association of PA, etc.).

All updates are documented within the Care Management System within one business day of occurrence.

MOC 2 Element D Factors 2 & 3: Describe the ICP development process and detail personnel responsible for the ICP development

The HRA, when completed successfully, is designed to identify barriers or safety risks that require follow-up for additional evaluation and coordination of care and services. Upon completion of the HRA, the ICP is created by the Care Coordinator with involvement from the member and the member's representative or caregiver as appropriate. The results of the HRA and member stratification are used to guide the creation of the ICP based upon identified goals and member preferences and are documented within the ICP by the Care Coordinator who also discusses the results with the member and member's representative or caregiver and shares the results with the member's PCP and member through a follow-up letter upon initiation of the ICP.

The HRA also identifies, regardless of diagnosis, members who may have needs for care coordination and additional evaluation, for example, positive screen for depression on the Patient Health Questionnaire-2 (PHQ2), food, transportation and housing insecurity, emotional or physical abuse, worsening health status, barriers to care, ancillary equipment needs, and other concerns amenable to intervention and/or recent emergency department visits. Upon evaluation of identified needs, members can be referred into care coordination for more intensive intervention. The Care Coordinator ensures customized support, which may include assistance with arranging transportation or medication reconciliation, help scheduling and coordinating appointments, and assistance obtaining prior authorizations or durable medical equipment. Once a member's needs have been adequately addressed, they can be de-escalated to a less intensive acuity or transitioned to self-management. Member stratification results from the use of AllCare Health's Care Management pathways assist in identifying the most supportive and appropriate care coordination strategy that will best meet each member's unique needs to target and improve beneficiary health outcomes.

Care Coordinators use the results of the HRA to guide the creation of the member ICP with involvement from the member and the member's authorized representative or caregiver. Care Coordinators, who may be nurses, social workers, respiratory therapists, intensive care coordinators, or health coaches, depending on the member's concerns, work with members to understand and address their needs. When eligible, members may be enrolled in special care tracks to focus on medication adherence, care visit compliance (ensuring follow-up with appropriate specialists), biometric monitoring, or admission avoidance if they have recently been discharged from the hospital.

Upon completion of the HRA in the Care Management System, it is immediately routed to an electronic assignment queue by the staff member completing the HRA task. This assignment queue is accessible to clinical staff and care coordination management who can evaluate and stratify the HRA results and determine the appropriate care management pathway. This is performed within one business day of HRA completion and route to the queue. The member stratification process occurs utilizing AllCare Health's four Care Management pathways, which help to further determine the member's health risk and special needs. To determine the member's appropriate pathway, AllCare Health Care Coordination management evaluates the suitable mix and intensity of care coordination services and activities within the designated pathway based on the member's initial identified medical, functional, cognitive, psychosocial, and mental health needs. The four pathways include Risk Management, Wellness, Complex Population Health, and Behavioral Health. Once the appropriate pathway is determined, Population Health management assigns each member to an appropriate care coordinator along the pathway within three business days of member stratification using the Care Management System. Member assignments to care coordinators are often followed up with an email notification by management to the care coordinator at the time of case assignment. The member is assigned to a care coordinator in "referred" status until they are assessed by the care coordinator who then assigns an acuity level to the member once the appropriate level and frequency of outreach necessary to meet the member's needs has been determined. The acuity of members ranges from levels one - four. Level four indicates the highest level of intervention required from the care team. An automated initial care plan is started upon case assignment, which will auto-assign a Program Welcome Call, tasked to occur within one business day of case assignment.

Care Coordinators use the results of the HRA to guide the creation of the member's individualized care plan (ICP). The ICP is developed and completed within 30 days of HRA completion. The ICP is comprised of goals, interventions, tasks, problems, barriers, and outcomes. The problems are specific to identify issues based on the member's answer to a particular question within the HRA. The intervention is targeted to address the associated barrier and the task accompanies the intervention. Care Coordinators then work with the member to identify member-led appropriate short and/or long-term goals, which are reflected within the ICP. The ICP is updated based on the findings of the HRA or reassessment HRA, along with any changes in health status or triggering event, or as applicable with any updates from an ICT meeting, at least annually, as well as any data findings based on analytics on claims information from the member's claims history and AllCare Health's stratification process as previously discussed in MOC 2B Factor 4. As an assessment is completed with the member, the Care Management System dynamically generates the member's ICP with prioritized goals and interventions, which at the time of initial HRA, reflects the member's comprehensive care management needs.

The member and/or member's caregiver is included in the ICP development whenever possible, and information from the primary care provider, specialists, non-professional caregivers, LTSS case managers, health records, specialist records, and pharmacy data are

used to aid in the full development of the ICP. Every member of the ICT aims for ensuring the member and/or his or her caregiver is engaged and empowered within the process and in decision-making. The Care Coordinator empowers members and/or caregivers through education, open communication, motivational interviewing, and partnership. Such empowerment encourages member and caregiver involvement, engagement, and improved success in meeting established goals.

The dynamically created ICP allows the Care Coordinator to coach the member on the most critical items during interactions. This ICP is used in subsequent coaching/education calls to guide the focus of the interventions. The Care Coordinator shares updated ICPs with the member and their primary care provider and other providers or caregivers, as appropriate.

The ICP is reviewed and updated at least every 90 days and annually and may be adjusted at any time depending on a member's individual needs or change in health status. Reasons for updating the ICP include transitions of care, significant change in condition, changes to member's goals, needs, risks, member request, and/or provider direction. The Care coordinator works with members to address the most pressing issues facing the member. The ICP is developed for each member and focuses on the member's needs to ensure timely access to medically necessary services and reduce unnecessary utilization.

During all subsequent interactions, the Care Coordinator asks questions and evaluates changes to update and add to the ICP. This ensures the members ICP is always up to date as the member's needs and healthcare preferences change over time.

AllCare Health utilizes Care Coordinators comprised of RNs, LPNs, Social Workers, Respiratory Therapists, Intensive Care Coordinators, and health coaches as primary care managers for the development of the care plan and ongoing management. The type and skillset of the primary care manager to be assigned to each member is based on the member's identified needs and barriers. AllCare Health's Care Management System content is overseen by care coordination management. This includes proprietary questions and answer logic for the development of the ICP. In addition, individual interventions can also be skill dependent to ensure appropriate licensed professionals are referred and part of the ICT for specific care plan interventions. ICPs are reviewed at ICT meetings and oversight is the responsibility of the Vice President of Population Health.

Care Coordinator Nurses are used in the more complex cases, the most vulnerable, and severely chronically ill. These Care Coordinators hold active unrestricted licensure as a Registered Nurse or Licensed Practical Nurse and have direct patient care and case management experience. Additional Case Management certification is preferred.

AllCare Health has policies and procedures in place to guide the creation, content, and updating parameters of a member's ICP as the enrollee's health care needs change. The Case Owner in collaboration with other members of the ICT, PCP, and member/caregiver participate in updating the ICP. In special complex cases, this team may include specialty Care Coordinators and participants. In some instances, inclusion of Social Workers, Community Resource Specialists, and Health Coaching is necessary to further support the team during evaluations, interventions, and appropriate care action plans.

The ICP is developed and shared with the member and the member's PCP via telephone/mail/fax/face-to-face encounter. In instances when there is no communication with the member, outreach strategies are initiated, which may include visiting the member or coordination of an intervention at the time of the next visit with the PCP. As the ICP is also shared with the PCP, it may be made available to the member/caregiver during this visit.

MOC 2 Element D Factor 4: Specify ICP is documentation and maintenance

The ICP is documented and maintained in AllCare Health's Care Management System. Any changes to the ICP are made directly within this system. The system maintains historical information and previous ICPs are available for retrieval at any time. When new HRA information is received, it is added to the member record for processing by the Care Coordinator.

Documentation

All documentation of assessments, ICP and related follow-up communications are documented and updated in the Care Management System within one - three business days of occurrence by the Care Coordination team. This system is only accessible by AllCare Health staff; however, the ICP is shared securely via fax/mail/telephone to the primary care providers, and available online to the member in the AllCare Member Portal, or can be mailed to the member, by the Care Coordination team. Member records are maintained in accordance with HIPAA, state and federal privacy laws, and professional standards of health information management.

Oversight

The Vice President of Population Health is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers, or other involved parties. The information available in the care management system includes but is not limited to the following:

- Notes, including a summary of team conferences and all communications with the member/family, healthcare providers, and any other parties pertaining to the member's care.
- Physician treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring if available.
- Facility admission information and discharge plans.
- Member connections outreach attempts to connect with a hard-to-reach or unable-to-locate member.
- AllCare Health developed ICP.

Communicating Changes in Member Status to the ICT

The Care Coordinator is in a unique position to know and understand all facets of the member's condition and abilities. It is the responsibility of the Care Coordinator, as a member of the ICT, to inform other team members about any changes in the member's health status within three calendar days, so that the team can track the progress of the ICP and make any

modifications needed to improve outcomes or support a member during a significant health event or transition in care.

Reviewing, Analyzing and Updating the ICP

The ICP continues to evolve with the member's unique situation to ensure the member has access and coordination of all needed care. The ICT, led by the Care Coordinator, is responsible for reviewing, analyzing, and revising the care plan with an interdisciplinary focus. The ICT also considers alternatives for health care delivery, available funding options, and other methods to help the member progress.

The ICP is reviewed and modified by the Care Coordinator with any significant life/health event as needed but no less than every 90 days and annually after the initial assessment. Modifications involve the entire ICT, including the member and/or their caregiver. The Case Owner or a member of the ICT team completes the ICP changes after the review with the assistance of the full ICT and with the involvement of the member or member's caregiver within one business day of occurrence. The PCP's input is critical as well. Life/health events may include recent new diagnoses or complications of prior diagnoses, recent hospital stays, caregiver changes, living arrangement changes, or even financial changes. Revisions need to be reasonable, understood, and accepted by the member and/or their caregiver to encourage full and active participation with the ICP.

MOC 2 Element D Factor 5: Describe ICP updates and modifications

The Care Coordinator has the responsibility of periodically updating the ICP. At minimum, this is every 90 days and annually, or with a transition of care, and/or with any significant change in health condition or triggering event. Follow up is usually performed telephonically but may require coordination of face-to-face interventions with the PCP or other members of the ICT. At a minimum, every member's ICP is made available no later than three business days after initiation of care coordination services with the member, provider, and authorized caregivers after the HRA assessment and ICP initiation.

The Care Coordinator follows up according to the schedule for activities within the ICP and will reassess member's progress toward overcoming barriers to care and meeting treatment goals. During follow up assessments, changes to the ICP may occur as new needs, preferences, or barriers to care are identified.

Updates to the ICP are communicated via fax/mail/telephone/face-to-face to all appropriate stakeholders and may include the member, network providers, health plan, and ICT. Providers who engage with the ICT are informed of the member changes in health status, recommended course of action, alternatives, and supports to achieve best outcomes and referrals to additional treating providers or resources to support accomplishment of goals. Referrals may be done via email, phone, or fax. A verbal review of the ICP is discussed during direct contacts with the member and a copy of the plan action steps is provided to the member or designated caregiver. Phone outreach to members or caregivers is used to convey updates to the plan and to address questions and problem solving, as indicated. All communication is documented in the Care Management System within one business day.

Communication barriers or preferences are assessed and documented as part of the ICP to support members within their fullest ability. Consideration is given for level of cognitive development, health literacy, vision, speech or hearing impairments, language choice and comprehension, cultural preferences, religious or spiritual considerations and need for caregiver surrogate communication. Use of alternative tools are used to include members in care planning discussions, including interpreter services, large print media, and TTY phone lines.

ICP communications may occur in a variety of formats based on the member's care coordination needs, including, but not limited to:

- Face-to-face meetings – Internal or external meetings with caregivers (with or without other members of the ICT, such as a home health care nurse, or members of our internal integrated care team).
- Telephonic – Direct calls with member/member's representative and/or providers .
- Case reviews/rounds - Internal meetings with ICT.
- The ICP is available securely in the AllCare member portal.

MOC 2 Element E: Interdisciplinary Care Team (ICT)

MOC 2 Element E Factor 1: Detail ICT membership

All SNP members will have an ICT that reflects and supports each member's stratification results, goals, and preferences as determined through the HRA, other assessments, and the ICP development process. All SNP members and their caregiver/representative are invited to participate in the ICT. During the completion of the HRA, the Care Coordinator identifies the needed ICT member best suited to help mitigate barriers and documents the recommendations in the ICP. The Care Coordinator also ensures each identified member of the ICT has had the appropriate SNP Model of Care training and is aware of the expectations regarding their participation. The ICT is comprised of individuals with the knowledge, understanding, and ability to target and manage the specific medical, functional, cognitive, psychosocial, and mental health needs of members.

AllCare Health has an Interdisciplinary Care Team (ICT) approach, which utilizes a variety of skill sets to ensure the best possible outcome for the member. Internal AllCare Health ICT participants may include the Care Coordinator, Program Specialists, Community Resource Specialists, Pharmacy Coordinators, Behavioral Health Coordinators, other Program Coordinators, Oral Health Representatives, Pharmacists, and Medical Directors. External participants may be comprised of Primary Care Providers, Specialty Care Providers, Behavioral Health Providers, Ancillary Services, Community-Based Organization representatives, faith-based representatives, various state agencies, and other members as appropriate to the member's needs and preferences. External participant's training and expertise are additionally verified through the credentialing and contacting process. ICTs are generally comprised of interdisciplinary clinical and nonclinical staff and are led by a Care Coordinator and informed by the member's HRA and ICP. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, which permits

the licensed professional staff to focus on the more complex and clinically based service coordination needs. The Care Coordination team works closely with the Benefit (Utilization) Management team to coordinate care when members are hospitalized and assist with discharge planning and prior authorization activities. The teams utilize a common Care Management System to maintain centralized health information for each member, which includes medical, behavioral health and all other services the member receives. The clinical staff consults with and/or seeks advice from the medical directors as needed, based on severity and complexity of the member's needs.

Members, PCP, and caregivers are invited and encouraged to attend ICT meetings. They may also request an ICT meeting. The member's Welcome Letter, which includes their care plan, also includes instructions on how to request or attend the meeting. In some cases, the member's complexity will require inclusion of community care managers, care coordinators, mental health, and addictions professionals, etc. These meetings may be requested by any member of the ICT. The Care Coordinator will coordinate scheduling and invite known members involved in the member's care.

The HRA and ICP assist in identifying medical, functional, cognitive, psychosocial, and mental health needs, which provide information on how the ICT should be composed. The need to incorporate resources into the ICT is often indicated through the HRA, ICP and through discussions with the member and member's representative/caregiver, results of assessments by the PCP and involved specialties and disciplines, socioeconomic challenges to care and/or need for psychosocial support services. Examples of resources include specialty providers, respiratory therapists, behavioral health or chemical dependency clinicians, and ancillary professionals such as nutritionists, health educators and pharmacists. Professionals who provide support services such as in-home or residential care are invited to collaborate as needed. Other resources can be included with member permission, such as family or friends, caregivers, spiritual counselors, who can support the care plan in partnership with the member. Each member of the ICT serves as a potential contributor to the ICP, with adjustments made as indicated in collaboration with the member, the member's authorized representative or caregiver, the PCP, and other team members.

MOC 2 Element E Factor 2: Describe ICT roles and facilitation of enrollee participation

Member-Centric Team Approach

The composition of the ICT is member-centric and is designed to improve the health status of SNP members by offering an integrated, person-centered approach to care planning and service coordination. The member's identified care management pathway assists with identifying the necessary team members with the best ability to offer knowledge and expertise in developing an ICP that meets the individual's medical, functional, cognitive, psychosocial, and mental health needs and preferences as identified through the HRA and ICP development process. The ICT is responsible for the following:

- Evaluating and implementing an individualized care plan with the member, members representative and/or caregiver's participation.

- Conducting Care Coordination meetings on regular basis, according to the member's condition and needs; these meetings may be held face-to-face, via conference call or web-based interface.
- Conducting regular case review meetings.
- Detecting transitions in care or change in health status after a request for prior authorization is received from the member's PCP or facility.
- Distributing reports to team members.
- Maintaining records of team meetings.
- Documenting meetings.

Member

The member is a critical component of a successful ICT as their participation in the HRA and in discussions with their Care Coordinator will assist in driving the design of the ICT as well as ensuring their goals, strengths and preferences are communicated and incorporated into the ICP. Engagement of members, member representatives, and caregivers in the process is essential for developing the ICP, as it is tailored to each member's specific needs, preferences, and abilities. Effective engagement strategies include clearly outlining the benefits of the Care Management team and focusing on the Members' prioritized goals and concerns from the start, which fosters a level of trust in the process and relationship.

In rare cases where the member may not be included in the ICT if it is determined by the Care Coordination team or their Medical Providers that their involvement would be detrimental to their health and hinder progress towards goals. Furthermore, a member has the right to decline to participate if they choose.

Care Coordinators

RNs, LPNs, RTs, MSWs, LCSWs, ICCs; Establish and implement the ICP/ICT for SNP members, coordinate team activities to ensure that needed care and services are provided, outreach to obtain authorization for necessary care services, educate members on self-management techniques, and provide ongoing assessment of the member's response to care and services. Care Coordinators collaborate directly with the member and their support system to achieve an optimal level of health and function. They hold a key position in the ICT.

Community Resource Specialist

Community Resource Specialists anticipate, identify, and help members to overcome barriers within the health care system to ensure prompt resolution of emerging health crises. Community Resource Specialists proactively communicate all concerns to the health care team to help bridge.

gaps and bolster support and guidance towards the review and revision of the ICP. This position includes both Traditional Health Workers (THWs) and Community Health Workers (CHWs).

Program Analyst – (UM, Claims, Member Services)

A Benefit (Utilization) Management program specialist or a claims specialist may participate in the ICT to provide real-time answers to pending claim issues or member barriers to receiving care and resources. When needed, the oral health program specialist will also attend ICT for pertinent member issues related to oral health care concerns and oral health. At times, other areas of the organization may be invited to provide their expertise.

Pharmacist/Pharmacy Coordinator

The pharmacist and/or pharmacy coordinator, in conjunction with the member's provider, ensures there is a consolidated pharmaceutical therapy plan, identifies drug interactions, minimizes side effects, and works with Care Coordination to establish a pharmaceutical therapy program.

Behavioral Health Coordinator

The LCSW and social support care coordinators are the team members responsible for ensuring behavioral health needs are identified and addressed. In addition to participating in the ICT, the LCSW and social support care coordinators consult with the behavioral health team as needed to facilitate identification of behavioral health issues for SNP members.

Medical Director

The AllCare Health Medical Director team provides consultation as needed before, during, and after an ICT meeting. Consultations may be facilitated by conducting clinical reviews, providing direction and education on appropriate member interventions based on assessment results and guidance on important clinical education related to the member's clinical conditions. The medical director also may provide peer consultations with practitioners.

Primary Care Provider

The primary care provider (PCP) serves as the coordinating provider for all care delivery within the outpatient setting for the member and receives the ICP and health record updates for the member from the care coordinators. PCPs are invited to discuss and provide feedback on the member's care plan via an ICT meeting.

Ad Hoc Members

Other members of the ICT may include specialty providers, mental health professionals, home health staff, other care coordinators, social service agencies' care managers, and others depending on the member's needs, as identified. Ad hoc members are responsible for providing insight into the member's needs, including what support they may be providing the member. The composition of the ICT may depend on the member's identified stratification pathway and acuity level.

AllCare Health ensures that the number of members who are assigned to each Care Coordinator does not exceed each Care Coordinator's capacity to meet all the ICC needs of such assigned members. AllCare Health maintains staffing standards such that the complexity,

scope, and intensity of the needs of the members receiving ICC services can always be met by the appropriate staff. This is accomplished through a variety of methods: Stratification of members by their pathway and acuity level, supervisory chart audits, and caseload oversight during complex case reviews at Interdisciplinary Team meetings.

Member risk stratification results during the completion of the HRA allows the Care Coordinator to identify the needed ICT member skill sets best suited to help mitigate barriers and documents the recommendations in the ICP. The ICT is comprised of individuals with the knowledge, understanding, and ability to target and manage the specific medical, functional, cognitive, psychosocial, and mental health needs of members. Stratification of the member acuity occurs at the time of care coordination assignment and is fluid due to the ever-changing needs of the member. The acuity of members ranges from levels one - four. Level four indicates the highest level of intervention required from the care team. The acuity of the member is reviewed with regularity and as needed. Supervisory audits are conducted monthly on ten percent of each care coordinator's active caseload, which provides information as to the care coordinators' ability and capacity to meet the needs of their assigned members. Caseload oversight is conducted by Physicians, Pharmacists, Benefit (Utilization) Management, Community Partners, Care Coordination team and Members at the interdisciplinary team meetings. This setting provides a comprehensive analysis of care planning and review of member goals of care in which collective input and collaboration occur. AllCare Health provides a robust caseload and staffing management system. These measures offer a comprehensive approach to ensure that the numbers and acuity of members assigned to each Care Coordinator does not exceed the care coordinator's capacity to meet the needs of such assigned members.

Leveraging Information to Improve Member Outcomes

AllCare Health's Care Coordination team make use of all available data, including historical and ongoing claims data, in home assessments, pharmacy data, utilization data, information obtained from members, caregivers, providers and formal and informal supports to achieve a better overall understanding of the health status (physical and mental) and functional status of SNP members. In-home assessments often identify acute as well as chronic issues of concern. Care Coordinators monitor and analyze daily, weekly, and monthly member reports that track inpatient and ED utilization, chronic illness prevalence, and LTSS status. The Care Coordinator ensures that acute issues are quickly brought to the attention of the member's PCP, and the chronic issues of concern are brought into the ICT process and addressed in the member's ICP.

MOC 2 Element E Factor 3: Evaluate enrollee outcomes

The overall goal of the ICT is for the successful implementation of the ICP. The Care Coordinator is in a unique position to know and understand all facets of the member's condition and abilities, which not only help to guide the composition of the ICT but to also leverage the value of the ICP to evaluate outcomes and continually manage and improve the health status of SNP enrollees. The Care Coordinator is responsible for coordinating and leading the member's ICT meeting and for the overall maintenance of the ICP.

Communications within the ICT for best coordination of care include access to shared electronic records and the secure communication of the ICP with external ICT members. AllCare Health currently has access to EPIC electronic medical record systems and some SNF EMRs in addition to the regional HIE. These are referenced by the care team in the development of the ICP. AllCare Health's Care Management System allows for access to and inputting documented consultations and communication updates between care team members. All assessment and planning information is housed within the Care Management System and is accessible to the internal ICT participants.

Each member of the ICT, including the member, the member's representative or caregivers, PCP and Care Coordinator contribute to the development and implementation of an effective interdisciplinary care process by offering personal, professional, and cultural knowledge and perspectives. Each of these participants and any others involved in the member's care are invited to attend the ICT. Members and their authorized representatives are provided with necessary resources by the care coordination team according to any updates from the ICT. The ICP is updated within one business day of ICT meeting occurrence, and results of the ICT are shared with the member and the member's PCP via mail/fax/telephone/face-to-face encounters. Members are provided access to and the contact information for their ICT through a detailed welcome program letter and the provision of business cards.

MOC 2 Element E Factor 4: Describe communication plan

It is the responsibility of the Care Coordinator to facilitate communication among the member, member representative/caregiver and applicable team members and to ensure documentation of ongoing information exchange. All AllCare Health staff involved in the member's care has access to the Care Management System record and can document all interactions with the member, including authorizations and care plans. Members receive information about their ICT through mail and telephone communications. As an ICP evolves, it is the responsibility of the Care Coordinator to maintain ongoing communication on updates and changes to other SNP personnel in the ICT, enrollees, and caregivers along with community organizations.

ICT Communication

Interdisciplinary Team Meetings are conducted weekly, with individual members discussed as frequently, as necessary, based upon their complexity and level of need. During the meetings, the team discusses the progress of the member and provides recommendations for changes to the ICP. The medical director may reach out to the member's physicians to obtain clinical information on an as needed basis. The ICP is updated by the Care Coordinator within one business day of the ICT meeting and is made readily available to the member/caregiver and the members PCP. ICT attendance is kept track of by Care Coordination management through a verbal roll call recorded on a sign-in sheet, stored in an organized manner within the AllCare Health computer network drives within one business day of occurrence. All Situation-Background-Assessment-Recommendation (SBAR) communications are documented within the electronic Care Management System within one business day of occurrence and are also

stored securely within the AllCare Health computer network drives. This process is overseen by the Vice President of Population Health.

Communicating Health Information to Members and Providers

In addition to developing, implementing, and communicating the ICP, AllCare Health communicates educational topics and health information through the AllCare Health website and provider portal that addresses general health information, introduce standards of care and services, and includes reminders for ongoing care such as preventive health services or smoking cessation.

Resolving Communication Barriers

To overcome communication barriers and support member's engagement in care and service planning, the following strategies enhance communication with members who have hearing impairment, language barriers, and/or cognitive deficiencies:

- **Hearing impaired:** Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
 - Speech reading (lip reading).
 - Written and visual aids (including providing items in braille).
 - Visual language systems (telecommunications device for the deaf TDD).
 - Interpreters.
- **Language barrier:**
 - AllCare Health utilizes interpretation services when no staff is available to provide interpretation services.
 - Members may request printed materials translated into another language free of charge.
- **Cognitive deficiencies:** Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
 - Repeat information.
 - Write essential elements and use pictures.
 - Choose the best time of day to communicate.
 - Keep the environment calm.
 - Keep the environment quiet.
 - Keep the communication simple and/or going slowly.
- **Documenting and Addressing Member Dissatisfaction:** Any member complaint or grievance identified by the ICT in their interaction with the member, their caregiver, or provider is carefully recorded and forwarded immediately to the AllCare Appeals and Grievance department for resolution and tracking.
- **Ongoing Communication Strategies:** The success of the ICT in developing, maintaining, and updating a person centered ICP depends on effective communication. To that end, AllCare Health develops several avenues for communication. The ICT (including the member/caregiver) is kept informed through conference calls, email communications, mailings, and reports. The ICP is available to all ICT staff. To ensure complete and

consistent documentation AllCare Health documents all ICT reviews and activities in its Care Management System.

MOC 2 Element F: Care Transition protocols

MOC 2 Element F Factor 1: Facilitate continuity of care

Continuity of care for our members is ensured by standard operating procedures and Transition of care (TOC) policies with an emphasis on building and maintaining strong relationships with both in-network and out-of-network providers across different health care settings. While in most cases the member will be able to obtain needed services from an in-network provider, there are situations where enrollees may need to receive care from providers that are out of network. These cases are reviewed for medical necessity by the appropriate staff, including, but not limited to, medical directors, AllCare plan pharmacists, and the AllCare Behavioral Health medical directors; the process is facilitated by the Care Coordinator. The AllCare Health Care Coordination team ensures that Care Coordination services are provided to members transitioning between levels of care (step up, step down, and lateral transitions) and all facility types (not exclusive to hospital and Skilled Nursing Facility (SNF)), including home and community-based, as well as hospice and other palliative care settings. A tailored transitional member care plan is developed in collaboration with the member, community providers, and partners to minimize adverse events, avoid unnecessary readmissions, and reduce emergency room visits. AllCare Health has dedicated TOC staff who are notified of member transitions through authorizations, claims, and real-time reporting and using the software platform PointClickCare (POC), a collaborative software platform that connects care settings across the country. Staff also have access to admission, discharge, transfer (ADT) reports, ICT members, and referral notifications in the form of standard and electronic mail, secure email, phone, or fax. Upon identification of a member's TOC need, a TOC case is assigned by care coordination management to a TOC Care Coordinator within three business days. Members who are transitioning will be offered and encouraged to complete or update the HRA and to receive extra services provided by the AllCare Health TOC program. These additional services are designed to support members transitioning from an acute care setting. The TOC program ensures that members have access to their discharge instructions, understand their post-discharge plan, and receive medication review. Additionally, assistance is provided in arranging appointments, lab services, meal benefits, home services, durable medical equipment (DME), and other necessary ancillary services as appropriate. All members, regardless of health care setting, will receive an HRA to update the care plan and evaluate if any additional services or support are needed, as applicable. Health care settings include but are not limited to home, acute care, residential care, skilled nursing facility, hospice care, rehabilitation, and home health services. Members transitioning from any setting are offered steps that include educating the member and family/friend caregivers to understand and practice self-care management and to follow the care plan, including elements such as how to self-manage medications and attending primary care provider appointments as scheduled. The goal for any member transition of care is:

- Assessment and evaluation of barriers to care, including access and education to newly prescribed medications.
- Creation or update of an ICP to address any new barriers with targeted interventions.
- Promote education opportunities for self-management activities identified in the ICP.
- Frequent communication with the member and the member's care team to ensure follow-through interventions to mitigate barriers to care
- Coordination and communication with the ICT, including PCP, community resources, and other care team members.
- Frequent evaluation of the ICP to timely address member needs, including medication review by a care coordinator.
- Facilitate and coordinate a safe transition through the various levels and episodes of care.

The Care Coordinator serves as the primary point of contact during transitions, ensuring that the ICT is involved in the care of the member and has the most current ICP information. Additionally, the care coordinator works to ensure that the member has all follow-up appointments scheduled.

MOC 2 Element F Factor 2: Identify care transition personnel

Care Transitions are monitored and overseen by the TOC Care Coordination team, which includes the VP of Population Health, the Director of Care Coordination, Supervisors of Care Coordination, Care Coordinators, and a team of Community Resource Specialists. The Chief Medical Officer and medical directors provide consulting and supervisory functions within the team.

The TOC Care Coordinator is responsible for ensuring care is coordinated across health care settings through the management of the member's ICP. This includes advocating for the member's right to choose and optimal health to ensure the member receives appropriate support and services. Once a transition has been identified, the Care Coordinator begins coordinating the transition with the PCP and specialty providers to ensure the member is connected with the appropriate treatment, services, and equipment. This may include:

- Contacting the member, members representative, and/or caregivers to determine their understanding of the transition.
- Contacting facility and providers to determine what information may be needed before the transition occurs.
- Communicating with members of the ICT during the transition process.
- Discussing discharge plans with the member and/or caregiver.
- Identifying barriers and how to address them.
- Ensuring follow-up services and appointments are scheduled, medications are reviewed, and education is provided.
- Providing referrals to APD/AAA offices for Long Term Services and Supports.
- Updating and documenting changes to the ICP in the care management system and communicating changes to the ICT.

MOC 2 Element F Factor 3: Transfer ICP elements and describe the transition process

Care Coordinators are responsible for transferring elements of the member's ICP between health care providers and settings. Communication and planning for a safe and seamless transition begin with the receiving health care facility or setting in advance of the transition. Communication and planning continue through the discharge and transition process to ensure a consistent flow of information before, during, and after the transition. The Care Coordinator will proactively convene and coordinate with ICT members, including staff from both the transferring and receiving health care settings to ensure all members of the care team have a shared understanding of the ICP to further eliminate potential gaps in care. If the transition is unplanned, the Care Coordinator will, upon notification, reach out to the receiving health care setting to provide a synopsis of the member's history and care plan. The Care Coordinator will then further establish plans for ongoing communication to prepare for future transitions. The Care Coordinator will share essential elements of the ICP through warm handoffs, by telephone or in person, through Interdisciplinary Team meetings (IDT) and by providing a copy of the ICP and member information to each health care setting. During and throughout the transition of care, the Care Coordinator is responsible for collaborating with the member, providers, and all members of the ICT, providing updates, assessing needs, and coordinating care and services. The Care Coordinator communicates regularly by telephone or in-person with the member, member's representative or guardian, caregivers, and staff representatives of the health care settings to identify and support coordination needs until the member is fully transitioned. Once the care transition is complete, the Care Coordinator updates the ICP, including resources and support needs identified throughout the process, any updates from the HRA, and changes discussed with the member. The Care Coordinator ensures the ICP is updated and communicated to the health care settings and with the PCP. The Care Coordinator also communicates with the member and if applicable, their caregiver(s) to ensure understanding of the transition and provide support for any unmet coordination needs and to share the updated ICP. Care Coordinators document all care management activities, plans, and communications in the Care Management System.

Steps before, during, and after a transition.

Prior to Transition

The assigned Care Coordinator is responsible for identifying that a transition is pending and for collaborating with the member and the rest of the ICT to plan and prepare for a safe transition. AllCare Health's contracted providers assist in communication efforts by participating in the HIE, allowing for real time electronic notification in PointClickCare to notify AllCare Health of members needing transitions of care support. To promote continuity of care, the Care Coordinator will reach out to the receiving health care setting upon notification that a transition has or is about to occur to provide a synopsis of the member's history and care plan and establish plans for ongoing communication to prepare for future transitions. When AllCare Health is notified by a hospital of any member transition, the assigned Care Coordinator will be notified by Care Coordination Leadership within three business day of event notification to ensure that care transition protocols are implemented as soon as possible.

During Transition

During any transition of care event, the Care Coordinator notifies the member's primary care provider and pertinent members of the ICT that a transition is occurring. The Care Coordinator collaborates with the member and providers involved in the transition to plan for any services and supports the member needs upon discharge. The Care Coordinator also determines if the member is eligible for additional benefits. If the member is eligible and wants to access additional benefits, the Care Coordinator will facilitate communication between the member, primary care provider, discharging facility, and others, as appropriate. (e.g., Mom's Meals, DME Vendors, HRS, Home Services, etc.). The Care Coordinator documents the transition of care functions performed in the ICP and case notes and communicates the current facility plan of care to the receiving facility (e.g., acute care facility) to ensure continuity of care.

After Transition

After each transition, the Care Coordinator documents admission and discharge dates in the ICP within one business day of being notified of a facility discharge. In follow-up to a transition of care event, the Care Coordinator contacts the member, the members representative, or caregiver, either by phone or through a face-to-face visit within two business days of notification of facility discharge, to discuss the changes that occurred during the transition of care event. The post-discharge contact includes, but is not limited to, discussion of the following:

- Discharge instructions.
- Transportation.
- Understanding of instructions and changes to self-management activities (using teach back method).
- Confirmation that all new prescriptions are filled.
- Medication review.
- Updated ICP.
- Assistance in scheduling follow-up appointments with the PCP and other care providers as applicable.
- Ensuring member has received post-discharge benefits and referrals (Mom's Meals, DME, and/or Home Services).

MOC 2 Element F Factor 4: Describe access to enrollee personal health information

Members are invited to actively engage in the development of initial, updated, transitions of care, and annual ICPs. These are shared with the member and or member's representative or guardian as they are completed or updated. Members can then share this information with other providers as needed. The member's PCP also receives the ICP via a case file with the member's goals, risk segment level, confirmed list of conditions, current medications, and any unmet care gaps. Once this information is shared with the PCP, the information is incorporated into the member's Electronic Health Record (EHR).

Additionally, members or member's representative may at any time request a copy of their ICP or personal health information. Care Coordinators ensure that members and authorized representatives have access to their personal health information to facilitate communication of health history and health needs with appropriate providers, specialists, and systems of care, for both in-network and out-of-network. Members and authorized representatives can request medical records from systems of care and providers at any time. The information can be shared with the member and authorized representative according to the entity's policy and procedures, which may include a hard-copy or electronic copy. Care Coordinators may facilitate member's health information between settings and providers to facilitate treatment, payment, and health care operations. Any sharing of personal health information follows HIPAA privacy and information security requirements.

MOC 2 Element F Factor 5: Describe approach to self-management activities

Once the HRA is completed, the Care Coordinator explains to the member and caregiver(s) any identified risks, and reviews care guidelines and self-management techniques appropriate for the conditions identified in the assessment and history. Care Coordinators tailor education to meet the member's unique condition using evidence-based guidelines. Care Coordinators use the teach-back method to assess the member's understanding of health status and self-management activities. Members and/or caregivers are provided education materials from the Healthwise program written at a sixth grade reading level with pictures to illustrate self-management techniques. In addition, members are offered education on goal setting and where to seek problem solving support, symptoms to watch for, and appropriate actions to take to manage their conditions and avoid transitions. The ICP is tailored to the member needs identified through discussion with the member and caregiver(s) following the HRA. For those members who are unable to complete the HRA because they are unable to be reached, or decline, a system generated "Unable to Reach" or "Opt Out" Letter is sent to the member and the ICT. These letters inform the member how to get connected with their Care Coordinator should the member, member representative or guardian if they have Care Coordination needs. Members are educated about the AllCare Health Member Portal, the AllCare Health website, 24-7 nurse helpline, and generalized resource information specific to member needs. Care Coordinators will utilize active listening, open ended questions, patient centered language, validate members emotions and consider cultural context, and motivational interviewing techniques, when engaging with the member, members representative, and ICT in the creation of an ICP.

MOC 2 Element F Factor 6: Describe notification process for designated point of contact

All members receive a Welcome Packet with business cards and a letter upon enrollment to care coordination services identifying who their Care Coordinator is and how to connect with them. Care Coordinators are the primary point of contact for members, member's representative or guardian, and/or caregivers. Throughout the transition process additional points of contact may be identified. It is the responsibility of the Care Coordinator to ensure the member, member representative and/or caregiver are provided the information and

education about the point of contact, including name and contact information, which may be telephone or standard mail. The Care Coordinator will provide this information in the format of the member's preferred method of communication.

MOC 3: Provider Network

AllCare Health provides a comprehensive contracted network of primary care providers, specialists, and facilities with specialized clinical expertise pertinent to the diagnostics and treatment of the special needs population. This network is managed and monitored by Credentialing and Provider Network staff through the process of credentialing and recredentialing practitioners and the assessment of organizational providers. These processes include a system of communication and coordination to ensure that the assessed needs of AllCare Health members are met.

MOC 3 Element A: Specialized Expertise

MOC 3 Element A Factor 1: Describe specialized network

Our Special Needs Plan (SNP) provider network is strategically designed to serve our target population, as defined in MOC 1, and includes providers with expertise in managing complex medical, behavioral, and social needs. We ensure that members receive care from specialists, facilities, and interdisciplinary teams with experience in chronic disease management, disability care, geriatric services, and behavioral health interventions.

To address these needs, our provider network includes primary care physicians trained in geriatric and chronic disease management, along with specialists, including but not limited to internal medicine, cardiology, endocrinology, nephrology, pulmonology, rheumatology, oncology, and behavioral health. We also contract with skilled nursing facilities, rehabilitation centers, and community-based organizations to provide comprehensive and accessible care. Our approach ensures that members receive specialized services from providers experienced in managing conditions prevalent in our SNP population.

Network adequacy is maintained through geographic analysis and provider access standards, ensuring that specialists are available within the required time and distance parameters. AllCare Health's time and distance dashboard uses ESRI's ArcGIS software integrated with the PowerBI software application. Efforts are continuously made to expand provider contracts in underserved regions, such as Southern Oregon, where access to specialty and subspecialty services remains a challenge. Our ICP team facilitates timely referrals and prior authorizations to ensure members can easily navigate the healthcare system. Additionally, we utilize telehealth services to improve access to specialty care, particularly for members in rural areas or those with transportation barriers.

To further support the continuum of care, our network includes contracted acute care hospitals, behavioral health facilities, and home health services. Provider engagement efforts strengthen relationships within the network, streamline referrals, and enhance care coordination. The DSN Oversight Committee oversees network performance through regular

monitoring of Time and Distance Dashboard, provider performance reviews, and utilization management tracking. This data informs strategies to enhance provider participation, address gaps in care, and improve overall member outcomes.

By integrating primary care, specialty services, behavioral health, and social supports, we ensure that our SNP members receive high-quality, well-coordinated care tailored to their specific medical and social needs. Our approach is designed to meet not only regulatory requirements but to exceed expectations in providing comprehensive, member-centered healthcare solutions.

MOC 3 Element A Factor 2: Include evidence of provider expertise

AllCare Health ensures that it provides each member with an ICT that includes providers with demonstrated experience and training and who are authorized to practice independently under state law. AllCare Health verifies providers are properly credentialed per the CMS, the Oregon Medicaid program, and AllCare Health policies prior to providing health care services and facilitating ICTs to our SNP members.

Our general guidelines for credentialing of applicable practitioners are as follows

AllCare Health requires all network practitioners to complete an Oregon Practitioner Credentialing (or Recredentialing) Application (OPCA or OPRA). These applications include all the information necessary for primary source verification. Forms can be found at: <http://www.oregon.gov/OHA/OHPR/ACPCI/pages/index.aspx>

In addition to the completed application, AllCare Health requires the following information to be included (as applicable):

- Completed, signed, and dated Attestation, including any necessary explanations.
- Completed, signed, and dated Authorization and Release.
- Completed, signed, and dated Attachment A (mark N/A if not applicable), including any necessary explanations.
- Copy of Oregon State License and/or Registration as well as current licenses from other states where members will be seen.
- Where applicable, verification of clinical privileges (in good standing) from the applicant's admitting facilities (i.e., hospitals).
- Current and active Oregon Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) certificate (if applicable) as well as current certifications from other states where members will be seen.
- Except for facilities, verification of medical school graduation or successful completion of the applicable accredited education program, as applicable.
- Copy of current Liability Insurance Certificate.
- List of Medical Malpractice carriers for the past 5 years.
- Copy of Board Certificate(s).
- Copy of Physician Associate (PA) Practice Description and Collaboration Agreement.
- Copy of Medical School diploma and/or completion certificates from medical training (preferred).

- Where applicable, work history in a month/year format.
- Educational Commission for Foreign Medical Graduates certificate.
- Verification of active medical practice in IPA's service area.
- Except for facilities, professional references obtained by IPA.
- Verification of individual provider National Provider Identifier number.
- Verification of Tax Identification number associated with billing entity.

General guidelines for initial credentialing of facilities are as follows:

- AllCare Health requires all network facilities to complete an Organizational Provider Credentialing Application. This application can be obtained from AllCare Health.
- In addition to the completed application, AllCare Health requires the following information to be included (as applicable):
- Completed, signed, and dated Attestation.
- Completed, signed, and dated Authorization and Release.
- Copy of all Federal, State, and/or local professional licenses, certification, and/or registrations specifically required to operate as a health care facility.
- Copy of all Federal, State, and/or local business licenses, certifications, and/or registrations specifically required to operate as a health care facility.
- Copy of all Accreditation Certificates and copy of most recent survey results.
- Copy of Federal Register Final Notice documenting deeming authority to any applicable accrediting organization, which exempts provider from the CMS survey process.
- Copy of most recent CMS survey, including any corrective action plan(s).
- Internal Revenue Service Form W-9.
- Current and active Oregon DEA and/or CDS certificate(s) as well as current certifications from other states where members will be seen.
- Copy of current Liability Insurance Certificate.

Once all required paperwork is submitted, the following information is verified by the Credentialing department or other delegated credentialing entity (as applicable):

- License is current and active at the time of credentialing decision.
- Liability/Malpractice insurance is active at the time of credentialing decision.
- Board information is verified.
- Clinical privileges are verified.
- DEA or CDS is verified.
- Quality of Care issues are reviewed for recredentialing.

Additionally, the Credentialing department checks to see that the providers

- Are not sanctioned by the Office of the Inspector General.
- Have not "opted out" of Medicare.
- Have no negative issues on the National Provider Data Bank (NPDB).
- Are not excluded by the System for Award Management (SAM).
- Are not on the preclusion list and precluded from receiving payment for Medicare Advantage items or Part D drugs.
- Are not on the death master file.

Plan participation is determined by the AllCare Health Chief Medical Officer or Lead Medical Director in conjunction with the AllCare Health Board of Governors appointed Credentialing Committee or by another delegated credentialing entity.

Original quality improvement and peer review information will be maintained by the Quality Improvement Committee in separate confidential files. Provider credentials must be re-verified at least every three years. Providers must report immediately to AllCare Health's Credentialing Department any change in the information maintained in their credentialing file. All primary source verification data must be no more than 180 days old at the time of final committee action on the application; except that education and training, application attestation, work history, and DEA certification must be confirmed valid at the time of Credentialing Committee review and action.

AllCare Health continuously monitors sanction and complaint activity related to all credentialed providers. The Credentialing Committee, which meets monthly, will determine if the provider's recredentialing application will be approved or denied.

All actions taken by the Credentialing Committee are subject to review, modification, and reversal by the Board of Governors, which may intervene on its own initiative, at the request of the Credentialing Committee, or otherwise.

MOC 3 Element A Factor 3: Update provider information

AllCare Health receives provider information from several sources:

- Delegated contracted credentialing organizations.
- Direct provider notifications.
- Online demographic update requests.
- Submission of claims.
- Benefit (Utilization) Management department via prior authorizations.

Information is received and disseminated to staff to validate and process the updates of provider data in the AllCare Health credentialing information system, ensuring the accuracy of our provider data and resultant provider directory.

All Oregon Licensing agencies, the Office of Inspector General, and the System for Award Management websites are reviewed at least once every 30 days for any sanction activity involving credentialed providers' state professional licenses. The Medicare Opt-Out Report is reviewed quarterly within 30 days of its release. If a credentialed provider is identified on the Opt-Out report, their credentialing will be immediately revoked, and the provider will be notified accordingly. AllCare Health places records of relevant reports in the provider's credentialing file and maintains them for at least five years. Every member complaint regarding a credentialed provider is promptly logged and evaluated. A comprehensive report is provided to the Credentialing Committee every six months of all credentialed providers and at the time of recredentialing for evaluation. Complaint related information is maintained in the credentialing file. Further, if ongoing monitoring and review reveals sanction activity or complaints, which may indicate poor quality medical care, the Chief Medical Officer (or

such person's designee) reviews all available information to determine whether to initiate peer review activity under the organization's Peer Review Policies. Further action is taken in accordance with relevant portions of these policies and procedures.

AllCare Health documents provider information into our Contracting/Credentialing software – Intellicred.

All updates to provider information are requested through quarterly provider profile updates administered by AllCare's Provider Engagement Team. All Provider and Facility information is updated in AllCare Health's Provider Portal. To ensure provider and facility information is entered correctly into our claims software – EZ Cap, all changes made to provider and/or facility information inside Intellicred are captured in an automated change report. The information captured in the report is added manually to the EZ-Cap claims application to ensure both Intellicred and EZ-Cap have matching provider information.

AllCare Health also uses a third-party vendor that is completing Secret Shopper calls to our primary care and behavioral health provider network. This is to ensure accuracy with the information provided to AllCare Health by our provider network.

MOC 3 Element A Factor 4: Facilitate collaboration with the ICT

Each SNP member selects or is assigned and has access to a Case Owner who is considered the hub of the ICT and ensures the timely delivery of any specialized services needed. The Case Owner and Intensive Care Coordination Team helps the member access the necessary services and ensures their delivery. The Case Owner works to ensure that the ICP accurately reflects the assessed needs as prioritized by the member and notifies ICT members, as appropriate. It is the Case Owner who collaborates and communicates with providers when a referral for services is needed. The Intensive Care Coordination team and providers have access to the provider web portal to monitor and identify service utilization. Network providers and facilities ensure delivery of specialized services in compliance with the Provider Participation Agreement. This agreement directs how network providers and facilities deliver efficient services to members.

Each member's goals and progress are reviewed by the AllCare Health's Interdisciplinary Care Team (ICT). The ICT meets for the purpose of collaborating with and on behalf of the member and addressing any challenges or changes the member has to their health. The ICT may consist of the member, the Case Owner, the member's primary care provider (PCP), and any other health specialists related to that member's specific health needs, i.e., psychologist, physical therapist, and/or pharmacist. The ICT may also be requested by any one of the participants as well, including the member.

The PCP is an integral part of a member's ICT as he or she will know the member's health history, challenges, and opportunities. The PCP will be able to contribute related health data, recommendations that fit the specific needs of the member, and other information that may assist other specialists in addressing higher levels of care. The PCP works collaboratively with the TOC Case Owner to support the member through transitions of care. The PCP is requested

to provide any updates to the ICP as they see appropriate and communicate changes to the Case Owner. He or she receives the post-HRA letter and can communicate with the Case Owner either by telephone or fax.

Specialists are invited to an ICT when the discussion will include their areas of specialization such as mental health, chemical dependency, physical therapy, medication therapy, home care, etc. These participants are extremely helpful in the creation of a care plan that will include services, treatments, or protocols specific to the needs of the member. AllCare Health has policies in place to monitor the delivery of timely and effective care and runs reports, which are shared back with the provider network with staff follow-up, as necessary.

AllCare Health has a broad network of providers to provide care and services to our enrollees. The network encompasses all required provider types as well as fulfilling the geographic requirements. Authorizations and claims data are monitored to ensure timely access to services, along with Member satisfaction surveys. Providers also provide “days to next available appointment” as part of quarterly network monitoring.

Case Owners interact with the member’s primary care provider or specialist to ensure the needs of the member are met. As appropriate, the member’s assigned Case Owner assists the member in managing and accessing the specialized services needed and serves as a communication hub between the various members of the ICT. The Case Owner is the ICT member responsible for communicating with the member and/or caregiver, other ICT members, and appropriate stakeholders regarding any reports and the delivery of services to the member. Examples of how communication is facilitated amongst the ICT include:

1. From providers to members/caregivers: providers update members/caregivers during in-person, virtual, and telephonic visits.
2. Sharing with ICT and other stakeholders: the Case Owner facilitates communication with the ICT and relevant stakeholders verbally, via the provider portal, fax, electronically, and other avenues as they become available. This communication may also occur during interdisciplinary care conferences or informal timely updates, depending on the situation or need.
3. Reports of rendered services: reports and data are communicated amongst the ICT through the provider portal, verbally, fax, mail, or other avenues as they become available.

The Care Coordination team incorporates relevant information, such as delivery of specialized services or a particular plan of care into the ICP and/or care management notes. The information documented in the care management system is updated when new information is received regarding services. This communication is completed via secure email, telephone, fax, and mail, as well as through the electronic ICP.

MOC 3 Element B: Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CTPs)

MOC 3 Element B Factor 1: Monitor use of guidelines and protocols

AllCare Health evaluates practice guidelines, standards and policies for oral health care, medical and behavioral health practice to ensure alignment with evidence-based practice, community standards, and relevant law. The AllCare Utilization Management Clinical Practice Guideline and Utilization Review Committee (UMCPGURC) reviews, adopts, and disseminates evidence-based clinical practice guidelines (CPGs). UMCPGURC ensures CPGs are relevant and pertinent to our member and provider population, and that decisions for benefit and utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with Medicare and Medicaid adopted guidelines.

Clinical practice guidelines are reviewed and updated at least every two years or as needed to reflect current standards and scientific knowledge. Guidelines are available to community clinicians, network providers, and members via our provider portal and website.

To evaluate delivery of services in accordance with approved guidelines, annual performance measurements are conducted using the Healthcare Effectiveness Data and Information Set (HEDIS), which includes claims data, lab data, electronic health record (EHR) data, and manual medical record reviews.

UMCPGURC reviews and recommends evidence-based clinical practice guidelines and nationally recognized protocols. The AllCare Quality Improvement Committee approves the recommended GPGs before they are posted to the provider portal and public website. Examples include:

- Available peer-reviewed, evidence-based community standards.
- Governmental agencies (i.e., Agency for Healthcare Research and Quality and Health Evidence Review Commission).
- National centers/institutes (i.e., Institute for Health and Health Care Improvement, National Academy of Medicine, and National Heart Lung and Blood Institute).
- Recognized professional medical associations (i.e., American Medical Association, American College of Cardiology, etc.).
- Voluntary health organizations (i.e., American Diabetes Association, American Heart Association, etc.).

These guidelines are used to assist providers and members in making decisions about appropriate health care for specific clinical circumstances, including self-management of chronic diseases, such as diabetes. The guidelines are intended to improve the quality and consistency of care our members receive from network providers for both preventive services and chronic conditions. Each network provider's contract contains language stipulating delivery of services in accordance with evidence-based clinical practice guidelines and nationally recognized standards.

Some examples of evidence-based clinical practice guidelines that may be approved or adopted and are currently being considered as appropriate to the SNP population include:

- Asthma
- Heart disease
- Depression
- Diabetes
- Respiratory therapy
- Hypertension
- Renal disease
- Adult and child preventive screening
- Recommended adult immunization
- Tobacco cessation

Our evidence-based clinical practice guidelines are shared with all appropriate contracted providers as part of our provider education and via website links on provider website/portal.

To monitor our network providers, use of evidence-based clinical practice guidelines and nationally recognized protocols, we conduct annual performance measurements using the Healthcare Effectiveness Data and Information Set (HEDIS), which uses claims data, lab data, electronic health record (EHR) data,; member care gap reports, provider score cards and medical record reviews. HEDIS measures are presented to the Quality Improvement Committee, annually. The measures are reviewed for significant changes and are discussed at that time. In addition, Oregon Health Authority Metrics are also used to monitor and evaluate network providers.

Adherence to guidelines is also monitored through the Benefit (utilization) Management program. Authorization requirements are designed to eliminate barriers for members with chronic conditions and/or special health care needs. Decisions regarding what services should require prior authorization are made to target services that are high risk, frequently overused, and high cost. Benefit Management policies, guidelines, and criteria outline utilization requirements necessary for authorizing procedures, diagnostic treatments, provider specialties, and include code sets and item-specific requirements. Authorization determinations are made using evidence-based, established local, state, or nationally accepted criteria, including clinical practice guidelines, adherence to regulatory guidelines, and plan-specific requirements. AllCare Health gives practitioners with clinical expertise the opportunity to advise or comment on the development or adoption of Benefit Management criteria. Clinical Practice Guidelines are posted on the provider portal and on AllCare Health's public-facing website. Complete criteria sets are maintained electronically, and are available for reference to authorized entities, providers, and members upon request. In addition, medical directors, care coordinators, and Benefit Management staff have regular meetings to discuss cases that may be outliers and for any hospitalization over 7 days, adding multiple levels of oversight to the process.

Additionally, the Chronic Care Improvement Program (CCIP) for Medicare Advantage members ensures members with chronic conditions are effectively managed. Our CCIP

focuses on Diabetic medication adherence and is intended to increase medication adherence as well as enhance patient safety for our members with Diabetes.

The Medication Therapy Management (MTM) program offers a comprehensive approach implementing best practice evidence and clinical guidelines to improve medication prescribing and reduce the risk of adverse events and improve medication adherence. The goal of the MTM program is to improve the safety and effectiveness of pharmacotherapy for members, leading to improved medical outcomes and efficiencies. A comprehensive medication review is offered at least annually to all identified members enrolled in the plan's MTM program.

To ensure network providers and community organizations follow Care Transition Protocols, AllCare Health Population Health care coordination team meets regularly with community partners, agencies, primary care providers, or specialists to discuss challenges and barriers and ensure effective communication and coordination among behavioral health, oral health, physical health, specialty providers, and agencies, including non-emergent medical transportation (NEMT). Case Owners collaborate closely with Patient Centered Primary Care Home (PCPCH) care management teams to monitor cohorts of high-risk, high-needs members and receive alerts from PointClickCare (an ED notification system) of members who enter the Emergency Department (ED) so that care coordinators can intervene. As part of utilization management concurrent review, AllCare Health begins discharge planning at admission, using established guidelines and ensure planning is continuous throughout the stay and a clear plan is in place prior to discharge. Case Owners convene and participate in interdisciplinary care team (ICT) meetings and develop individualized care plans, which are shared with the member, family, and or natural supports. Case Owners coordinate with providers and community agency partners to manage care between settings, including hospitals, Oregon State Hospital (OSH), acute care nursing and rehabilitative facilities, hospice, home health, and home. Care coordination practices integrate cross-system education, timely information sharing, and coordination to avoid duplication of effort and to ensure effective deployment of interdisciplinary nursing and psycho-social resources when a member has a transition of care or change in condition.

MOC 3 Element B Factor 2: Specify challenges and exceptions to guidelines

We recognize that clinical practice guidelines are simply guidelines and require regular review against best practice evidence and community care standards. In the case of vulnerable SNP members, clinical practice guidelines may require modification or may not be appropriate, especially for those with complex health care needs; therefore, the final decision about clinical care for each SNP member is left to the provider's professional judgement.

Challenges identified include:

- American College of Cardiology/American Heart Association guidelines on hyper tension, which may recommend a blood pressure range too low for a member's condition.
- American Geriatrics Society Beers Criteria guidelines, lists potentially inappropriate medications for older adults; however, certain medications listed on Beers Criteria may

be appropriate for certain members, and provider clinical judgment may override the criteria.

- Certain psychiatric disorders that may put the member at high risk for certain recommended therapies.
- Late state chronic conditions in which providing recommended preventive service may not be appropriate or the member may not be able to tolerate preventive screenings.
- For example, colonoscopy may be medically inappropriate, difficult, or painful for a 57-year-old female member with severe developmental delay requiring 24-hour care, or a member enrolled in hospice may not be appropriate for or be able to tolerate preventive screenings.

In cases where clinical practice guidelines or nationally recognized protocols are not appropriate, or the need for modification is identified, staff consult with the medical director, member's primary care provider and interdisciplinary care team (ICT).

Participation agreements require providers to follow best practices and clinical practice guidelines and protocols when the treatment is appropriate for the member. However, at times, a network provider may need to make clinical judgments that supersede the clinical guidelines to best treat a member's condition and unique needs. Members' own health beliefs are another challenge as members may refuse a procedure, test, or behavioral modification that the provider recommends. A member's age and frailty factor as well as health literacy can also present challenges. Quality performance outcome measures (through HEDIS) do not always account for the possibility of member's refusal or the judgment of a provider that a service is contraindicated.

The member's Case Owner collaborates with the member and primary care provider or specialist as part of the ICT to communicate current issues that may affect decisions regarding the use of clinical practice guidelines and nationally recognized protocols for the care of the member. The primary care provider or specialist, along with the member, make the final determination whether to follow the clinical practice guidelines and nationally recognized protocols. The factors considered in this decision are as follows:

1. The member's preference/willingness to have the procedure or undergo behavioral modification.
2. The member's ability to tolerate the procedure (physically or mentally, due to age or frailty).
3. The member's cultural, religious, and personal beliefs.
4. Whether the procedure is clinically contraindicated due to the complexity of the member's condition.

For those members and/or caregivers who have chosen not to follow the clinical practice guidelines and nationally recognized protocols, the Case Owner works with the primary care provider and/or specialist to educate the member, caregiver, and ICT members about recommended and appropriate medical interventions with the goal of improving the member's understanding of the rationale behind the recommendations. ICT members are also educated

to help them understand why the clinical practice guidelines or nationally recognized protocols were not followed and ensure that recommendations are acted upon.

MOC 3 Element B Factor 3: Detail the decision process to modify guidelines

To ensure the adopted guidelines are appropriate, they are reviewed and updated at least every two years or more frequently as appropriate. If there is a situation where a guideline is deemed inappropriate and modified for the entire SNP population, the medical director will bring these findings and research to the Quality Improvement Committee. AllCare Health communicates approved new and updated clinical practice guidelines to the provider network (contracted and non-contracted) through the website, provider portal, and provider manual. AllCare Health providers are expected to remain current in their knowledge of changes in nationally recognized protocols and clinical practice guidelines related to condition specific treatment standards, as required by their professional licensure and through the credentialing process.

If care guidelines are not appropriate to a specific member's unique circumstances and needs, the Case Owner will communicate with the medical director who determines if it is possible to modify the guideline. Clinical evidence is reviewed and decision-making criteria applied to determine potential modifications and scope. Alternative options and recommendations are developed. The Case Owner will discuss these options with the member. With the options outlined, the member can make an informed choice.

Members of an ICT may include the member, the member's PCP, specialists involved in their care, pharmacists, home health, etc. During the ICT, clinical practice guidelines are reviewed along with alternative options and recommendations. If modifications are considered, associated risks and benefits of the modification are discussed. Once approved, the member plan is updated to include the specific modification needed. Changes in recognized care protocols must be supported by the member's primary care provider and are documented in the member's ICP. The changes to the member's ICP are communicated to the ICT by the Case Owner. The provider documents the discussion, and any alternatives offered along with the member's choice in the medical record. The members of the ICT will be expected to then act and support decisions and follow the modified protocols.

MOC 3 Element B Factor 4: Oversee care transition protocols

Case Owners coordinate and ensure that transition protocols outlined in MOC 2, Element E are followed by providers involved in each individual care transition. Case Owners oversee the transition process concurrently to ensure that members transition safely, that complications are minimized and ensure that appropriate resources are in place. The assigned Case Owner operates as the primary point of contact during transitions to ensure that all parties involved in the care of the member have the most current information, and that interventions needed to ensure health and well-being are appropriately coordinated.

During any transition of care event to or from any facility, a Case Owner ensures and verifies that the ICP has been updated and communicated with all ICT members, including the providers pertinent to the care transition to ensure continuity of care and to inform them of any necessary support services or individualized member needs. The Case Owner will then monitor to ensure all services and supports occur as planned. This procedure is followed during each transition of care event.

During the transition of care event, the member, provider and/or caregiver are contacted, either by phone or face to face to either discuss the transition plan or the changes that occurred during the transition of care event. The direct member or caregiver contact is completed either by Case Owner or by verifying that contact has already occurred by the member's PCP/appropriate provider. The contact includes, but is not limited to, discussion on the following:

- Discharge instructions.
- Understanding of instructions and changes to self-management activities.
- Confirmation that all new prescriptions are filled.
- Medication reconciliation by the Clinical Pharmacist.
- Assistance in scheduling a follow-up appointment with the primary care provider within seven days of the transition of care event.

The goal of the transition of care protocols is to

- Assess and evaluate barriers to care, including access to newly prescribed medications.
- Create or update the ICP to address any new barriers with targeted interventions.
- Promote education opportunities for self-management activities identified in the ICP.
- Frequent communication with the member and the member's care team to ensure follow-through interventions to mitigate barriers to care.
- Communication with the ICT including PCP, community resources, and other care team members.
- Frequent evaluation of the ICP to timely address member needs, including medication reconciliation by the Clinical Pharmacist.
- Facilitate a safe transition through the various levels of care through appropriate coordination of care.

MOC 3 Element C: MOC Training for the Provider Network

MOC 3 Element C Factor 1: Implement MOC provider training

The Provider Network Department ensures that the initial and recurring annual trainings for providers who routinely see SNP members adhere to the CMS regulatory requirements. Our Special Needs Plan Model of Care (SNP MOC) training content is developed by the Provider Network Department in collaboration with the VP of Population Health and approved by the Chief Medical Officer. The Provider Network Department prepares all the training materials annually, including content development of the presentation and ensures the current version is posted on the Provider Education page on the provider website.

The Provider Network Department utilizes reporting to determine the target audience for training. All in-network PCPs will be included in the denominator to complete the training. Reporting will be conducted on a quarterly basis to assess SNP member's utilization of out of network providers and if found, will include these providers in the denominator as well. Any new clinics/providers will be provided an in-person (if possible) orientation that details the SNP MOC.

As part of a comprehensive approach to provider training, AllCare Health's Provider Network Department has developed the following strategy to ensure that providers that treat this vulnerable population on a routine basis can understand and be engaged in the care of the SNP members.

D-SNP Model of Care (MOC) Training

Hazel Clements, MA, PMP
VP of Population Health



Welcome



AllCare Health is dedicated to achieving the best possible health outcomes for members in our Medicare Advantage Special Needs Plan or SNP

We recognize Special Needs Plan members may experience multiple chronic health concerns, economic instability and other social factors which negatively impact quality of life and health outcomes.

We enroll all eligible individuals – regardless of mental or physical condition, health status, claims history, genetic information, medical history, disability, age, sex, sexual orientation, marital status, race, ethnicity, religion or political beliefs.

Welcome



As a provider to this vulnerable population, your role is both central and critical to impacting positive health outcomes.

AllCare Health Plan – alongside our network of providers and community partners – is here to support your work with our Special Needs Plan Model of Care.

The time, support and care you provide for some of the most vulnerable members of our community is appreciated.

Thank you,
AllCare Health Plan



About this Training

AllCare Health Plan ensures that initial and annual trainings for in-network and out-of-network providers who routinely see special needs plan members (SNP) adhere to the Centers for Medicare and Medicaid Services regulatory requirements. [42 CFR 422.101 (f)(2)(iii)]

AllCare Health's Special Needs Plan Model of Care, or SNP MOC, training content is developed by the Population Health department in collaboration with the Provider Services and Marketing Department.

Training materials are updated annually to ensure content is current and covers the elements of care that are being delivered according to the SNP MOC Program. Training is provided in-person, via virtual webinar, and/or through computer-based technology. All training must be documented via signed attestation.



Learning Objectives



This training examines the four elements of a Medicare SNP MOC as they pertain to AllCare Health Plan Medicare Advantage Special Needs Plan. During this training, you will leave with an understanding of:

- Service area demographics, chronic conditions and barriers faced by our SNP members.
- How Care Coordination is achieved between providers and AllCare Health Plan and our Care Management team.
- Clinical Care Guidelines and how AllCare Health Plan determines and shares quality and performance improvements.
- Additional resources and programs to support members.



Part 1: Understanding Our SNP Members

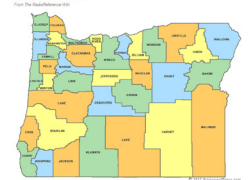
Who Are Our SNP Members

AllCare Health Special Needs Plan is a D-SNP plan open to eligible individuals in Jackson, Josephine, Curry and Southern Douglas counties.

Members must meet “means tested eligibility requirements” for the Oregon Health Plan (Medicaid) and be enrolled in Medicare Part A and Part B due to age and/or disability.

SNP members represent one of the most economically disadvantaged and medically vulnerable groups in our 4 county service area.

Oregon Counties



CMS.gov



Who Are Our SNP Members – By Age Group

SNP Members by Age Group

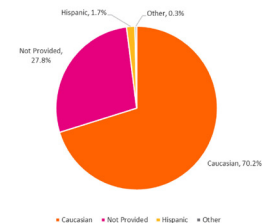


Who Are Our SNP Members – By Race & Ethnicity

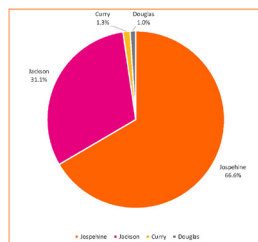
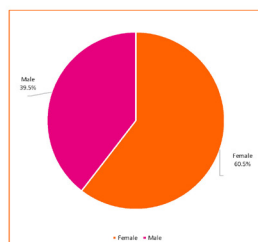
While SNP members may predominantly speak English and be classified as Caucasian, providing culturally and linguistically appropriate services is essential.

Culturally and linguistically Appropriate Services (CLAS) are respectful of and responsive to an individual's culture and communication needs.

For assistance in understanding how to better implement CLAS in your practice, please reach out to AllCare Health Plan's Provider Services Team.



Who Are Our SNP Members – By Gender & County



Who Are Our SNP Members – By Chronic Conditions

Top 10 Chronic Conditions

Neck & Back Injury/Pain
Diabetes
Chronic Kidney Disease
COPD
Rheumatoid Arthritis, Osteoarthritis
Sleep Disorders
Hypertension
Anxiety Disorder
Depressive Disorder
Bipolar, Schizophrenic Disorder

AllCare Population Health reviewed DSNP member claims for 2023, to determine the prevalence of chronic conditions among our Special Needs Population.

Approximately 69.3% of SNP members were identified as having a chronic condition that impacts them mentally, physically or behaviorally.



Who Are Our SNP Members – By Behavioral Health

Behavioral Health Conditions are a growing concern for our members

Behavioral Health Conditions

Depressive Disorder
Anxiety Disorder
Bipolar Disorder
Schizophrenia and other psychotic disorders
Substance Use Disorders
Personality Disorders
Learning Disabilities, ADHD, Conduct disorders and Hyperkinetic Syndrome

Behavioral Health conditions cause reduced social engagement. Depression may exacerbate other health conditions and cause increased pain. In turn, these factors may affect member's quality of life and precise care they are given.

Members ability to accomplish goals, maintain behaviors and adhere to care plans may be impaired by depression and anxiety disorders.



Challenges

In addition to chronic health conditions, our SNP members may experience additional challenges which impact overall health.

 Social Support Social Support is the perception and actuality of available assistance – be that emotional, informational, tangible or intangible.	 Economics To qualify for Medicaid benefits, an individual's means-tested income and assets must already be near or below the federal poverty line.	 Educational Attainment Educational attainment has a direct & measurable impact on behavior, socialization, economic security and health literacy.	 Transportation Transportation, particularly for rural members without access to public transportation networks presents many concerns.	 Housing Our service area – and Oregon – is in an ongoing housing crisis. For low-income individuals or those with accessible needs, access to affordable housing can be daunting.	 Food Insecurity Food insecurity is the state of being without reliable access to a sufficient quantity of affordable, nutritious food.
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Part 2: Care Coordination

AllCare Health Plan Care Coordination supports both member and provider with essential care management services such as health assessments, individualized care plans, education, transportation assistance and coordination for transitions of care.

Care Coordinators may be RNs, LPNs, Clinical Social Workers, Respiratory Therapists, Intensive Care Coordinators, Community Health Workers. They are matched to member needs by the Health Risk Assessment.



Care Coordinators reinforce provider recommendations and seek to motivate care plan adherence through targeted interventions which develop healthy habits while mitigating behavioral and social barriers to self-care.



Part 2: Care Coordination

In most cases, Care Coordinators will contact providers upon member assignment through a letter or phone call. Additional methods of communication may be facilitated by circumstantial need.

Care Coordinators are available- **Monday through Friday, from 8 am to 5 pm**

By Calling **541-471-4106**

Email: Provider Rapid Response ProviderRapidResponse@allcarehealth.com

Customer Care team is available- **Monday through Friday, from 8 am to 8 pm**

By calling **541-471-4106**



Part 2: Care Coordination

Each Members care coordination is predicated on standard SNP MOC elements



Part 2: Care Coordination- Continued

Each Members care coordination is predicated on standard SNP MOC elements

The Health Risk Assessment, or HRA, is completed by the member, members representative or with the help of the AllCare Health Care Coordination team and includes questions around medical, functional, cognitive, oral and psychosocial health, social determinants of health and safety of environment.

HRA results may generate a referral for care coordination to address resource needs (community health worker) or clinical needs (RN or behavioral health care coordinator).

Care coordinators perform a comprehensive assessment, the outcome of which drives creation of the member-centered and trauma-informed care plan. Members and providers are sent a copy of the care plan.

Care coordinators arrange Interdisciplinary Care Team meetings, or ICT, on a cadence appropriate to a member's needs. ICT meetings include the member, provider and other participants of the member's Interdisciplinary Care Team.

Care plan goals, interventions and outcomes are reviewed and updated during ICT meetings. Changes in condition and identified obstacles to care are also addressed.



Part 2: Care Coordination- Health Risk Assessment

- Members are mailed a paper HRA upon enrollment into the plan
- Goal is to complete the HRA within 90 days of enrollment, annually and at any time there is a Health-Related Circumstance Change or Transition of Care. They can be completed in person, by phone, mail or online.
- Questions focus on medical, functional, cognitive, oral and psychosocial health, social determinants of health and the safety of the members environment.
- Assists in identifying barriers to care and provides education to our member.



Part 2: Care Coordination – Individualized Care Plan

- Members, members representative, providers and / or family participate in the creation, which is conducted in a trauma – informed, culturally and linguistically appropriate manner.
- Maintained and monitored by the Care Coordinator
- Updated annually or as transitions of care or diagnosis indicates, and based on members health status, and members progress towards goals
- Assists in identifying barriers to care and provides education to our member
- ICPs are mailed to the member and shared to the PCP, ICT and caregivers and stored in the AllCare Health Care Management System



Part 2: Care Coordination – Interdisciplinary Care Team

- Facilitated and overseen by the Care Coordination Team
- Meeting cadence is determined by the member's unique needs
- All ICTs include minimum of an AllCare Health Care Coordinator, member and member's PCP
- ICT participants may include specialty providers, Community Based Organizations and family members
- ICTs work to share information to update the care plan and ensure that services are not duplicated for this member



Part 2: Care Coordination – Face to Face Encounter

- Ensure the member has a Face-to-Face encounter with a provider within the first 12 months of enrollment and at least annually ongoing
- Conducted in person, or through visual, real-time, interactive telehealth encounter
- Wellness visits, annual physical, care plan review, health related education, encounter to manage, treat and oversee health care each represent activities conducted for the qualifying face to face encounter
- Vendors may perform the Face-to-Face encounters for some members. The vendor will supply a copy of their assessment/recommendations to the members provider of record
- Care Coordination activities are driven by Face-to-Face encounters to follow up on needed care or services



Patient- Centered Primary Care Homes



Clinics recognized by the Oregon Health Authority for their commitment to a comprehensive, patient centered model of primary care organization and delivery

PCPCHs utilize a coordinated, team-based approach to support whole body health with a focus on:

Accessibility
Quality
Safety

This model and the SNP Model of Care are naturally comparable. Both strive to respect an individual's unique perspective and challenges, encourage active patient and family participation in care planning and goal setting.



Role of the PCP



Integral to any ICT, the PCP contributes related health data, recommendations that fit the specific and unique needs of the member and other information that may assist specialists in addressing higher levels of care.

PCPs and PCPCHs:

Provide oversight, negotiate or consult with other ICT members to prioritize care and eliminate contradiction or duplication in care

Provide updates to the individualized care plan as they see appropriate and communicate changes with the care manager

Support and encourage members to continue with interventions contained within the individualized care plan

Work collaboratively with care managers during transition of care periods to support the member



Transition of Care



A transition of care occurs when a member moves from one care setting to another — such as returning home from inpatient hospitalization or outpatient surgery, changing PCPs or the initiation of home-based services



When a transition of care event is identified, the Care Coordinator coordinates between the member, PCP and Interdisciplinary Care Team.



Transition of Care- continued



Following a transition of care event, the care manager contacts the member to assess the following:

- Assesses member's understanding of discharge instructions.
- Ensures member has a post-hospital follow-up appointment.
- Identifies potential barriers (Transportation).
- Reviews any new care needs.
- Links member with all needed services (Medications, home health, DME, etc.).
- Educates for post-transition care (medication compliance, provider follow-up).
- Collaborates with provider.
- Updates individualized care plan.

Finally, the care manager updates and redistributes the individual care plan to all parties involved in members care.



Questions or Concerns

AllCare Health is here to assist your practice



For questions regarding the SNP MOC or care coordination, contact our care coordination team.

Care Coordinators are available- Monday through Friday, from 8 am to 5 pm Or by calling 541-471-4106



Or Email: Provider Rapid Response ProviderRapidResponse@allcarehealth.com



To reach any of other AllCare Health departments—please call our dedicated provider lines, Monday through Friday, from 8 a.m. to 8 p.m.

541-471-4106



AllCare Provider Portal

AllCare Health is here to assist your practice



The **AllCare Provider Portal**—is your resource to:

- Receive important health plan communications
- Verify member eligibility
- Submit requests for PCP assignment via the contact us page
- Submit referrals and prior-authorizations and check their status
- Request an update to an authorization
- Provide a secure submission of support documentation
- Check on the status of a claim
- View prior-authorization guidelines
- Access health plan policies, procedures, and guidelines
- Search the exclusive Oregon Health Plan (OHP) Line Locator tool



Part 3: Clinical Care Guidelines

SNP Goals and Quality Improvement

- AllCare Health Plan Utilization Management Clinical Practice Guideline and Utilization Review Committee reviews, approves and disseminates evidence-based clinical practice guidelines and nationally recognized protocols to community clinicians, network providers and members.
- Approved clinical practice guidelines are available online at <https://www.allcarehealth.com/medicaid/resources/clinical-practice-guidelines>
- AllCare Health Quality Improvement Committee meets monthly to review member data and Transformation and Quality Projects
- The QI Committee supports the development and monitoring of quality improvement goals to the SNP MOC Population Health team



SNP Model of Care Goals

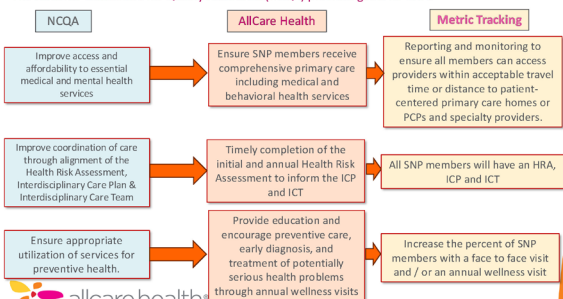
The National Committee for Quality Assurance (NCQA) provides goals for SNPs

- Improve access and affordability to essential medical and mental health services
- Improve coordination of care through alignment of the Health Risk Assessment, Interdisciplinary Care Plan & Interdisciplinary Care Team
- Ensure appropriate utilization of services for preventive health.
- Improve seamless transition of care across all healthcare settings and providers.
- Ensure appropriate utilization of services for chronic conditions.



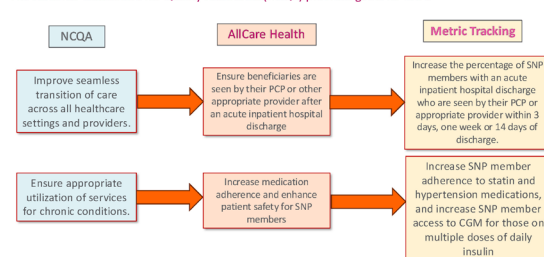
SNP Model of Care –Continued

The National Committee for Quality Assurance (NCQA) provides goals for SNPs



SNP Model of Care –Continued

The National Committee for Quality Assurance (NCQA) provides goals for SNPs



MOC Oversight

- Clinical leadership is provided by department supervisors, managers, and directors
- The Chief Medical Officer has overall executive responsibility for the Model of Care
- AllCare Health Quality Improvement and Compliance Departments monitor performance and compliance

Additional D-SNP Benefits

- Medication Therapy Management
- Diet and nutritional education
- Behavioral health services and social work support
- End-of-life support and Advance Care Planning
- Home and community-based services partnerships
- Non-emergency medical transportation (NEMT)
- Meal programs during transitions of care

Part 4: Provider Resources

We are here for you!
 Provider Relations representatives are available to support you by assisting with educational requirements, data and reporting, compliance, care coordination and to resolve any operational issues you may have. Please contact us using the following methods:
Phone: (541) 471-4106

Provider Website: Learn more about our innovative medical services that reduce costs and increase practice efficiency.
Provider Portal: This is where you can go to find out information related to member eligibility, referrals and prior-authorizations, claim status, policies and procedures and tools that assist with day-to-day processes.
AllCare IPA: AllCare IPA is committed to helping doctors and providers deliver better and more cost-effective care to our local communities

This Completes Your 2024 SNP MOC Provider Training

Please complete your training attestation [here](#)

From all of us,
 Thank you!

See appendix for larger version

Out-of-network providers that see members on a routine basis are tracked for adding to the network. All Single Case Agreements have language that the provider is required to follow AllCare Rules and Standards that would include these types of training. Participation in these training courses would also be utilized to assess if a provider should continue to be contracted.

Initial Training is presented to Primary Care providers that are contracted with AllCare Health's Medicare and Medicaid plans. PowerPoint presentations are usually conducted as part of the new provider outreach and/or during an office visit within 90 days of being newly contracted. If unavailable to review in person, the newly contracted provider is emailed information to inform them how to complete the required SNP MOC training. This can be completed in various ways: phone, face to face, web-based presentation, or PowerPoint training. All training is followed by an attestation of participation.

Annual Training. Email reminders with instructions and training availability dates are sent to existing contracted providers for annual training. Reminders are sent quarterly until the training and attestation are completed.

Utilization reports are run quarterly to capture any newly identified in-and-out-of-network providers that routinely treat the SNP population. Outreach is made at this time to inform of the training requirements, and providers are added to the training list for future education. SNP MOC training is provided using one of the following methods:

Phone – AllCare Health offers one on one training over the phone. The training is supported with hard copies of the training slides along with the attestation for the provider to complete and email or fax back.

Face-to-Face Provider Office Visits – Whenever possible, trainings will be conducted in person. This approach uses PowerPoint presentations by Provider Relations staff and handouts of the presentation slides. Training may include large and small group practices or one-on-one meetings with individual providers and their office staff.

Web-based Provider Training – Webinars are scheduled twice a year and offered before and after provider office hours to limit disruption in daily schedules. Providers that receive the training via the webinar have an opportunity to collaborate on ways to improve health outcomes and receive attestation. Web-based provider training may also be completed using a PowerPoint presentation via the online self-paced training module located on the provider website.

SNP MOC training is accessible on the AllCare Health provider website year-round. Providers can access the PowerPoint presentation and attestation form at the AllCare Health Plan web site as well as on the AllCare Health provider portal.

The SNP MOC training focuses on key components, presents goals, and provides a description of the unique composition and needs of our members.

MOC 3 Element C Factor 2: Document and maintain evidence of training

The Provider Network Department documents training through a tracking document that includes all applicable providers. When the provider completes the attestation after completion, a notice is generated, which prompts the Provider Network Department to mark the training as complete. A reminder email will be sent to providers and their respective office manager who have not yet completed the training on a quarterly basis.

The SNP MOC training is made available to all in-network and out-of-network providers through multiple communication venues.

- The SNP MOC training is available through the provider portal and offered via in-person or virtual means at quarterly provider training provided by the Provider Network Team.
- Base contracts contain the provision that all providers will follow CMS guidelines for training and required education.
- AllCare Health will ensure the training, and the requirements are communicated to all office managers.
- Newly contracted providers receive an email notification about the required training with links to access the training and opportunity for onsite training.
- Information regarding the training will be given during each of the quarterly provider webinars.
- During the 3rd and 4th quarters, monthly reminders will be sent with a “Final Notice” status until the provider becomes compliant. November will be the final notice before non-compliant names are submitted to the Chief Medical Officer. The reminder will include directions on how to access available training as well as clarification of the consequences of failure to complete.

The recording of providers who have and have not completed the SNP MOC training is documented and stored within the Provider Network Department for review by the Chief

Medical Officer in the fourth quarter. The Chief Medical Officer then meets with the Provider Network Team to review the list and prioritize providers for direct outreach.

MOC 3 Element C Factor 3: Describe challenges to training completion

Ensuring all in-network providers and out-of-network providers seeing members on a routine basis complete the SNP MOC training can be an ongoing challenge. Many providers have reported having limited time to attend or complete the training. To accommodate this challenge, a formal schedule has been set to send reminders on a steady and frequent basis. Reminders for scheduled training are sent through email, newsletter, in-person, and through the provider portal to provide multiple options for our busy providers. We have also provided multiple modalities to complete the training, such as scheduled over the phone, face to face, and web-based computer training.

In addition, providers have reported that the training will be redundant to other SNP MOC trainings by other payers. If applicable, verification of completion of SNP MOC training offered by another payer may be accepted if content is able to be reviewed for completeness.

AllCare Health will run regular reports to identify every out-of-network provider that services each of our SNP members and add them to the list for SNP MOC education and training. Claims and utilization management data will be reviewed, and out-of-network providers will be outreached by the Provider Network department for SNP MOC training, once identified.

Providers that do not receive the required MOC training will be sent a reminder (as outlined previously) and will be scheduled to receive the training in a timely manner by the Provider Network department. Providers that fail to complete the training will be contacted by the Chief Medical Officer and if needed, this will be escalated to our Compliance Department for further action, including, but not limited to, completion of a Corrective Action Plan or potential loss of contract.

MOC 3 Element C Factor 4: Address incomplete or deficient training

In the last quarter of the year, reminder emails will be sent to non-compliant providers and their office manager (if applicable) notifying them that a short window remains to fulfill this requirement. Specific deadlines will be given along with consequences of non-compliance.

Actions to ensure that relevant training is completed and/or for dealing with noncompliance are developed through coordinated efforts of appropriate AllCare Health staff (Population Health and Provider Network) and providers. Actions that AllCare Health takes in response to noncompliance with required Model of Care training include but are not limited to the following:

1. **Notifications:** As the first step in the escalation process, AllCare Health makes attempts to contact providers to ensure satisfaction with the training requirement.
2. **Education:** Additional education is provided to those who have not completed the training to emphasize the importance of applying this model for AllCare Health

members. In addition, network providers are referred to their contract obligations, which identify the need to follow all AllCare Health policies and protocols.

3. **CAP or individual disciplinary action plan:** This is the last step in our escalation process. If all other avenues have been exhausted, AllCare Health may implement a CAP or disciplinary action. Following the exhaustion of applicable internal policies and procedures and contractual requirements, AllCare Health may make the determination to terminate a contracted provider and/or facility that does not comply with the required training.

All AllCare Health agreements include the following termination language

8.2. For Cause Termination. In addition to paragraph 8.1, and subject to the termination requirements, if any, in the attached exhibits, either Plan or Contractor may terminate this agreement by giving written notice to the other stating its intention to terminate and stating with particularity an alleged material breach of this agreement. If the alleged breach is not cured within 30 days after notice is given, and the alleged material breach occurred, the other party may then terminate this agreement immediately upon written notice. This right of termination is in addition to all other rights and remedies. By example only, failure to adhere to Plan's Rules and Standards is a material breach. Failure to exercise this remedy is not a waiver with respect to repeated breaches or a continuing breach.

Not participating in annual training would be considered a breach of contract and failure to adhere to AllCare Health Rules and Standards.

MOC 4: MOC Quality Measurement and Performance Improvement

MOC 4 Element A: MOC Quality Performance Improvement Plan

MOC 4 Element A Factor 1: Detail quality improvement (QI) process

AllCare Health is committed to excellence in the quality of care and services provided to members and to the competence of its providers, practitioners, and ancillary networks. In embracing the principles of Health Care Transformation, the Plan's Quality Improvement Program (QI Program) is focused on the following: improving member satisfaction, improving the health status and quality of care for our members and communities served, improving member safety and member access to medical, oral health, mental health care, and social services in the most integrated and cost-effective manner as possible.

The Health Plan's QI Program establishes a formal process for the development and implementation of an effective clinical and non-clinical quality improvement program, promotes objective and systematic monitoring and evaluation of clinically related activities, and continuously acts on opportunities for improvement, including determining if the Model of Care structure effectively accommodates AllCare Health's dually eligible Special Needs Plan member's unique needs. These strategies include addressing scheduled and ad hoc auditing requirements, reporting requirements, identification of responsibility, timelines, consequences for noncompliance, committee involvement, transparency, board approval, staffing requirements, and QI project design and implementation. The QI Program reviews annually the

overall effectiveness of the Model of Care and appropriateness of care and services furnished to SNP members. The QI program focuses on activities related to health care access and availability, member satisfaction, patient safety, continuity and coordination of care, disease management, clinical pharmacy programs, preventative health, health equity, member rights, over/under utilization of services, and quality of service. Through the Board of Governors, focused efforts have been part of the quality strategy in addressing the Social Determinants of Health and Health Equity (SDOH-E): sufficient food, housing, utilities, domestic violence, and non-emergent medical transportation (NEMT). Specific data sources used to measure effectiveness of MOC are described in MOC 4 Element A Factor 2.

The scope of the QI Program is reflective of the health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality of clinical care, quality of services provided to members and access to needed clinical, behavioral health, oral health, NEMT, and flexible services in an equitable and appropriate way.

Performance and outcomes measures gathered by survey data such as HEDIS, CAHPS, HOS, and STAR data, to name a few, are reviewed, analyzed, and interpreted by all participants of the QIC and are translated operationally to guide improvement processes.

AllCare Health's QI Program encompasses the following program documents and processes: the QI Program Description, the Quality Improvement Work Plan, and the Quality Assurance Performance Improvement Review.

Quality Improvement Program Description

This QI Program Description is a written description of the QI Program and its structure that defines the scope, objectives, activities, and structure of the QI Program. The following specific factors are contained within the document:

- Description of the QI Committee structure that oversees the QI functions of the company.
- Description of the QI Committee's accountability to the Board of Governors.
- Description of the roles, structure, function, and meeting frequency of QI related committees.

The Program Description is revised, as necessary, and reviewed, and approved annually by the CEO, CMO, Board Chair and the CCO. The Quality Program Description reflects comprehensive Quality Improvement Policies and Procedures based on contract requirements, state, and federal laws.

Quality Improvement Work Plan

The QI Work Plan is a dynamic document that is updated frequently during the year and reflects progress made on QI activities throughout the year utilizing the Plan, Do, Study, Act (PDSA) process for rapid and sustained opportunities for improvement. The QI Work Plan addresses the following:

- Planned projects/activities for the year.
- Planned monitoring of previously identified issues.

- Rationale for each activity.
- Accountability for each activity.
- Performance goals for each activity, as appropriate.
- Planned evaluation of each activity.

Quality Assurance Performance Improvement (QAPI) Review

The QAPI Review captures QI activity results on an annual basis and identifies opportunities for improvement, which will then be incorporated into the following year's Quality Improvement Work Plan. Following this evaluation, the goals, effectiveness, and scope of the QI Program are documented in a formal QAPI Report. The report is driven by the objectives outlined in the QI Program Description and the goals/objectives detailed in the QI Work Plan. The report summarizes activities and outcomes of the QI Program. The QAPI Review includes the following:

- A description of completed QI activities that address the quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of the results of QI initiatives.
- Evaluation of the overall effectiveness of the QI program.

The QIC provides ongoing guidance and monitoring, as appropriate, regarding quality management projects, and goals. The Committee approves quality improvement projects that specifically address performance, and outcome measures and evaluates the effectiveness of the quality improvement program.

MOC 4 Element A Factor 2: Describe QI data collection

The data sources utilized for clinical quality improvement measurement may include but are not limited to the following: medical record review findings, utilization review data, encounter data, claims data, provider/member grievances and appeals data, provider and member survey findings, and demographic statistics. Annually required HOS and CAHPS survey data are CMS projects that provide valuable information regarding members' perceptions and feedback about their overall health status and access to care. Annually, HEDIS data is collected from utilization management records and medical chart review. Other data sources reflect the membership population in terms of age, REAL-D data, other demographic, geographic, disease categories, and special needs status.

AllCare Health continually collects data to assess progress on outcomes measures and performance. This is supported by detailed documentation on all goals and by continuously evaluating and presenting them to internal stakeholders and the QIC to garner feedback throughout the year. The MOC evaluation process supports the Annual Evaluation and includes:

- a) A description of how the effectiveness of the MOC is evaluated through:
 - o Review of processes that identify and stratify Members based health risks.

- o Review implementation of the Individualized Care Plan and how it addresses identified health risks.
 - o Review of improved care coordination through effective communication, networks, and documentation of care.
 - o Review of improved coordination of care for vulnerable Members through the implementation of the MOC.
 - o Review of grievance data and trends.
 - o Review of potential quality concern referrals.
 - o Analysis of utilization data.
- b) A description of the methodology used.
 - c) Specific measurable performance outcomes that demonstrate the ability to see improvements.
 - d) A description of how documentation on MOC evaluations is maintained and made available.
 - e) Identified opportunities for improvement.
 - f) A description of how actions are determined based on the results of MOC evaluations.

Measures selected for monitoring will reflect State and Federal requirements, including the SNP MOC, and health plan initiatives. Selection of other topics for monitoring is made by identifying areas that are high in volume, high risk, high cost, reflect health care disparities or poor outcomes for our membership population. Selections are made on the probability that such focused review and monitoring will have a positive impact on the health and well-being of the members and communities served.

AllCare Health recognizes that a focus on reduction of medical errors is critical to the delivery of safe and effective health care. The goal is to always promote and encourage patient safety. Physicians, hospitals, and other health professional partners are required to use evidence based clinical practice guidelines, outcomes-based medicine, and processes and systems aimed at reducing errors and improving health outcomes. AllCare Health believes that our collective success in improving patient safety is dependent upon looking at the definition of 'health' through a health equity lens, attention to clinical outcomes-based practices, patient needs, and informed members.

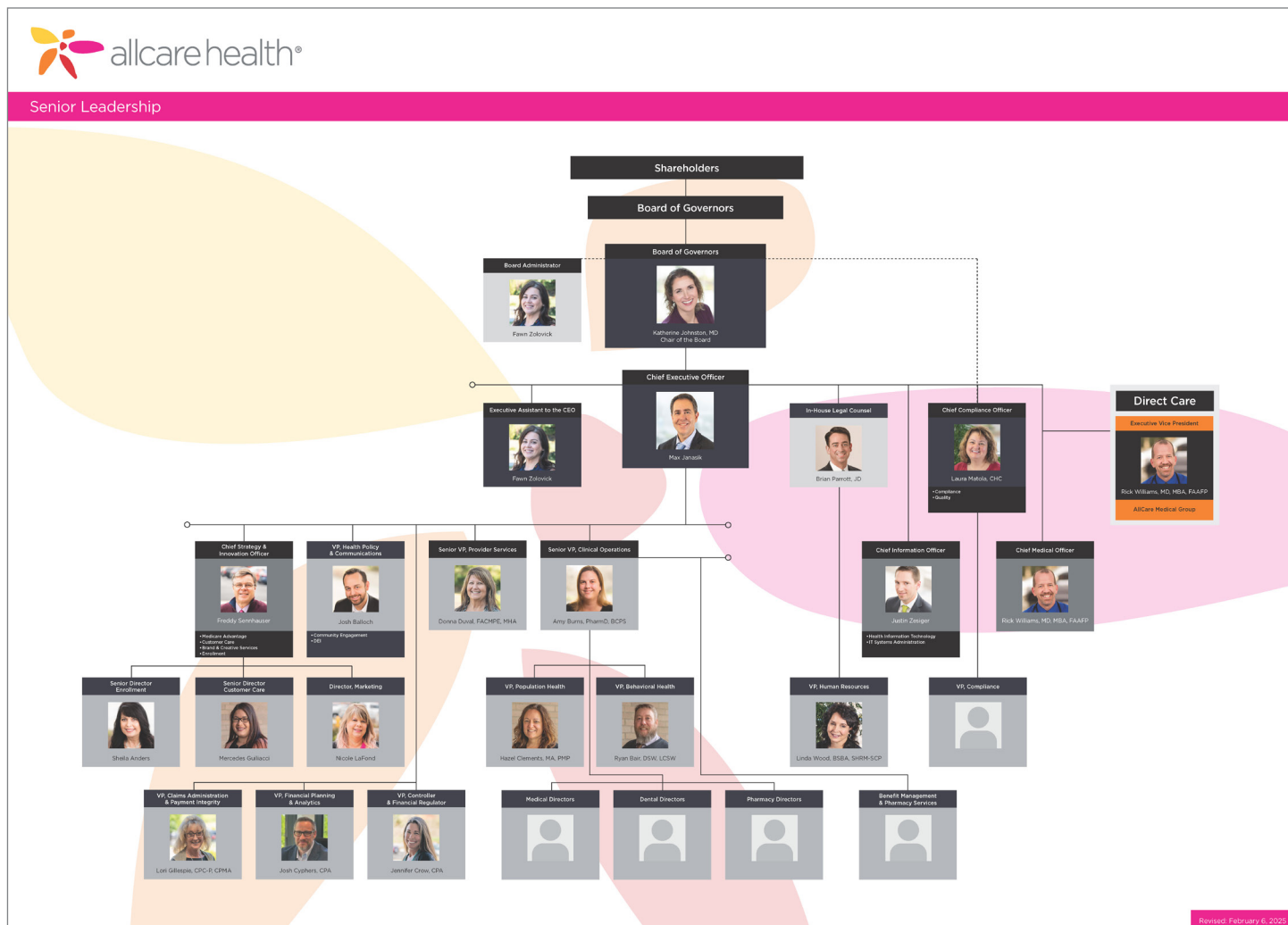
A high-level overview of the annual evaluation of the Model of Care is included during the Quality Assurance Performance Improvement Review. The Model of Care annual report will have detailed information on the performance and improvement opportunities for the Model of Care identified in the goals and outcomes and AllCare Health's performance in obtaining these. Beyond performance metrics, this report provides detailed recommendations for identified areas of improvement. If recommending specific actions, consideration is given to the prevalence of the problem, its effect on member care and safety and professional practice, and the potential ability to effect change. Whenever possible, AllCare Health attempts to participate in collaborative activities that have the maximum potential to effect change in partnership with our members, providers, other health plans, and/or AllCare Health partners.

To ensure continuous quality improvement, AllCare Health takes actions to improve the Model of Care through a variety of means. The primary changes that are undertaken include, but are not limited to, changes to the following:

- Measurable objectives for each action.
- Time frames for improvement plan.
- Parties responsible for implementation.
- Policies and procedures.
- Staffing patterns (CCM ratios and personnel).
- Provider and facility network.
- Systems of operation.
- Communication of results internally and externally.

AllCare Health uses the Plan-Do-Study-Act (PDSA) cycle to coordinate continuous quality improvement activities. If initial interventions do not result in the expected improvements to the Model of Care or other quality improvement activities, the plan of action is analyzed for possible unexpected barriers and revised as indicated prior to re-implementation until desired results are achieved or until AllCare Health and/or partners and providers are able to otherwise demonstrate the concern has been resolved. A formal review of all quality improvement activities occurs on a quarterly basis.

AllCare Health Structure and Accountability



Revised: February 6, 2025

Quality Improvement Committee

The Quality Improvement Committee is comprised of six board appointed providers currently with representation from the following disciplines: 2 Family Practice physicians, 1 OB-GYN physician, 1 Urgent Care physician, 1 pediatric NP (Board Liaison and Chair) and 1 Behavioral Health MA, LPC, CCP. Non-voting members of the QIC may include: The Senior VP of Clinical Operations, QI Director, Vice President of Behavioral Health, VP Compliance, Chief Medical Officer, Lead Medical Director, Oral Health Medical Director, Sr. Director Oral Health Integration Coordinator, Chief Compliance Officer, and VP of Population Health.

The Quality Improvement Committee (QIC):

1. Reports to the Board of Governors every other month (through the CMO). The QIC meeting minutes are included in the Board Packet.
2. Responsibilities include the oversight of all Quality Improvement program's structure, scope, criteria, and activities, including any Quality Corrective Action Plans or Corrective Work Plans. Oversight of delegated functions is the primary responsibility of

the Compliance Committee but audit reports or Compliance/FWA CAPs are brought to the QIC as an informational item.

3. Provides oversight of quality of care, quality of service standards, and professional review protocols by monitoring grievance/appeal trends, and recommending corrective action when needed.
4. Ensures effectiveness and status of the clinical QI program activities, including provider satisfaction with UM processes (physical, behavioral, and oral health), patient safety, continuity and coordination of care, disease management, preventative health, and over/under utilization.
5. Determines and oversees quality improvement projects, performance improvement projects, health/wellness/prevention outreach and activities.
6. Reviews individual practitioner quality issues identified through internal processes to address professional performance and submits monthly quality of care, quality of service and adverse events data to the Credentialing Committee on providers applying for re-credentialing.
7. Recommends reporting providers to their licensing boards.
8. Reviews individual practitioner concerns when referred from the Compliance and Program Integrity Committee, Medicaid Fraud Control Unit, Department of Justice or Office of Inspector General.
9. The QIC is:
 - a. Charged with oversight of under- and over-utilization activities and processes.
 - b. Responsible for strategic medical management activities to ensure that members receive optimal, cost-effective care that enhances health outcomes.
 - c. Reviews reports and program updates.
 - d. Reviews medical policy and other appropriate UM Program documents for comprehensiveness and appropriateness, and facilitates inter/intra-departmental communication.
 - e. Makes recommendations to the UM Program representatives for areas of focused review and monitoring.
 - f. Assesses, reviews, and makes recommendations for new technology and procedures.
 - g. Forwards recommendations to the Credentialing Committee regarding provider requests to offer specialized services to ensure providers have the required credentials to perform the services.
 - h. Reviews and affirms clinical practice and preventative health practice guidelines annually.
 - i. Make recommendations to the CMO regarding changes in benefit plan design.

- j. Evaluates and recommends revisions to existing utilization decision-making guidelines and adoption of new criteria for standardized UM decision-making.
- k. May appoint specific sub-committees or task forces to address specific topics for review and study.

The overarching role of the QIC is to recommend an ongoing Quality Improvement program in each of these specialty areas, make specific recommendations as required by individual cases or situations and facilitate quality improvement efforts when opportunities are identified. With the assistance of individual staff and department participation, the following internal quality teams collect, analyze, report, and act on information to evaluate and improve the Model of Care:

The Quality Director and Lead Medical Director and VP of Population Health are charged with authority and accountability for all quality improvement activities and processes. The Quality Director, Lead Medical Director and the Board appointed subcommittees serve as a point of network and interdepartmental integration for quality improvement activities and may include representation from:

- Behavioral Health.
- Benefit Management and Pharmacy services.
- Business Development.
- Claims.
- Utilization Management Clinical Practice Guidelines Utilization Review Committee.
- Clinical Quality Management.
- Compliance.
- Contracts.
- Customer Care.
- Credentialing.
- Health Equity, Inclusion, and Language Access.
- Legal.
- Medical Policy.
- Provider and Network Services.
- Peer Review.
- Population Health (Care Coordination and Intensive Care Coordination).
- Executive and Management staff.

The Quality Director, Lead Medical Director, VP of Population Health, and QIC are responsible for monitoring and evaluating the results of quality initiatives and initiating performance improvement activities when the goals are not met or when areas for improvement are identified. Additionally, the subcommittees support activities related to pharmacy management, disease management, patient safety, clinical operations management activities, and health/wellness/prevention activities.

CHIEF EXECUTIVE OFFICER

The Chief Executive Officer is responsible for ensuring that sufficient resources are allocated to the day-to-day operations of the Quality Program. The Chief Executive Officer is responsible for monitoring the results of the Health Plan's quality of service and care, and for ensuring that fiscal and administrative management decisions do not compromise the quality of care and service provided by the Health Plan.

CHIEF MEDICAL OFFICER

The Chief Medical Officer (CMO) reports to the Chief Executive Officer (CEO) and is designated by the Board of Governors for oversight of the Program activities. The CMO is also responsible for the requisition of adequate resources and staffing and participates in all sub-committees. The Chief Medical Officer has overall responsibility for the success of the Quality Assurance Performance Improvement Program and Quality Improvement Work Plan and are ultimately accountable to ensure that corrective actions and follow-up occur in pursuit of improvement in clinical care and service provided to members. The CMO, medical directors, and clinical pharmacists develop general medical and pharmacy policies and ensure that clinical practice guidelines are reviewed at minimum annually and support medical necessity decision-making activities.

The CMO and the medical directors are responsible for clinical quality improvement program development, implementation, evaluation, and day-to-day operations oversight. Analysis of program results will be conducted within the Quality Improvement Department with support from applicable departments within the Health Plan when necessary.

QUALITY AND COMPLIANCE MANAGEMENT

The Chief Compliance Officer and the Quality Director are responsible for the overall Quality Improvement Program structure, evaluations, and day-to-day operations. This includes assisting the CEO and Lead Medical Director and providing guidance and assistance to the Health Plan Leadership Operations and the Quality Improvement Committee in their quality improvement activities. The Chief Quality Officer is responsible for the advancement of the Health Plan's strategic quality course. This is accomplished by mobilization of resources to ensure appropriate design, development, implementation, and evaluation of quality improvement measures as well as initiatives that address preventative health and wellness. Statistical analysis of program results is conducted within the Quality Improvement Department with support from other departments within the Health Plan when necessary.

The Chief Compliance Officer is responsible for reporting results of Quality Assurance Program Improvement and Quality Improvement Work Plan activities to the CEO and Board of Governors.

CREDENTIALING DIRECTOR

The Credentialing Director and Credentialing Manager oversee the day-to-day credentialing activities and implement approved Credentialing Policies and Procedures and communicates quality data to the CMO, Credentialing Committee, and QI Director. The QI Director

communicates provider quality data to the Credentialing Director/ Credentialing Manager monthly. The Credentialing Manager provides monthly reports to the QI Director for the Quality Improvement Committee that includes a list of providers under review by the Board of Medical Examiners and other related Boards.

SENIOR VP OF CLINICAL OPERATIONS

The Senior VP of Clinical Operations is responsible for the development and implementation of benefit design and utilization management for medical, behavioral health, and pharmacy and all aspects of pharmacy services. This position provides operational oversight to ensure that plan benefits and utilization activities are aligned with the Quality Improvement Program and under physician review when appropriate, including identification of areas/cases for quality review, analyzing data for trends including over and under-utilization, ensuring regulatory compliance of the utilization management process, and annual review of utilization management criteria.

VP OF POPULATION HEALTH

The VP of Population Health is responsible for the design, development, implementation, and analysis of the Disease Management Programs for chronic conditions as well as working with the Quality Improvement staff on initiatives that promote health/wellness/prevention. The QIC has oversight responsibility of all Disease Management activities and initiatives conducted for the Health Plan members. The CMO has overall physician-oversight responsibility for the Disease Management Program development/activities in Health Plan programs.

The disease management programs strive to improve and standardize processes of care, improve chronic condition management, improve member compliance with treatment, perception of their quality of life, sustain improvements made, and decrease medical utilization while not compromising quality of care.

Care Coordination (CC) Case Manager is designed to meet the needs of a population defined as having potential needs above that of the general population. All staff designated as CC support staff participate in interdisciplinary care meetings and seminars that focus on customer service, communication and listening skills, motivational interviewing, knowledge of State and Federal guidelines and rule changes, patient benefit information, internal referral/prior authorization processes, and available community resources. The Care Coordination Team has the potential to bridge services to best meet the needs of those members with special health care needs and chronic conditions.

OTHER DEPARTMENTS

Management and staff from all Health Plan departments—including Quality Improvement, Medical Operations Management, Information Systems, Pharmacy, Customer Care, Claims, Credentialing, Medical Policy, Membership, Sales/Marketing, Legal, Benefit Support and Reconsideration, Network Services/Development, and others as needed—actively participate in the design and implementation of quality improvement activities. Interdepartmental

collaboration, communication, and coordination of these initiatives take place through the Health Plan's standing committee meetings and ad hoc project-based meetings.

MOC 4 Element A Factor 4: Determine whether goals met/not met

The Quality Improvement Program requires that if an outcome is not met, the root cause/underlying issue is identified, interventions are analyzed and developed, new outcome measures are redefined if appropriate, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented. Goal and health outcome objectives related to the MOC are reviewed at least quarterly, and progress toward each part of the plan is evaluated at QIC meetings. The SNP-specific goals focused on overall improvements and what AllCare hopes to achieve are summarized below. Each outcome has distinct measurement criteria that requires a summary and recommendations for improvement as well as maintenance of the outcome results.

Baseline rates will be established for all measures utilizing Measurement Year (MY) 2023 performance results. Operational performance is evaluated utilizing a variety of internal data sources such as claims and encounter data, authorization data, member & provider surveys, reports, Health Risk Assessment (HRA) results, call center data, enrollment, and pharmacy data. As per our quality review process, the results of the measures are reviewed and improvement activities are initiated in response to those results, which are then presented to the QI Committee for review, approval, and guidance for further action when goals are not achieved.

AllCare Health has identified benchmark data for existing goals and set improvement targets to support attainment, including identified monitoring and reporting standards, following AllCare identified Quality standards detailed above. AllCare will evaluate barriers identified to reaching goals and develop mitigation plans to overcome the barriers. The QIC will monitor the progress of each project.

Topic/ Applicable Party	Measurement/ Methodology/ Data Source	Measurement Objective	Benchmark Goal	Benchmark Source	Frequency of Measurement/Time Frame to Meet Goal
Goal: Improve and maintain beneficiaries' access to essential services (Medical, mental health, and social services).					
Member access.	GeoAccess mapping in relation to beneficiary demographics – Provider Network relations department collects this info using the _ArcGIS tool. % of members receiving timely follow-up care with both primary and specialty care in our service area.	% of members that meet travel time or distance standards, to access to care with both primary care and specialists in our service area.	Meet CMS/OHA (95%) MY 2024 Time Tier One, Two Three. MY 2024 Distance Tier One, Two, Three.	DSN PowerBI data tracking dashboard	Quarterly report MY 2024 Time Tier One: Met (95%). MY 2024 Time Tier two: Met (99%). MY 2024 Time Tier Three: Met (99%). MY 2024 Distance Tier one: Met (97%). MY 2024 Distance Tier two: Met (100%). MY 2024 Distance Tier Three: Met (100%).
Goal: Improve and maintain Affordable Care (decrease total cost of care).					
Identify and improve utilization for those members identified as high users of ancillary services.	Monthly report of high utilizers (top 25 members). % of high utilizer members who were engaged in care coordination, and have an Care Plan Alert in PointClickCare.	Reduce MLR and cost of care.	MLR of 85%.	Internal claims data is utilized.	Quarterly/annual MLR cost is currently greater than 1, Task force formed 4th Qtr. 2023, meet weekly to review and assess high-cost utilizers, determine interventions and strategies to support this cohort. Ongoing.
Goal: Improve or maintain Coordination of Care.					
Health Risk Assessment.	HRA completed within 90 days (initial) of enrollment/Care Management information system is data source.	Timeliness, Part C, and state Medicaid reporting.	100% timely HRAT completion rate.	CMS Technical Specification	Monthly/annually Members with a completed and timely HRA. MY 2023 99% completion rate. MY 2024 96% completion rate.

MOC 4 Element B: Measurable Goals and Health Outcomes for the MOC

MOC 4 Element B Factor 1 and 2: Identify goals and health outcomes measures

The goals in this section focus on improvements to overall plan members' health and includes detailed goals related to HRA, ICP, ICT, enhanced care transitions across all health settings and providers, ensuring appropriate utilization of services for preventative health and chronic conditions, access and affordability, and overall population health.

For each of the goals, we will identify the goal and then address the following five questions.

Question		
1.	Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.	Measurable Outcomes.
2.	Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level.	Outcome Attainment.
3.	Describe how the SNP establishes methods to assess and track the MOC's impact on SNP beneficiaries' health outcomes.	Annual Benchmark.
4.	Describe the processes and procedures the SNP will use to determine if health outcome goals are met. Includes specific timeframe for measuring.	Methods to Assess and Track.
5.	Describe the steps the SNP will take if goals are not met in the expected time frame.	Determining Outcomes/Goal Met Actions When Goal Is Not Attained.

Baseline rates are established for all measures utilizing Measurement Year (MY) 2023 performance results. Operational performance is evaluated utilizing a variety of internal data sources such as claims and encounter data, authorization data, member & provider surveys, reports, Health Risk Assessment (HRA) results, call center data, enrollment, and pharmacy data. External data sources may include, Health Information Exchange (HIE), Laboratory data, HEDIS®, CAHPS® and HOS. As per our quality review process, the results of the measures are reviewed and improvement activities are initiated in response to those results, which are then presented to the QI Committee for review, approval, and guidance for further action when goals are not achieved.

Access and Affordability of the Healthcare Needs

Goal: Improve Access and Affordability of the Health Care Needs for the SNP Population through the use of preventive strategies to improve chronic disease management and encourage compliance with treatment plan.

Measurable Outcome	Outcome Attainment	Annual Benchmark	Methods to Assess and Track/ Timeframe	Determining Outcomes/ Goal Met	Actions When Goal is not Met
Increase access to continuous glucose monitors for diabetic patients.	Increased compliance with glucose monitoring leading to increased compliance with treatment and decreased Hemoglobin A1C.	MY 2023 Determine baseline of 24% and goal to increase by 20%. MY 2023 goal: 40%. MY 2024 goal increase access to 50%.	Claims data reviewed quarterly. UM data reviewed quarterly.	MY 2024 data indicated 47% of members with diabetes diagnosis provided access to CGMs - Goal Met MY 2024. New Goal for 2025 increase access to 50%.	Outreach from care coordination, use of motivational interviewing, assess for barriers. Work with PCP and/or specialist. Modify ICP ICT meetings.

Increase access to in home monitoring for members with hypertension.	Provide electronic blood pressure cuff to increase compliance with home monitoring and medical treatment.	MY 2023 Determine baseline of 15%, and increase to 20%. MY 2024- 35%. MY 2025 goal increased to 40%.	Claims data reviewed quarterly. UM data reviewed quarterly. HEDIS data. Vendor data.	Percent of members with hypertension diagnosis with electronic blood pressure cuffs with documented BP readings and Medication compliance. 39% of members eligible for BP cuffs, received outreach, education and BP Cuffs for in home monitoring. Met MY 2024. New goal for 2025 is to increase access to 40%.	Outreach from care coordination, use of motivational interviewing, assess barriers. Work with PCP and/or specialist Modify ICP. ICT meetings.
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Coordination of Care and Appropriate Delivery of Services

Goal: Improved Coordination of Care and Appropriate Delivery of Services through early identification and proactive engagement of high-risk members into care coordination (timely HRAT, completed ICP, assigned ICT, face-to-face encounter annually).

Measurable Outcome	Outcome Attainment	Annual Benchmark	Methods to Assess and Track/ Timeframe	Determining Outcomes/ Goal Met	Actions When Goal is not Met
Health Risk Assessment	HRA Completed within 90 days (initial) of enrollment/ Care Management system is data source.	100%. MY 2023, 100% MY 2024, 100% MY 2025.	Electronic care management system reviewed monthly.	Percent of members with a completed and timely HRA. MY 2023 99% completion rate. MY 2024 96% completion rate.	Outreach from care coordination, use of motivational interviewing, assess barriers. Work with PCP and/or specialist. UTR Process. Risk Management and Wellness Care Management Pathways.
Individualized Care Plan	All members will have an Individualized Care Plan within 30 days of HRA completion.	100%. MY 2023, 100% MY 2024, 100% MY 2025.	Electronic care management system reviewed monthly.	Percent of members with a completed and timely ICP. MY 2023 100%, goal met. MY 2024 100%, goal met.	Outreach from care coordination, use of motivational interviewing, assess barriers. Work with PCP and/or specialist. ICP generated on claims data and PCP communications.
Interdisciplinary Care Team	All members will have an interdisciplinary care team annually.	100%. MY 2023, 100% MY 2024, 100% MY 2025.	Electronic care management system reviewed monthly	Percent of members with an assigned ICT. MY 2023 100%, goal met. MY 2024 100%, goal met.	Internal review including supervisory chart audits. Employee corrective action plan. Work with PCP and/or specialist. Modify ICP.

Enhanced Care Transitions Across all HealthCare Settings and Providers for all SNP Enrollees

Goal: Enhanced Care Transitions across all Health Care Settings and Providers for all SNP enrollees by increasing post-hospital discharge PCP visits and ensuring timely member contact by the transition of care team for all hospital and SNF admissions.

Measurable Outcome	Outcome Attainment	Annual Benchmark	Methods to Assess and Track/ Timeframe	Determining Outcomes/ Goal Met	Actions When Goal is not Met
Increase % of members with hospital admission who have follow up with PCP within 1 week of discharge (care coordination to attend if possible).	All members with a hospital admission will have a follow up with PCP within one week of discharge.	MY 2023 Benchmark identified: 79%. MY 2024 goal 84%. MY 2025 goal 90%.	Electronic care management system review. PointClickCare review daily to identify all admissions and discharges.	Percent of members with a PCP visit within 1 week of hospital discharge. MY 2024 Met 84%.	Outreach to members within 3 days of discharge, motivational interviewing, assess barriers. Work with PCP and/or specialist to schedule follow-up.
Timely member contact initiated by transition of care team for all hospital or SNF admissions.	All members experiencing a hospital or SNF transition will be contacted by the transitions of care team within three days of admission.	MY 2023 baseline 21%. MY 2024 goal of 25%.	Electronic care management system review. PointClickCare review daily to identify all admissions and discharges.	Percent of members who were contacted within 3 days of hospital or SNF admission and/or discharge. MY 2024 Not Met- 24%.	Internal review including supervisory chart audits. Employee corrective action plan. Review in late 2024 identified reporting challenges, and Care Management System changes are being made to capture reported work.

Ensure Appropriate Utilization of Services for Preventive Health and Chronic Conditions

Goal: Ensure Appropriate Utilization of Services for Preventive Health and Chronic Conditions by decreasing hospital readmissions and increasing rates of preventive screenings for members with diabetes.

Measurable Outcome	Outcome Attainment	Annual Benchmark	Methods to Assess and Track/ Timeframe	Determining Outcomes/ Goal Met	Actions When Goal is not Met
Decrease hospital admissions for members with > 1 admission for the same diagnosis annually.	Decrease in the number of hospital readmissions for members with chronic conditions.	Hospitalization for Potentially Preventable Complications, Chronic, Benchmark MY 2023: 60 events. MY 2023 goal of 50 observable events. MY 2024 goal of 40 observable events.	Claims data reviewed quarterly UM data reviewed quarterly. Electronic care management system review. PointClickCare review daily to identify all admissions and discharges.	Reduce hospital readmission events for members with avoidable chronic conditions. MY 2023 Met: 43 events.	Outreach to member, PCP office, other providers, and the care coordination team for completion. Assess potential barriers i.e., unable to contact or locate member. Complex Disease Management Pathway.
Improve access to preventive services for members with diabetes for annual screenings and evaluations related to diagnosis.	Increased preventive screenings for diabetic members i.e., eye exams, oral health care, podiatry, and renal screening.	Baseline data Oral Evaluations for MY 2023 at 20.3%, Goal for 2024 35%. Baseline data Vision exam for MY 2023 at 49%, Goal for 2024 60%. Baseline data Kidney Disease Monitoring for MY 2023 at 35%, goal for 2024 50%.	Claims data reviewed quarterly UM data reviewed quarterly. My 2023 Oral Exam: Met (25%). MY 2023 data Vision exam Met: (65%). MY 2023 Kidney Disease Monitoring Met: (41%).	Percent of members meeting clinical practice guidelines for preventive diabetic care.	Outreach to member, PCP office, other providers, and the care coordination team for completion. Assess potential barriers i.e., unable to contact or locate member. Complex Disease Management Pathway. Diabetic Oral health: Targeted outreach, education, worked with Dental Care Organization to access scheduling template, and supported additional clinical days and staff to support increased access.

These measures guide, encourage, and promote member compliance with their specific health care treatment plan through improving processes for chronic condition management, ensuring timely and appropriate access to care services, and providing seamless transitions of care.

Ongoing monitoring and progress are determined by the business area and occurs based on the available reporting. Twice a year, depending on the measure, preliminary and final results are reported to the designated oversight committee. Tools are updated annually to allow a year-over-year comparison of the results. Results are monitored by the business owners and progress toward meeting the benchmarks, action plans, and status is reviewed by the oversight committees bi-annually with full year review as part of the annual program evaluation. For items not being met, barrier analysis and corrective action plans are developed as appropriate.

MOC 4 Element B Factor 3: Track and assess goals

As a Medicare Advantage Organization, AllCare Health is required to collect and report annual Health Care Effectiveness Data and Information Set (HEDIS®), including the SNP specific HEDIS® metrics as directed in Chapter 5 of the Medicare Managed Care Manual. AllCare Health contracts with a NCQA-certified software vendor to produce the HEDIS® measures. The vendor follows the NCQA Technical Specifications and applicable Technical Update to define the eligible population/denominator and numerator compliance through proprietary software certified annually by NCQA. The HEDIS® reporting process is audited by a NCQA-licensed audit firm. For HEDIS® reporting, AllCare Health obtains and provides pharmacy, claims, encounter, membership, provider, and other supplemental data to the software vendor through a secure FTP transmission process.

As required by CMS and state agencies, HEDIS reporting activities must undergo an audit by a NCQA-certified HEDIS Compliance Audit Firm. The HEDIS audit program verifies that HEDIS production conforms to the Technical Specifications. AllCare Health is also required to contract with a NCQA-certified vendor to conduct the Medicare Consumer Assessment of Health Care Providers and Systems (CAHPS®) Study for Medicare members as outlined in the CMS Chapter 5 of the Medicare and Managed Care Manual. CAHPS® is an annual nationwide survey that is used to report information on Medicare beneficiaries' experience with managed care plans. AllCare Health receives written notification from CMS of the timeline in which the surveys are conducted, the number of surveys, and the expected number of Medicare members who will receive a survey. CAHPS® data are made available to all stakeholders. The results are shared with Medicare beneficiaries and the public.

As described in MOC 4.B.2, relevant measures are selected that will have an impact on the health outcomes of SNP members. AllCare Health has established processes and contracts with vendors, when appropriate, to collect SNP health outcome data through HEDIS® and annual HRAs, member experience and access to care through CAHPS®, internal surveys, data from provider network, delegation oversight, utilization of services, customer care services, communication systems, and transitions of care through internal information systems and

audits of case management and concurrent review files. Data is collected according to the established process for the individual metric and could be collected monthly, quarterly, or annually as with HEDIS® and CAHPS®.

The SNP member health outcomes from each of these measures are compared year to year and with available benchmarks and/or goals as part of the annual evaluation of the SNP MOC. Annual data and progress towards goals is collected, analyzed, and reported to stakeholders. Electronic and print copies of the evaluation of the SNP Model of Care will be prepared annually, reported to oversight, regulatory and accreditation organizations, and preserved as an official record. The complete document includes quantifiable measures, quantitative and qualitative analysis, barrier and opportunity analysis, actions taken to address barriers, goals met/unmet, and data definitions.

AllCare will use the MOC Annual Evaluation, which is approved by the Quality Improvement Committee, to assess the final performance and determine if health outcome goals were met. For any areas that did not meet goal, the Quality Improvement Committee will review and provide recommendations for quality activities and/or target reevaluations.

MOC 4 Element B Factor 4: Determine if goals are met

Population Health/Care Coordination works closely with the internal AllCare Health IT team to look at specific data for our member population related to our stated goals. Yearly goals will be presented to the QI committee for approval. Each goal and subsequent measurement are assigned to a business area. Managers of each area act as measure owners and are responsible for tracking measures and reporting progress. The Quality Improvement Committee reviews and analyzes the SNP specific measurable goals and health outcomes on at least a quarterly basis. The Quality Improvement Committee reviews the data and makes recommendations. Minutes are maintained for each meeting. Information on the goals is incorporated into the annual SNP MOC evaluation.

MOC 4 Element B Factor 5: Take actions when goals not met

AllCare Health has established processes and a culture that fosters quality improvement discussions and activities from multi-disciplinary areas to ensure quality of services, ongoing improvement, and compliance with regulatory requirements. One of the functions of the Quality Improvement Committee structure is to provide input and recommendations for corrective actions and monitoring previously identified opportunities for improvement. The structure of the QIC promotes plan integration and provider network accountability for the identification, evaluation, and measurement of key clinical and service activities. The results of the annual SNP MOC evaluation, including “met” and “unmet” goals are reported to stakeholders and the Board, and their recommendations are considered in determining quality improvement activities, projects, and specialized services and benefits to improve performance. Actions taken when program goals are not met are documented in the annual SNP evaluation and will vary according to specific metrics, goals and affected departments. Outcomes from the HEDIS®, CAHPS®, HRA, Medication Therapy Management (MTMP),

utilization, communication systems, and other program indices are analyzed at least annually. Action taken for metrics that do not meet goals can include Quality Improvement Projects or activities such as member outreach, provider education, or system and process changes designed to impact the measure outcomes and improve care or service. Interventions can include automated or live calls, newsletters, health calendars, emails, and educational materials designed to improve Flu/Pneumonia Vaccination, diabetes care, colorectal cancer screening, cardiac health, and member satisfaction, to name a few examples.

MOC 4 Element C: Measuring Patient Experience of Care (SNP Enrollee Satisfaction)

MOC 4 Element C Factor 1: Describing the survey

In addition to the fact that the following surveys are regulatory requirements, AllCare Health uses the information to gauge member satisfaction, identifies opportunities for improvement, and incorporates the results in the quality improvement process.

Member Satisfaction Surveys

Member surveys provide direct information about member perceptions of actual experiences and guide our efforts to make improvements in service delivery at both the system as well as the provider level. Results are reported to the Board of Governors at least annually or when results are available, as in the case of HOS. Member surveys include those conducted both externally and internally. Survey results, including national and local comparisons when available, are reported to the QI Committee and the Board of Governors annually. The QI Committee and the Board of Governors evaluate results and determine priority areas for improvement that are incorporated into the annual Quality Work Plan.

Surveys Conducted internally

Each year, AllCare randomly selects several hundred members to participate in its Net Promoter Score (NPS) survey. The quintessential NPS question asks, “On a scale of 0 to 10, how likely are you to recommend AllCare to a friend or colleague?” In addition to this key question, the survey includes several others covering overall quality of services received, happiness with coverage and benefits, ease of enrollment, satisfaction with the Customer Care team, and a comments section for any additional feedback. This initiative is a critical part of AllCare’s goals to assess and improve member satisfaction.

To streamline the process and in alignment with the implementation of AllCare’s texting platform, we will now be able to send the NPS survey via text to every member (with permission) with whom we have had or are currently in contact, making it easier to collect valuable feedback and drive improvements.

Surveys Conducted Externally

1. Medicare Advantage Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (MA-PD CAHPS)

- a. The MA-PD CAHPS is required by CMS for MAOs with a minimum enrollment of 600 eligible members as of July 1 of the previous year. It is required to be administered by an approved MA-PD CAHPS vendor on our behalf to assess the experiences of members in Medicare Advantage plans. Members surveyed must have been enrolled for at least six months, and the survey references their experiences in the prior six months.
 - b. The MA-PD CAHPS questionnaire covers the following domains of member experience: Getting Needed Care, Getting Appointments and Care Quickly, Doctors Who Communicate Well, Customer Service, and Care Coordination.
 - c. CMS publishes these results on its Medicare Plan Finder tool at www.Medicare.gov to help members choose a Medicare health or prescription drug plan. The MA-PD CAHPS measures that are scored for presentation on the Medicare Plan Finder include five composites, three overall ratings, and an individual survey item about flu vaccinations. The composite measures include the following: Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Getting Needed Prescription Drugs, and Care Coordination. The overall ratings include Overall Rating of Health Care Quality, Rating of Health Plan, and Rating of Drug Plan. The individual survey item is regarding the Annual Flu Vaccine.
2. Health Outcomes Survey (HOS)
- a. HOS is administered to dually eligible plan members using a CMS-selected sample. It collects information on dually eligible members, age 65 years and over, living in the community or institutionalized, to calculate frailty factors that are used by CMS, in addition to the diagnosis-based risk adjustment formula, to determine health plan payment rates. The HOS is also used to assess a health plan's ability to maintain or improve the physical and mental health functioning of its dually eligible members.
 - b. The survey was designed by CMS and NCQA. CMS determines the sample from members enrolled. The data is cleaned and analyzed for dissemination among the health plans. NCQA monitors and assesses survey vendor performance. The survey is administered to a random sample of members at the beginning (baseline survey) and end (follow-up survey) of a two-year period. A new baseline sample is surveyed annually.
 - c. According to www.hosonline.org/en/survey-instrument, the current HOS questionnaire, Medicare HOS 3.0, "consists of the following major components: the Veterans RAND 12-Item Health Survey (VR-12); questions to gather information for case-mix and risk-adjustment; questions to collect results for four HEDIS Effectiveness of Care measures; updated questions on race, ethnicity, sex, primary language, and disability status as part of Section 4302 of the Affordable Care Act; and additional health questions, including new and revised questions."

- d. Individual member level data is not provided to plans after baseline data collection. However, organizations receive the following from CMS:
 - o HOS Baseline Profile Report: This profile is made available to all plans participating in the previous year's baseline cohort. This quality improvement tool presents an aggregate overview of the baseline health status of each MAO's Medicare members. All report distribution occurs electronically through the Health Plan Management System (HPMS).
 - o HOS Performance Measurement Report and Data: After the administration of each follow-up cohort, a cohort-specific performance measurement report is produced. Survey responses from baseline and follow-up are merged to create a performance measurement data set. The HOS performance measurement results are computed using a rigorous case mix/adjustment model. The resulting aggregation of these scores across members within a plan yields the HOS plan level performance measurement results. The performance measurement reports, and corresponding data results are designed to support MAO quality improvement activities.

MOC 4 Element C Factor 2: Specify rationale for survey selection

Rationale for Tool Selection

MA-PD CAHPS is required by CMS and is implemented nationally. This report has a significant level of detail that provides AllCare Health with the ability to compare members' satisfaction and other pertinent information with national levels. The MA-PD CAHPS provides detail on members' perception of care in areas like rating of health plan and providers, rating of getting the care needed, communication with their provider, member education level, member access to technology, vaccinations, and their overall perception of their current health. This survey was chosen because it provides information that helps define our members and guides our decisions about future projects and program development.

HOS is also required by CMS for plans that meet the enrollment size criteria and is implemented nationally. This report also provides a significant level of detail that augments the MA-PD CAHPS. The HOS includes a different set of questions that focus on pain, activities of daily living (ADLs), instrumental activities of daily living (IADLs), chronic conditions, health and wellness, health literacy, cultural needs, caregiver status, and income. This report will compare AllCare Health scores to national scores, which will provide insight into how we are performing on a larger level. The HOS baseline reports compare AllCare Health scores to Oregon scores, which will provide insight into how we are performing locally. This survey was chosen because it provides members' perception of their health condition and risk factors, which, when coupled with the MA-PD CAHPS, gives a broader picture of our members, and how they are defined. This, in turn, helps guide decisions about future projects, improvement opportunities, and program development.

MOC 4 Element C Factor 3 & 4: Describe process for collecting enrollee feedback and analyze enrollee feedback and address identified issues

MA CAHPS

CAHPS surveys capture general information about member satisfaction with the plan and providers. AllCare Health will include additional questions that specifically solicit member feedback regarding the overall SNP program and program staff, including the usefulness of the information disseminated by the organization and the member's ability to adhere to recommendations. MA CAHPS results are reviewed annually with appropriate staff. Areas of strengths and weaknesses are identified, and interventions are chosen for areas needing improvement for performance improvement plans. During the analysis process, staff identify the strengths and weaknesses from the results of the survey and formulate a summary report of the MA CAHPS. The evaluation of the strengths and weaknesses is conducted through a formalized work group. This workgroup is made up of staff from relevant departments, including directors, managers, and other assigned staff. The workgroup reviews the report and evaluates the strengths and weaknesses, identifies opportunities for improvement and makes recommendations for improvement opportunities. Recommendations are made for each identified area of improvement. Each area of opportunity is reviewed for root cause/ underlying issue, interventions are analyzed and developed, outcome measures are defined, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented. The workgroup makes recommendations regarding action and these recommendations may include one of the following:

- Chronic Care Improvement Program (CCIP) and Performance Improvement Plans (PIPs).
- Corrective Action Plans (CAPs).
- Other intervention strategies.

The chosen path for monitoring the progress of the implementation and follow through is documented and reviewed quarterly by the QIC. If adequate progress is not being made, the workgroup analyzes and reviews, evaluates for barriers to progress, and makes alternative recommendations for an approach that will obtain the desired outcome.

In addition, member feedback will be collected annually at the time of the HRA renewals for all SNP MOC members. This approach will allow the proactive feedback on a broad sample of members and enable a large sample size. Additional questions will be added to both the print and phone scripts for the HRA specifically addressing member satisfaction with the SNP program as a whole and with plan staff. Feedback regarding member adherence to the individualized care plan goals and usefulness of ancillary materials provided will be assessed. The results from these questions will be collected by the SNP MOC staff, analyzed by SNP MOC leadership, and reported to the QI committee on an annual basis. These findings will be incorporated into the MOC performance improvement plan.

HOS

HOS results will be reviewed annually with appropriate staff. Areas of strengths and weaknesses are identified, and interventions are chosen for areas needing improvement. During the analysis process, staff identify the strengths and weaknesses from the results of the survey and formulates a summary report of the HOS results. The evaluation of the strengths and weaknesses is conducted through a formalized work group. This workgroup is made up of staff from relevant departments, including directors, managers, and other assigned staff. The workgroup reviews the report and evaluates the strengths and weaknesses, identifies opportunities for improvement, and makes recommendations for improvement opportunities. Recommendations are made for each identified area of improvement. Each area of opportunity is reviewed for root cause/underlying issue, interventions are analyzed and developed, outcome measures are defined, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented. The workgroup makes recommendations regarding action and these recommendations may include one of the following:

- Chronic Care Improvement Plans (CCIP)/Performance Improvement Plans (PIP).
- Corrective Action Plans (CAP).
- Other intervention strategies .

The chosen path for monitoring the progress of the implementation and follow through is documented and reviewed quarterly by the QIC. If adequate progress is not being made, the workgroup reviews, evaluates for barriers to progress, and makes alternative recommendations for an approach that will obtain the desired outcome.

MOC 4 Element D: Ongoing Performance Improvement Evaluation of the MOC

MOC 4 Element D Factors 1 - 4: Support ongoing improvement, evaluate results, assess ability to improve, and document and communicate lessons learned.

After reviewing quality performance indicators and measurement data, AllCare Health's Quality Director and Lead Medical Director make recommendations for improvements and facilitate the creation of workgroups as needed. These workgroups utilize Lean Six Sigma concepts such as Define Measure Analyze Improve and Control (DMAIC), and Plan-Do-Study-Act (PDSA) to develop new and improve existing processes. This methodology provides AllCare Health with the tools to effectively support ongoing improvements. Depending on the level of intervention needed reports are made to our QIC for input and action guidance. Recommended changes from the QIC will go back to the Quality Director and Lead Medical Director who will collaborate with staff to determine a pathway forward. After implementation of the changes, data will be re-reviewed to see if improvement were made.

The Quality Director and Lead Medical Director review quality performance measures quarterly. Results of the performance measures are also evaluated for benefit enhancements and network growth to adequately meet the population's needs. If benefit or network development needs are identified, other departments will be tapped to coordinate and

assess potential design benefits or network options to meet the specific needs. Based on performance, workgroups may be created to further analyze and understand root cause; this analysis is used to create action plans if SNP members' unique care needs are not being met. If over the duration of the program the SNP specific goals are not having the desired effect on improving health outcome of our SNP populations, a workgroup will re-evaluate for effectiveness to determine if new intervention or goal is necessary. Review of the performance and any action plans created are reported to the QIC on a regular basis.

Quarterly, the QIC reviews the measures and the effectiveness of our program in meeting the needs of our population. This analysis of continual quality improvement results for the SNP MOC are rolled into the Quality Assurance Performance Improvement (QAPI) Review annually.

Annual Quality Assurance Performance Improvement (QAPI) Review

The QAPI Review captures QI activity results on an annual basis and identifies opportunities for improvement. Opportunities for improvement may be incorporated into the following year's Quality Improvement Strategy Plan.

Following the annual evaluation, the goals, effectiveness, and scope of the QI Program are documented in a formal QAPI Report. The report is driven by the objectives outlined in the QI Program Description and the goals/objectives detailed in the QI Strategy Plan. The report summarizes activities and outcomes of the QI Program. The QAPI Review includes the following:

- A description of completed QI activities that address the quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of the results of QI initiatives; and
- Evaluation of the overall effectiveness of the QI program.

The QIC provides ongoing guidance and monitoring, as appropriate, regarding quality management projects, and goals. The Committee approves quality improvement projects and evaluates the effectiveness of the quality improvement program.

This results in a complete annual evaluation of the MOC. During the evaluation we document our performance on each section of the MOC, which includes our strengths, areas for improvement (lessons learned), and plans for improvement for the next year. This evaluation is reviewed by the QIC to guide strategic planning for the next calendar year. After the review and evaluation, workgroups are assigned to develop quality improvement projects.

The annual SNP MOC evaluation is reviewed by the QIC for input and recommendation for improvement and resource allocation; the evaluation is then reviewed and approved by the Board of Governors. The written evaluation is then shared with the organization by publishing it at an accessible internal site. Our providers also receive information on our SNP MOC evaluation during annual provider training and from our provider portal.

A high-level summary of this report is available upon request in written format and/or posted on the provider portal for stakeholders with a focus primarily on goal performance and recommendations for improvement. The full report can be requested by stakeholders from the Customer Care Contact Center and will be sent either electronically or printed and mailed to the requestor.

Members and providers are made aware of this information through various means, including newsletters, website postings, targeted mailings, provider trainings, provider portal, and provider email blasts. The performance of the Model of Care is summarized for all contracted providers, posted on the AllCare Health provider portal, and providers are sent an email blast alerting them of its posting.

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

MOC 4 Element E Factors 1 - 4: Describe communication of performance results, detail schedule for routine communications, detail ad hoc communications process, and identify staff responsible for communication of performance results

AllCare Health's website will include a page dedicated to informing members of AllCare Health's performance results and other pertinent information. Providers, members, and staff are also informed of SNP MOC outcomes through educational programs, meetings, updates, newsletters, and provider and member portal online articles. These communications inform stakeholders of AllCare Health's SNP MOC, progress towards goals for key HEDIS and customer satisfaction metrics, including improvement from the previous year in comparison to national benchmarks. A provider update, provided through a quarterly email newsletter, will also summarize the SNP MOC evaluation and progress towards goals.

Leadership, the Board of Governors, and management are made aware through the Quality Improvement Program and Annual Quality Assurance Performance Improvement (QAPI) Review.

The CCO, Quality Director and Lead Medical Director, and QIC are ultimately responsible for ensuring that information related to all AllCare Health quality activities, including MOC activities and outcomes, are communicated in a timely manner to the appropriate SNP stakeholders through various means, including newsletters, website postings, targeted mailings, provider trainings, provider portal, provider email blasts, and community forums. SNP stakeholders include the following:

- Department of Human Services (DHS).
- Aging and People with Disabilities (APD).
- Area Agency on Aging (AAA).
- Oregon Health Authority (OHA).
- CMS.
- SNP Members/caregivers.
- Population Health Department, including SNP personnel and staff.
- AllCare Health Board of Governors.

- Employees.
- Contracted providers, including SNP provider networks.
- Other Regulatory Agencies as appropriate.

Provider communications throughout the year inform providers of the outcomes of the SNP MOC program and projects. Provider webinars on assorted topics are conducted and can include information on quality outcomes for measures regarding preventive care, behavioral health, chronic disease management, care transitions, and member satisfaction. Quarterly webinars for providers present diverse topics and can include information on quality outcomes for measures regarding preventive care, behavioral health, chronic disease management, and member satisfaction. AllCare Health communicates all quality program activities, including quality improvement performance results and Model of Care analysis to multiple stakeholders at least annually and more often as indicated.

Methods of communication and frequencies are as follows

Communication Method	Frequency	Audience	Responsible Party	Message
Webinar	Quarterly	Providers	Provider Relations	Varied program outcomes and progress towards goals. Results from quality measures related to preventive care, chronic disease management, behavioral health, care transitions, and member satisfaction are reviewed according to the webinar topic.
Program Evaluation Report	Quarterly	QIC Committee		Outcomes, barrier analysis, opportunities, and summary of interventions to address low performance.
Email	Monthly	Providers	Provider Relations	Summarizes the SNP MOC evaluation and progress towards goals.
Goals Report	Annual	Health Plan Board of Governors		Summary of SNP MOC goals.
Online Article	Annual	General Public	AllCare Health Communications Department	Key outcomes compared to previous year and national standards.
Webpage	Annual	General Public; Members; Caregivers	Brand & Creative Services; Communications Department;	Informs members of AllCare's progress towards goals for key HEDIS® and Customer Satisfaction metrics, including improvement from the previous year and comparison to national benchmarks.
Email	Monthly	Staff	CMO	Various.

AllCare Health will communicate our SNP MOC and quality improvement performance results at least annually via our QI committee to the Board of Governors. Website postings will be used to communicate other pertinent quality improvement information to members. Annually,

members will have access to a summary of the Model of Care focusing on how the Model of Care can be used to improve their health outcomes. Instructions for accessing a copy of the full Model of Care document will be included in the summary.

The Quality Director and Lead Medical Director are responsible for ensuring that information about improvements and quality performance results, including the Model of Care, is made available to providers, members, regulators, staff, the Board of Governors, and all other stakeholders at a minimum annually and more often if appropriate. AllCare Health reports quality improvement performance results at least annually and as changes are identified.

Ad hoc methods of communication include

Communication Method	Frequency	Audience	Responsible Party	Message
Webinar	Quarterly	Providers	Provider Relations	Varied program outcomes and progress towards goals. Topics for the webinars change each year according to the initiatives targeted for improvement as a result of ongoing data collection and monitoring. At each webinar, providers are encouraged and given the opportunity to ask questions or share observations or best practices.
Email	Ad hoc	Providers	Provider Relations	Produced as needed to provide updates on quality initiatives and other topics.
Fax Blast	Ad hoc	Providers	Provider Relations	Produced as needed to provide updates on quality initiatives and other topics.
Personal Communication	Ad hoc	Providers	QI Employees, medical directors, Provider Relations staff	Customized communications, based on the specific intervention needs of the provider.
Online Article	Ad hoc	General Public; Members; Caregivers	AllCare Health Communications Department	
Email	Ad hoc	Staff	Population Health Dept.	Customized communications, based on specific intervention needs.

The CCO, Lead Medical Director, and QIC are ultimately responsible for ensuring that information related to all quality activities is communicated in a timely manner to the appropriate SNP stakeholders as previously identified. The following staff assist with the responsibility for communicating quality performance updates in a timely manner:

1. Vice President of Behavioral Health.
2. Director of Quality Improvement.

3. Chief Compliance Officer.
4. Provider Network Services representatives.
5. Customer Care representatives.
6. Vice President of Population Health.
7. Vice President of Benefit Management and Pharmacy Services.

The CEO has been charged with administration of organizational processes and the selection of qualified and capable staff to oversee and manage daily operations, which include the communication of the quality performance results of the Model of Care. The AllCare Health Board of Governors provides oversight for any delegated activities to ensure compliance and applicable regulatory requirements. The Board of Governors also has delegated monitoring and oversight functions to various committees. These groups are structured to include providers, practitioners, community members, and staff. Oversight and monitoring of the effectiveness of the Model of Care is delegated to staff with the expertise, experience, and skills, individually and collectively, to improve performance and to communicate the improvements to identified stakeholders. Staff and committees work together within and across departments to identify opportunities for improvement and to develop intervention strategies to improve the effectiveness of the Model of Care. Detailed staff information is provided in Chapter 2, Section A: SNP Staff Structure. The staff structure and roles detailed include personnel with oversight responsibility for monitoring and evaluating the effectiveness of the Model of Care.

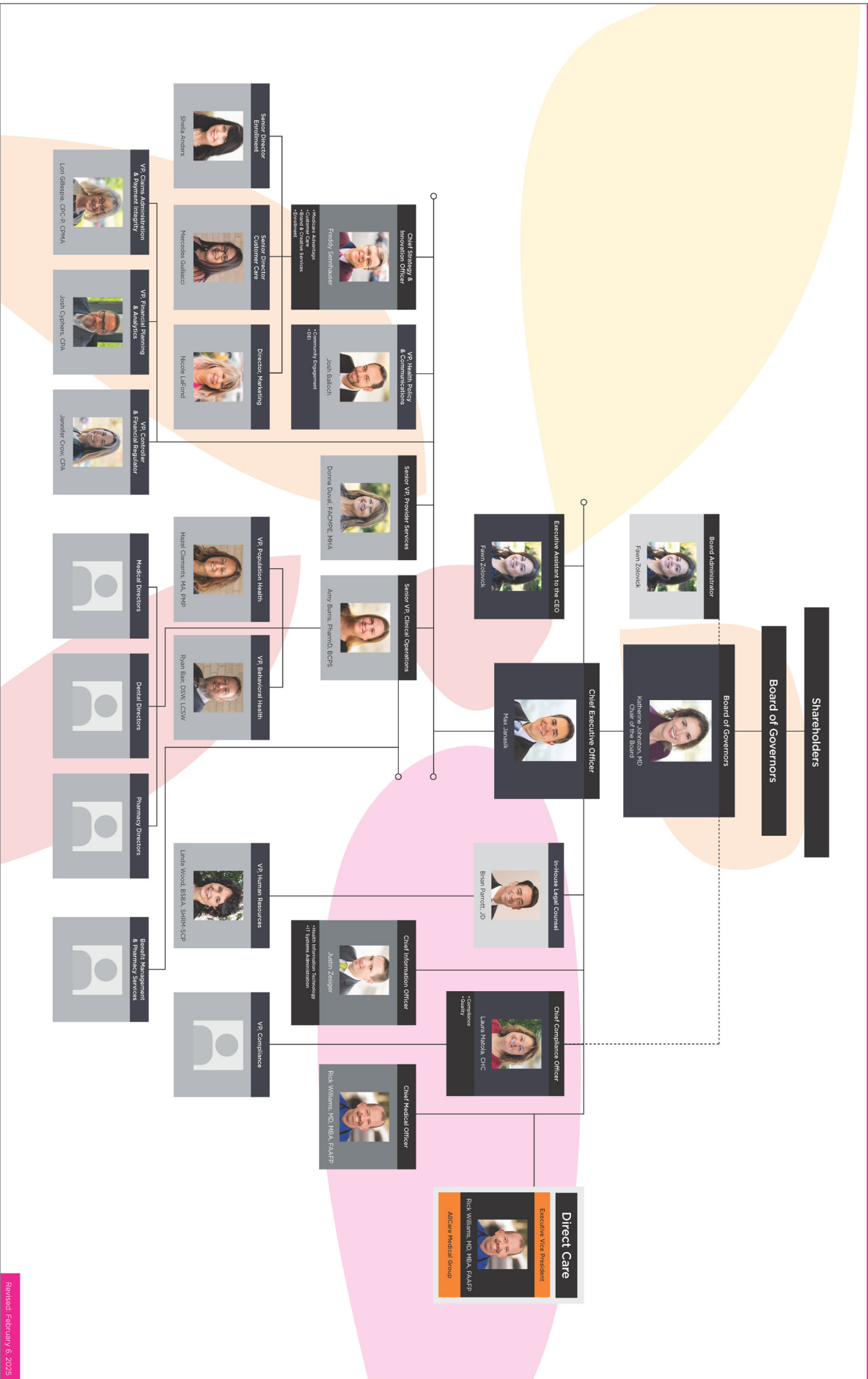
Externally, the QIC shares updates no less than on a quarterly basis with the externally facing providers, and to the Board of Governors. System and Network stakeholders are expected to disseminate information to their respective organizations.

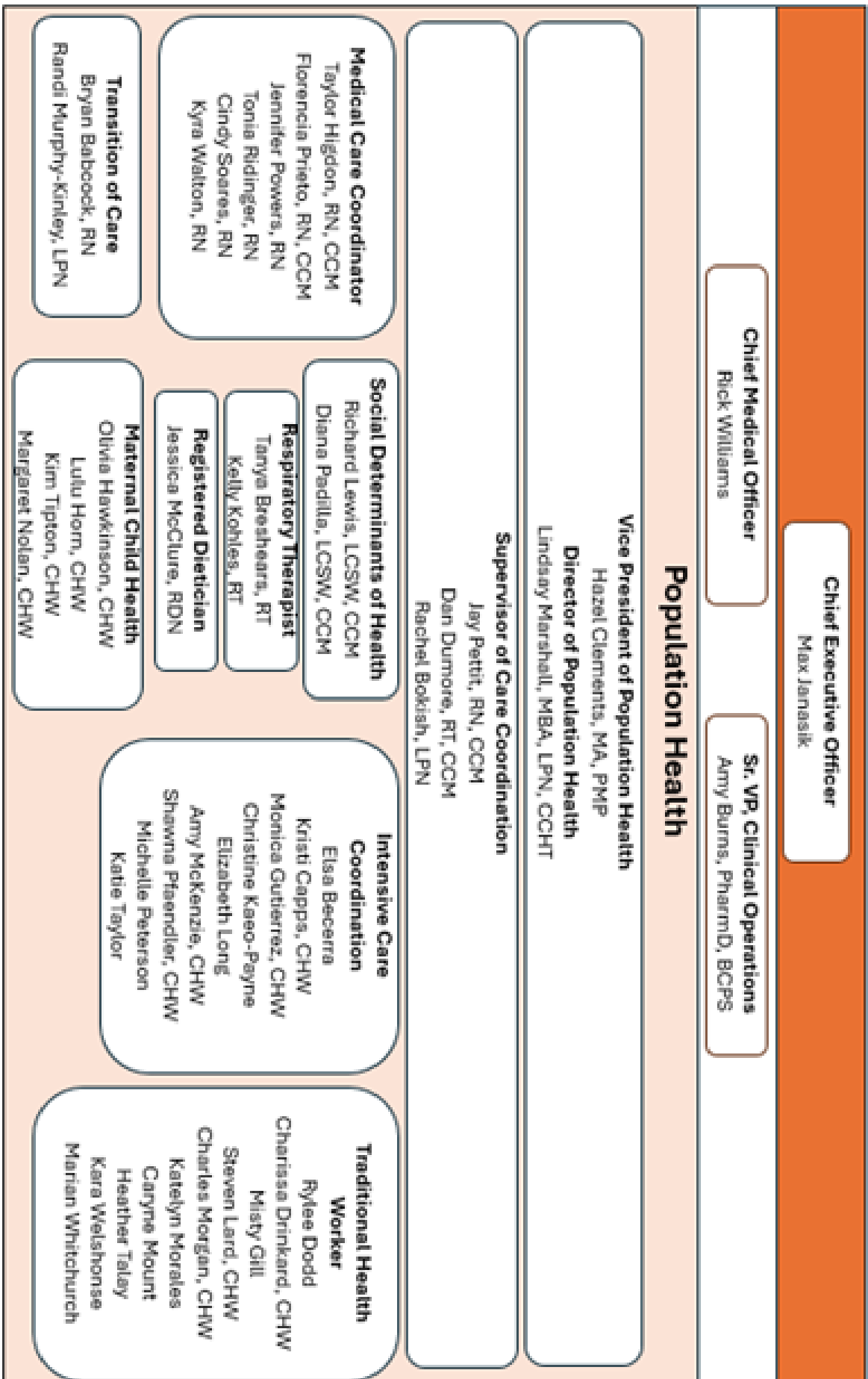
Annual webinars are conducted with providers on various SNP MOC program outcomes and progress towards goals. Results from quality measures related to preventive care, chronic disease management, behavioral health, care transitions, and member satisfaction are reviewed according to the webinar topic. The annual SNP program evaluation is reported and in addition to health outcomes, the report includes a barrier analysis, opportunities, and summary of interventions to address low performance. Information is shared with staff and providers at least annually through multiple modes of communication that include but are not limited to:

- Employee and provider trainings.
- Emails.
- Clinic visits.
- Website and/or provider portal.
- Provider newsletter.
- Ad hoc online provider email alerts are produced periodically throughout the year to provide updates on a variety of topics for quality initiatives. The communications are developed by the QI, Benefit Management, Pharmacy, or other departments, and

disseminated by the Provider Network Services department. Additional provider communication and education is provided on varied topics such as coordination of care, preventive care, etc. during quarterly meetings with our provider network. Ad hoc communication includes, but is not limited to the methods listed below:

- Staff meetings, emails, or Intranet postings.
- Provider clinic visits by Provider Network Services staff, emails, or letters from the Chief Medical Officer.
- Administrative Team, QIC, or Board of Governors via meetings, emails, face-to-face presentation from organizational leadership.







D-SNP Model of Care (MOC) Training

Hazel Clements, MA, PMP
VP of Population Health



Welcome



AllCare Health is dedicated to achieving the best possible health outcomes for members in our Medicare Advantage Special Needs Plan or SNP

We recognize Special Needs Plan members may experience multiple chronic health concerns, economic instability and other social factors which negatively impact quality of life and health outcomes.

We enroll all eligible individuals – regardless of mental or physical condition, health status, claims history, genetic information, medical history, disability, age, sex, sexual orientation, marital status, race, ethnicity, religion or political beliefs.



Welcome



As a provider to this vulnerable population, your role is both central and critical to impacting positive health outcomes.

AllCare Health Plan – alongside our network of providers and community partners – is here to support your work with our Special Needs Plan Model of Care.

The time, support and care you provide for some of the most vulnerable members of our community is appreciated.

Thank you,
AllCare Health Plan



About this Training



AllCare Health Plan ensures that initial and annual trainings for in-network and out-of-network providers who routinely see special needs plan members (SNP) adhere to the Centers for Medicare and Medicaid Services regulatory requirements. [42 CFR 422.101 (f)(2)(ii)]

AllCare Health's Special Needs Plan Model of Care, or SNP MOC, training content is developed by the Population Health department in collaboration with the Provider Services and Marketing Department.

Training materials are updated annually to ensure content is current and covers the elements of care that are being delivered according to the SNP MOC Program. Training is provided in-person, via virtual webinar, and/or through computer-based technology. All training must be documented via signed attestation.



Learning Objectives



This training examines the four elements of a Medicare SNP MOC as they pertain to AllCare Health Plan Medicare Advantage Special Needs Plan. During this training, you will leave with an understanding of:



- Service area demographics, chronic conditions and barriers faced by our SNP members.
- How Care Coordination is achieved between providers and AllCare Health Plan and our Care Management team.
- Clinical Care Guidelines and how AllCare Health Plan determines and shares quality and performance improvements.
- Additional resources and programs to support members.



Part 1: Understanding Our SNP Members

Who Are Our SNP Members

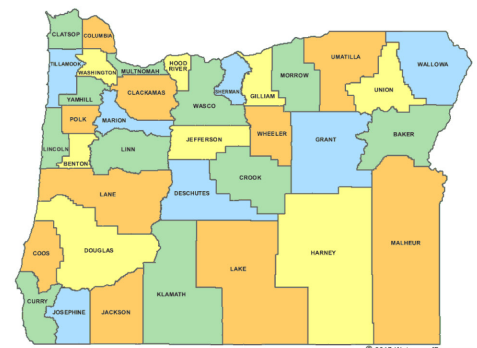
AllCare Health Special Needs Plan is a D-SNP plan open to eligible individuals in Jackson, Josephine, Curry and Southern Douglas counties.

Members must meet “means tested eligibility requirements” for the Oregon Health Plan (Medicaid) **and** be enrolled in Medicare Part A and Part B due to age and/or disability.

SNP members represent one of the most economically disadvantaged and medically vulnerable groups in our 4 county service area.

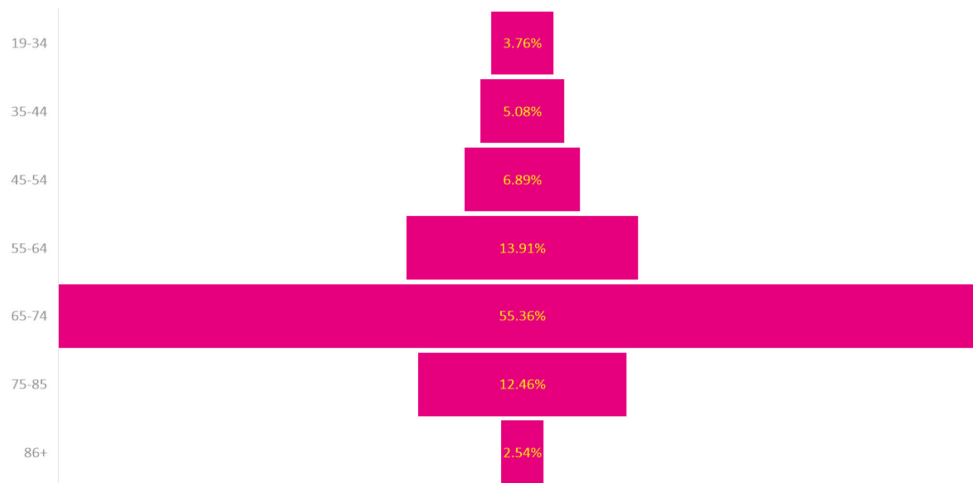


Oregon Counties
From The RadioReference Wiki



Who Are Our SNP Members – By Age Group

SNP Members by Age Group

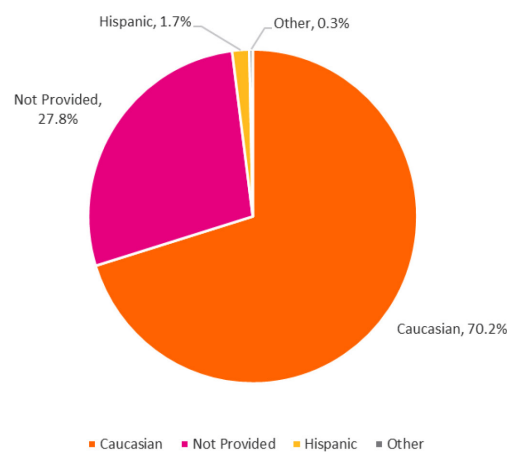


Who Are Our SNP Members – By Race & Ethnicity

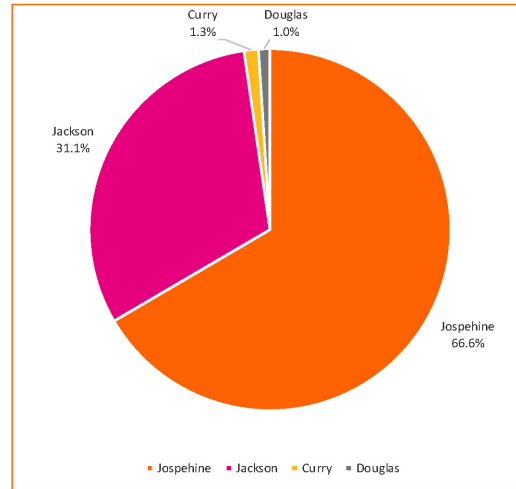
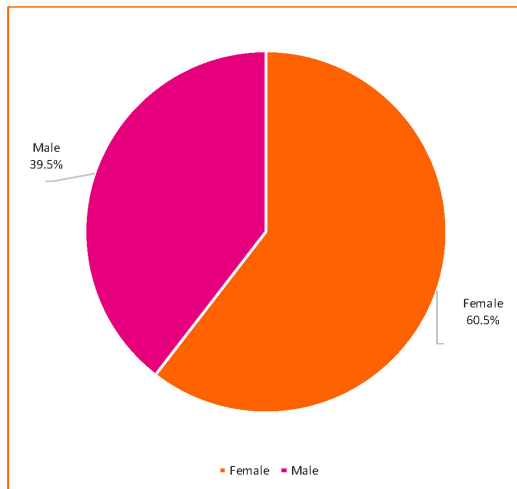
While SNP members may predominantly speak English and be classified as Caucasian, providing culturally and linguistically appropriate services is essential.

Culturally and linguistically Appropriate Services (CLAS) are *respectful of and responsive to an individual's culture and communication needs*.

For assistance in understanding how to better implement CLAS in your practice, please reach out to AllCare Health Plan's Provider Services Team.



Who Are Our SNP Members – By Gender & County



Who Are Our SNP Members – By Chronic Conditions

Top 10 Chronic Conditions

Neck & Back Injury/Pain

Diabetes

Chronic Kidney Disease

COPD

Rheumatoid Arthritis, Osteoarthritis

Sleep Disorders

Hypertension

Anxiety Disorder

Depressive Disorder

Bipolar, Schizophrenic Disorder

AllCare Population Health reviewed DSNP member claims for 2023, to determine the prevalence of chronic conditions among our Special Needs Population.

Approximately 69.3% of SNP members were identified as having a chronic condition that impacts them mentally, physically or behaviorally.



Who Are Our SNP Members – By Behavioral Health

Behavioral Health Conditions are a growing concern for our members



Behavioral Health Conditions

Depressive Disorder
Anxiety Disorder
Bipolar Disorder
Schizophrenia and other psychotic disorders
Substance Use Disorders
Personality Disorders
Learning Disabilities, ADHD, Conduct disorders and Hyperkinetic Syndrome

Behavioral Health conditions cause reduced social engagement. Depression may exacerbate other health conditions and cause increased pain. In turn, these factors may affect member's quality of life and precise care they are given.

Members ability to accomplish goals, maintain behaviors and adhere to care plans may be impaired by depression and anxiety disorders.



Challenges

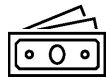


In addition to chronic health conditions, our SNP members may experience additional challenges which impact overall health.



Social support

Social Support is the perception and actuality of available assistance – be that emotional, informational, tangible or intangible.



Economics

To qualify for Medicaid benefits, an individual's means-tested income and assets must already be near or below the federal poverty line.



Educational Attainment

Educational attainment has a direct & measurable impact on behavior, socialization, economic security and health literacy.



Transportation

Transportation, particularly for rural members without access to public transportation networks presents many concerns.



Housing

Our service area – and Oregon- is in an ongoing housing crisis. For low-income individuals or those with accessible needs, access to affordable housing can be daunting.



Food Insecurity

Food insecurity is the state of being without reliable access to a sufficient quantity of affordable, nutritious food.



Part 2: Care Coordination



AllCare Health Plan Care Coordination supports both member and provider with essential care management services such as health assessments, individualized care plans, education, transportation assistance and coordination for transitions of care.

Care Coordinators may be RNs, LPNs, Clinical Social Workers, Respiratory Therapists, Intensive Care Coordinators, Community Health Workers. They are matched to member needs by the Health Risk Assessment.



Care Coordinators reinforce provider recommendations and seek to motivate care plan adherence through targeted interventions which develop healthy habits while mitigating behavioral and social barriers to self-care.



Part 2: Care Coordination

In most cases, Care Coordinators will contact providers upon member assignment through a letter or phone call. Additional methods of communication may be facilitated by circumstantial need.



Care Coordinators are available- **Monday through Friday, from 8 am to 5 pm**



By Calling **541-471-4106**



Email: Provider Rapid Response ProviderRapidResponse@allcarehealth.com

Customer Care team is available- **Monday through Friday, from 8 am to 8 pm**



By calling **541-471-4106**



Part 2: Care Coordination

Each Member's care coordination is predicated on standard SNP MOC elements



Part 2: Care Coordination- Continued

Each Member's care coordination is predicated on standard SNP MOC elements

The Health Risk Assessment, or HRA, is completed by the member, member's representative or with the help of the AllCare Health Care Coordination team and includes questions around medical, functional, cognitive, oral and psychosocial health, social determinants of health and safety of environment.

HRA results may generate a referral for care coordination to address resource needs (community health worker) or clinical needs (RN or behavioral health care coordinator).

Care coordinators perform a comprehensive assessment, the outcome of which drives creation of the member-centered and trauma-informed care plan. Members and providers are sent a copy of the care plan.

Care coordinators arrange Interdisciplinary Care Team meetings, or ICT, on a cadence appropriate to a member's needs. ICT meetings include the member, provider and other participants of the member's Interdisciplinary Care Team.

Care plan goals, interventions and outcomes are reviewed and updated during ICT meetings. Changes in condition and identified obstacles to care are also addressed.



Part 2: Care Coordination- Health Risk Assessment



Members are mailed a paper HRA upon enrollment into the plan



Goal is to complete the HRA within 90 days of enrollment, annually and at any time there is a Health-Related Circumstance Change or Transition of Care. They can be completed in person, by phone, mail or online.



Questions focus on medical, functional, cognitive, oral and psychosocial health, social determinants of health and the safety of the members environment.



Assists in identifying barriers to care and provides education to our member.



Part 2: Care Coordination – Individualized Care Plan



Members, members representative, providers and / or family participate in the creation, which is conducted in a trauma – informed, culturally and linguistically appropriate manner.



Maintained and monitored by the Care Coordinator

Updated annually or as transitions of care or diagnosis indicates, and based on members health status, and members progress towards goals



Assists in identifying barriers to care and provides education to our member



ICPs are mailed to the member and shared to the PCP, ICT and caregivers and stored in the AllCare Health Care Management System



Part 2: Care Coordination – Interdisciplinary Care Team



Facilitated and overseen by the Care Coordination Team



Meeting cadence is determined by the member's unique needs



All ICTs include minimum of an AllCare Health Care Coordinator, member and member's PCP

ICT participants may include specialty providers, Community Based Organizations and family members



ICTs work to share information to update the care plan and ensure that services are not duplicated for this member



Part 2: Care Coordination – Face to Face Encounter



Ensure the member has a Face-to-Face encounter with a provider within the first 12 months of enrollment and at least annually ongoing



Conducted in person, or through visual, real-time, interactive telehealth encounter



Wellness visits, annual physical, care plan review, health related education, encounter to manage, treat and oversee health care each represent activities conducted for the qualifying face to face encounter



Vendors may perform the Face-to-Face encounters for some members. The vendor will supply a copy of their assessment/recommendations to the members provider of record

Care Coordination activities are driven by Face-to-Face encounters to follow up on needed care or services



Patient- Centered Primary Care Homes



Clinics recognized by the Oregon Health Authority for their commitment to a comprehensive, patient centered model of primary care organization and delivery

PCPCHs utilize a coordinated, team-based approach to support whole body health with a focus on:

Accessibility

Quality

Safety

This model and the SNP Model of Care are naturally comparable. Both strive to respect an individual's unique perspective and challenges, encourage active patient and family participation in care planning and goal setting.



Role of the PCP



Integral to any ICT, the PCP contributes related health data, recommendations that fit the specific and unique needs of the member and other information that may assist specialists in addressing higher levels of care.

PCPs and PCPCHs:

Provide oversight, negotiate or consult with other ICT members to prioritize care and eliminate contradiction or duplication in care

Provide updates to the individualized care plan as they see appropriate and communicate changes with the care manager



Support and encourage members to continue with interventions contained within the individualized care plan

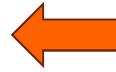
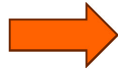
Work collaboratively with care managers during transition of care periods to support the member



Transition of Care



A transition of care occurs when a member moves from one care setting to another — such as returning home from inpatient hospitalization or outpatient surgery, changing PCPs or the initiation of home-based services



When a transition of care event is identified, the Care Coordinator coordinates between the member, PCP and Interdisciplinary Care Team.



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Transition of Care- continued



Following a transition of care event, the care manager contacts the member to assess the following:

- Assesses member's understanding of discharge instructions.
- Ensures member has a post-hospital follow-up appointment.
- Identifies potential barriers (Transportation).
- Reviews any new care needs.
- Links member with all needed services (Medications, home health, DME, etc.).
- Educates for post-transition care (medication compliance, provider follow-up).
- Collaborates with provider.
- Updates individualized care plan.



Finally, the care manager updates and redistributes the individual care plan to all parties involved in members care.



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Questions or Concerns

AllCare Health is here to assist your practice



For questions regarding the SNP MOC or care coordination, contact our care coordination team.

Care Coordinators are available- **Monday through Friday, from 8 am to 5 pm** Or by calling **541-471-4106**



Or Email: Provider Rapid Response ProviderRapidResponse@allcarehealth.com



To reach any of other AllCare Health departments—please call our dedicated provider lines, Monday through Friday, from 8 a.m. to 8 p.m.

541-471-4106



AllCare Provider Portal

AllCare Health is here to assist your practice



The [AllCare Provider Portal](#)—is your resource to:

- Receive important health plan communications
- Verify member eligibility
- Submit requests for PCP assignment via the contact us page
- Submit referrals and prior-authorizations and check their status
- Request an update to an authorization
- Provide a secure submission of support documentation
- Check on the status of a claim
- View prior-authorization guidelines
- Access health plan policies, procedures, and guidelines
- Search the exclusive Oregon Health Plan (OHP) Line Locator tool



Part 3: Clinical Care Guidelines



SNP Goals and Quality Improvement

- AllCare Health Plan Utilization Management Clinical Practice Guideline and Utilization Review Committee reviews, approves and disseminates evidence-based clinical practice guidelines and nationally recognized protocols to community clinicians, network providers and members.
 - Approved clinical practice guidelines are available online at <https://www.allcarehealth.com/medicaid/resources/clinical-practice-guidelines>
- AllCare Health Quality Improvement Committee meets monthly to review member data and Transformation and Quality Projects
 - The QI Committee supports the development and monitoring of quality improvement goals to the SNP MOC Population Health team



SNP Model of Care Goals

The National Committee for Quality Assurance (NCQA) provides goals for SNPs



Improve access and affordability to essential medical and mental health services

Improve coordination of care through alignment of the Health Risk Assessment, Interdisciplinary Care Plan & Interdisciplinary Care Team

Ensure appropriate utilization of services for preventive health.

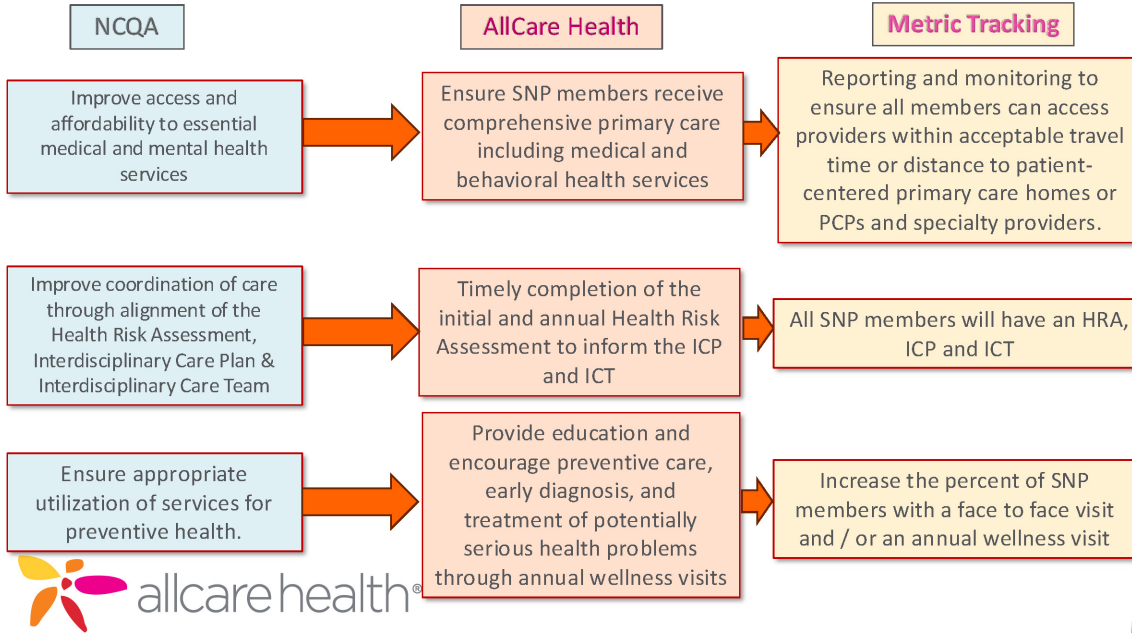
Improve seamless transition of care across all healthcare settings and providers.

Ensure appropriate utilization of services for chronic conditions.



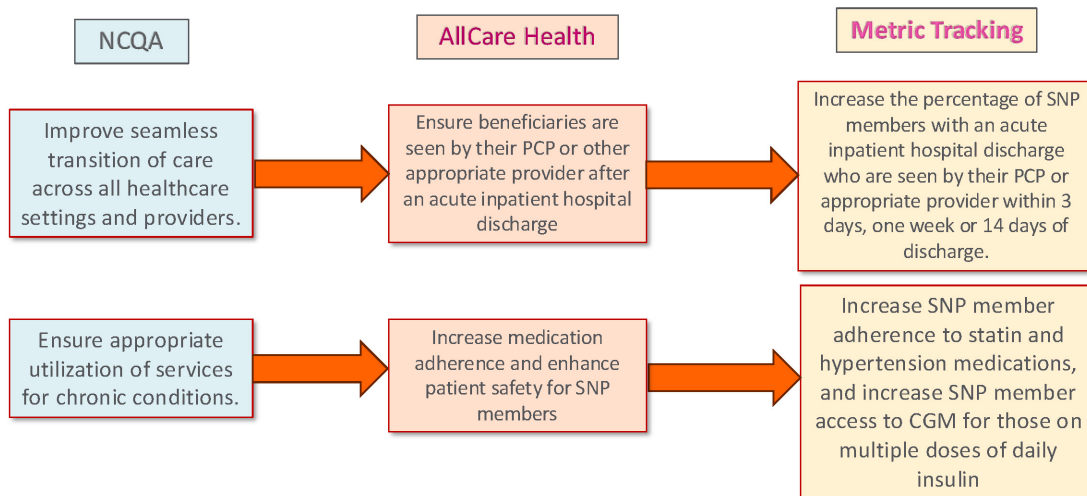
SNP Model of Care –Continued

The National Committee for Quality Assurance (NCQA) provides goals for SNPs



SNP Model of Care –Continued

The National Committee for Quality Assurance (NCQA) provides goals for SNPs



MOC Oversight



- Clinical leadership is provided by department supervisors, managers, and directors
- The Chief Medical Officer has overall executive responsibility for the Model of Care
- AllCare Health Quality Improvement and Compliance Departments monitor performance and compliance



Additional D-SNP Benefits



- Medication Therapy Management



- Diet and nutritional education



- Behavioral health services and social work support



- End-of-life support and Advance Care Planning



- Home and community-based services partnerships



- Non-emergency medical transportation (NEMT)



- Meal programs during transitions of care



Part 4: Provider Resources



We are here for you!

Provider Relations representatives are available to support you by assisting with educational requirements, data and reporting, compliance, care coordination and to resolve any operational issues you may have. Please contact us using the following methods:

Phone: (541) 471-4106

Provider Website: Learn more about our innovative medical services that reduce costs and increase practice efficiency.



Provider Portal: This is where you can go to find out information related to member eligibility, referrals and prior-authorizations, claim status, policies and procedures and tools that assist with day-to-day processes.

AllCare IPA: AllCare IPA is committed to helping doctors and providers deliver better and more cost-effective care to our local communities



This Completes Your 2024 SNP MOC Provider Training



Please complete your training attestation [here](#)

From all of us,

Thank you!





AllCare Health Plan, Inc., an Oregon Benefit Company

AllCareHealth.com/Medicare



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