



**Allwell from Arizona Complete Health**

**Dual-Eligible Special Needs Plan**

**H5590-006-001, H5590-006-002**

**Model of Care**

**Contract Year 2019**

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## Overview

Allwell from Arizona Complete Health, Based in Tempe, Arizona, is an affiliate of Centene Corporation, a nationally recognized MCO offering Medicare, Medicaid, US Department of Defense and Veterans affairs sponsored health insurance coverage for people of all ages and at all stages of life. Centene has extensive experience coordinating care for dual eligible members, including those requiring LTSS. The chart below shows the states in which Centene serves duals through Medicare Special Needs Plans (SNP), Medicare-Medicaid Plans (MMP; operating as part of a Centers for Medicare and Medicaid Services (CMS) Financial Alignment Initiative duals demonstration project) and managed Long Term Services and Supports (MLTSS) plans. Centene's experience with these models and combinations of models gives us a deep insight into the importance of coordinating Medicaid, Medicare and LTSS, as well as, the challenges to doing so under varied coverage and eligibility scenarios. In fact, Superior Star + Plus, our Texas affiliate offering MLTSS, D-SNP and MMP products to more than 140,000 members, was recently chosen by the Long Term Quality Alliance as an “exemplar” plan and a national leader in integration efforts.<sup>1</sup>

PLAN TYPE	AR	AZ	CA	FL	GA	IL	KS	LA	MI	MO	OH	OR	PA	SC	TX	WA	WI
MLTSS Plan			•	•		•	•				•		•		•		
D-SNP		•	•	•	•						•	•	•	•	•		•
MMP			•			•			•		•			•	•		
MAPD	•	•					•	•		•	•			•		•	

From its origin in 1984 as a single health plan, Centene has continuously grown – both, in the scope of its mission and the services it provides. Today, Centene supports over 12.3 million children and adults in 29 states, in both rural and urban areas, served by 240,000 physicians and 2,300 hospitals and is the largest Medicaid plan in the country.

According to a 2010 report issued by the Kaiser Foundation, there are over 9 million low-income seniors and younger people with disabilities in the US who rely on coverage from both Medicare and Medicaid. Approximately 7 million residents reside in Arizona.<sup>2</sup> When members, caregivers and providers are forced to navigate a delivery model that includes multiple funding streams, overlapping and conflicting benefit packages and complex eligibility and regulatory requirements, the result is too often fragmented, inefficient care. The clinical complexity of the dual eligible population is further impacted by physical, intellectual, cultural and language barriers which lead to both gaps in care and poor health outcomes. Allwell from Arizona Complete Health builds on the experience and best practices of our Centene affiliates in

<sup>1</sup> Windh. J, Atkins, G.L, Simon, L, Smith, L, Tumlinson, A., (2016). Integration Lessons from Five Exemplar Plans, Project to Develop the Business Case for LTSS Integration, (Working Paper No.1). Long Term Quality Alliance.

<sup>2</sup> Census.gov

addressing these challenges because we are committed to improving the health of our members through innovative, person-centered solutions.

Centene's core philosophy is that quality healthcare is best delivered locally while best practices are continuously shared among the health plan affiliates to ensure a combination of high quality services that are relevant and culturally sensitive to the communities we serve. We strongly support the move towards greater care coordination for the dual eligible population and have developed this Model of Care to ensure delivery of high quality, coordinated care and services.

Improving access to essential, and clinically appropriate, services such as medical, behavioral health, social, and community based services and supports, for D-SNP members is our primary goal. The dual eligible population experiences significantly greater health care needs compared to the general population, and many of these needs require care management and service coordination in order to effectively negotiate an often fragmented delivery system. A study conducted by CMS in 2014 indicated that among the FFS Medicare-Medicaid population included in the study, 60% had diagnoses across at least three of the physical and mental health categorical condition groups, while 25% had diagnoses spanning five or more condition groups. Three quarters of the study group had at least one heart related condition, and 41% had one or more mental health conditions (excluding substance use disorders).<sup>3</sup>

D-SNP members' co-occurring and/or co-morbid conditions are frequently compounded by limited access to services, cultural and linguistic barriers, and functional limitations. Allwell from Arizona Complete Health meets this challenge through a holistic, person-centered, member-driven, integrated physical and behavioral health approach delivered by well-trained, experienced Care Managers (RNs and Licensed Social Workers) supported by an integrated care team of other clinical and non-clinical staff.

By maintaining a locally recruited, culturally sensitive and diverse staff, an extensive network of primary care and specialty providers, outpatient and tertiary institutions, allied health professionals, labs and other diagnostic centers, as well as coordination with community-based organizations (CBO), we demonstrate our deep respect for our members and assure personal choice. Allwell from Arizona Complete Health has specialized in Medicaid managed care in Arizona since January 1, 2008. Beginning in January 2008 the contract with the Department of Health Services for Arizona has included Medicaid members in the categories of low income elderly, persons with a disability and persons who are dual eligible. Allwell from Arizona Complete Health is a Full Benefit Dual Eligible Special Needs Plan that has held a full risk contract from Centers for Medicare and Medicaid (CMS) since January 1, 2008. Allwell from Arizona Complete Health is committed to delivering quality, appropriate and medically-necessary care for dual-eligible beneficiaries. Our system of care, outlined below, reflects pertinent clinical expertise and staff structures to support quality care for this population. Our processes of care meet or exceed the goals and objectives for initial and periodic assessment, as

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<sup>3</sup> Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees. Centers for Medicare & Medicaid Services, September, 2014.



well as care and care management. We strive for continued improvement, using process/outcome measures to evaluate our performance.

It is Allwell from Arizona Complete Health's objective to achieve the Triple Aim of 1) improving the health and quality of life of our members, including those who require LTSS; 2) enhancing our members experience of care; and 3) lowering the per capita cost of health care provided to our members; and to expand it to include a Fourth Aim<sup>4</sup> related to the improvement of the work life of our providers and their staff as well as their experience and satisfaction with Allwell from Arizona Complete Health.

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<sup>4</sup> Bodenheimer and Sinsky, From Triple to Quadruple Aim: Care of the patient requires care of the provider; Annals of Family Medicine 12:6 Nov-Dec 2014 pp 573-576.

## MOC 1: Description of D-SNP Population (General Population)

### Element A: Description of overall D-SNP population

#### *Eligible Population*

Allwell from Arizona Complete Health Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) target population includes members who are:

- Eligible for Medicare Part A, Part B.
- Eligible for a full Medicaid benefit.
- Age 21 years and older
- Residents in one of the following counties of Arizona: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.

#### *1. How we determine, verify and track eligibility of D-SNP Members*

Allwell from Arizona Complete Health maintains processes for identifying, verifying and engaging D-SNP members to ensure eligibility for appropriate care coordination services.

Identifying D-SNP Eligible Members: Determining member eligibility begins when a potential member completes an application, either directly or through a sales representative, for our Medicare Advantage D-SNP product, and they submit the completed application to the Enrollment Department.

Verification: Eligibility is then verified through the Batch Eligibility Query (BEQ) process (or the CMS MARx web portal if the BEQ process is unavailable) to confirm that the member is eligible for full Medicare benefits, including Part A, B and D Medicare, the Medicaid eligibility is verified via the State website or telephone number provided by the State. We also verify that the member lives within our specified service area. In addition, at least annually all D-SNP Members Medicaid eligibility is verified to ensure active Medicaid coverage.

With each member contact, eligibility is then verified through the State of Arizona AHCCCS Online portal to confirm that the member is eligible for a qualifying level of Medicaid.

Tracking: Enrollment Specialists maintain an internal member database to track and ensure data accuracy by conducting reconciliation with the CMS Transaction Replay Report, Monthly Membership Report and State Medicaid files. If a member is flagged for benefit termination, the Enrollment Specialist triggers an eligibility notification letter to advising the member of the current or future termination.

#### *2. Social, cognitive and environmental factors, living conditions and co-morbidities associated with the D-SNP population*

### Dual Eligibles Nationally:

Nationally, there are over 9 million Americans enrolled in Medicare and Medicaid with annual total spending cost for their care that exceeds \$300 billion across both programs. In 2009<sup>5</sup>, 19% of Medicare enrollees were co-enrolled in Medicaid, using 34% of total Medicare expenditures, and 14% of Medicaid enrollees were co-enrolled in Medicare, using 35% of total Medicaid expenditures. Among the full and partial Medicare-Medicaid fee-for-service enrollees, 25% require long term care either in an institution or in the community and they account for 80% of all Medicare-Medicaid enrollees' total expenditures.

In general, dual eligibles are two-thirds low-income elderly adults while one-third are people under 65 with disabilities. Dual eligibles are more likely to be female, more ethnically diverse, more likely to have greater limitations with activities of daily living, less likely to have a high school diploma and higher education, more likely to be lower income, live in an urban area and live in an institution, alone or with a child/non-relatives<sup>6</sup>. Forty-four percent have 3 or more chronic conditions, with 39% having diabetes or other endocrine or renal disorder; 37% having heart disease or other cardiovascular disorder, and 33% having a psychiatric disorder.<sup>2</sup>

### Dual Eligibles in Arizona:

There are approximately 171,000 dual Medicare-Medicaid eligible members in Arizona, which represent 2.5% of the total population of the state, and average \$4.179 billion in Medicaid expenditures.<sup>6</sup>

Much of Arizona is rural, but the majority of the population lives in metropolitan areas. Among the state's fifteen counties, Maricopa, Pima, Pinal, Yavapai and Mohave have total populations of 200,000 or more. A majority (87%) of the state's population lives in metropolitan areas; more than 87% of the state's total population resides in the five large counties.<sup>7</sup> This D-SNP has members living in Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma counties which have a combined population of approximately 5.7 million.<sup>8</sup>

### Demographics of the State of Arizona<sup>6</sup>:

The tables below describe the demographics of the State of Arizona. The majority of the Arizona population lives in urban areas and the members of this D-SNP live in Maricopa County, the largest county in Arizona. The State demographics below can be considered a representation of the Allwell from Arizona Complete Health membership.

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<sup>5</sup> Medicare-Medicaid Enrollee Information National, 2009 – CMS/Medicare-Medicaid Coordination Office

<sup>6</sup> CMS.gov "Medicare-Medicaid Enrollee State Profiles"

<sup>7</sup> <https://suburbanstats.org/population/arizona/list-of-counties-and-cities-in-arizona>

<sup>8</sup> <https://suburbanstats.org/population/arizona/list-of-counties-and-cities-in-arizona>

Total Population in Arizona	6,392,017

## Age and Gender

Male Population:	3,077,592
Under 5 years:	232,202
5 to 9 years:	230,929
10 to 14 years:	228,436
15 to 17 years:	137,137
18 and 19 years:	86,131
20 years:	43,307
21 years:	41,994
22 to 24 years:	124,609
25 to 29 years:	213,024
30 to 34 years:	201,299
35 to 39 years:	201,302
40 to 44 years:	197,953
45 to 49 years:	205,766
50 to 54 years:	197,227
55 to 59 years:	175,476
60 and 61 years:	67,504
62 to 64 years:	97,566
65 and 66 years:	55,691
67 to 69 years:	76,773
70 to 74 years:	101,700
75 to 79 years:	75,259
80 to 84 years:	50,485
85 years and over:	35,822



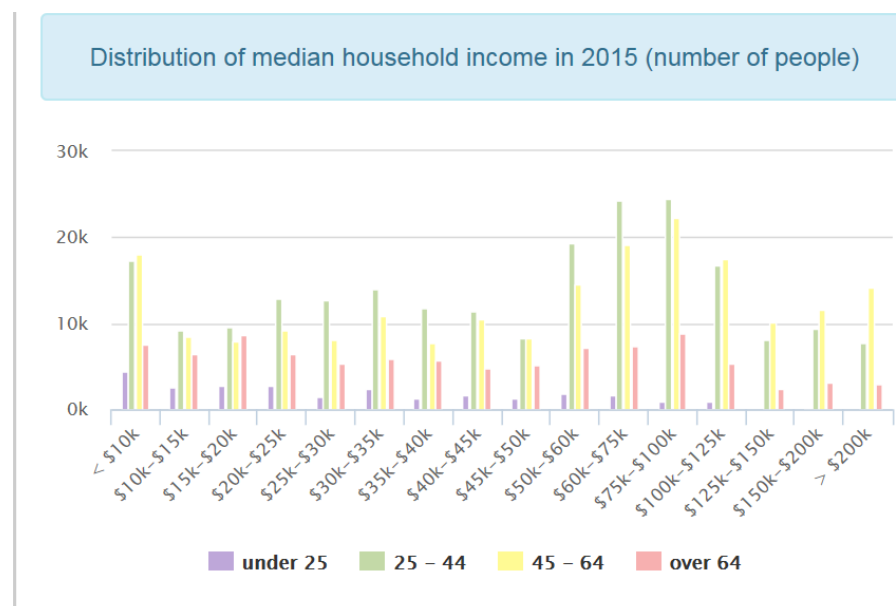
Female Population:	3,175,041
Under 5 years:	222,815
5 to 9 years:	222,156
10 to 14 years:	219,252
15 to 17 years:	131,184
18 and 19 years:	81,650
20 years:	41,913
21 years:	41,081
22 to 24 years:	122,678
25 to 29 years:	212,277
30 to 34 years:	202,950
35 to 39 years:	204,210
40 to 44 years:	199,588
45 to 49 years:	213,270
50 to 54 years:	211,890
55 to 59 years:	195,787
60 and 61 years:	75,364
62 to 64 years:	107,860
65 and 66 years:	62,574
67 to 69 years:	85,968
70 to 74 years:	111,522
75 to 79 years:	84,731
80 to 84 years:	64,631
85 years and over:	59,690

### Ethnicity

Race	Population	% of Total
Total Population	6,392,017	100
White	4,667,121	73
Hispanic or Latino	1,895,149	29
Some Other Race	761,716	11
American Indian	296,529	4
Black or African American	259,008	4
Two or More Races	218,300	3
Asian	176,695	2
Three or more races	15,238	Below 1%
Native Hawaiian Pacific Islander	12,648	Below 1%
Native Hawaiian	3,837	Below 1%
Alaska Native tribes	797	Below 1%

### Languages

Language	Population	Percentage
English	4,633,662	76.80%
Spanish	1,230,730	20.40%
German	23,020	0.38%
Chinese	19,765	0.33%
French	16,480	0.27%
Apache	10,700	0.18%
Pima	6,695	0.11%
Hopi	5,660	0.09%
Mandarin	5,135	0.09%

Income Level or Financial Indicator <sup>9</sup>Comorbidities and chronic conditions <sup>10</sup>

The comorbidities and chronic conditions listed below are specific to the Allwell from Arizona Complete Health membership based on responses to the Health Risk Assessments.

Diabetes	32%
Heart Failure	8%
Hypertension	57%
Obesity	20%
History of Stroke	10%
Osteoporosis	24%
Impaired Vision	32%
Memory Problems	28%
Mental Health Problems	27%

Collectively, the above data presents a diverse population that ranges in age, culture and socioeconomic status. Other than social and environmental factors, the above data shows a high prevalence of comorbidities and chronic conditions. With this in mind, our Integrated Care Team, Care Managers, and Utilization Managers focus on providing multiple medical resources to members. For example, our Integrated Care Team Meeting process helps coordinate preventive care for each health plan member during each year. Overall, our D-SNP population requires culturally diverse care with a focus on social, medical, and environmental support.

<sup>9</sup> [www.city-data.com/income/income-Phoenix-Arizona.html](http://www.city-data.com/income/income-Phoenix-Arizona.html)

<sup>10</sup> As self-reported by Dual – SNP Members on the 2015 HN HRA

In general, dual eligible members are disproportionately of low income, less likely to have a high school diploma or higher education, demonstrate low health literacy and are elderly, frail and/or have chronic illnesses or disabilities.

### ***3. Medical and health conditions impacting D-SNP Members***

Eighty one percent of dual-eligible members in Arizona have one or more chronic conditions and 40% percent have three or more. The most prevalent conditions are heart disease/failure and other cardiovascular conditions 29%, mainly hypertension and heart failure; diabetes, other endocrine conditions, ESRD and other renal disorders 39%; psychiatric and mental health 30%, mainly depression and bipolar disorder; Alzheimer's and other dementias 13%; asthma and COPD 18%; arthritis, osteoporosis, and other joint-related" at 30% and health conditions associated with physical disabilities 30%.<sup>2,4</sup>

Prevalence of certain conditions varies by age group. Among the dual-eligible members under 65 years of age, higher prevalence is seen for depression 30%; intellectual disability 8%; personality disorder 46%. Among the dual eligible members 65 years or older, higher prevalence is seen for Alzheimer's disease 23%; all heart related conditions (atrial fibrillation-35%; heart failure - 23%; hypertension - 66%; ischemic heart disease - 36.6%; diabetes - 34% ).<sup>5,11</sup>

In general, they are high utilizers of services such as emergency room, hospital outpatient services, inpatient services, physician's visits, prescriptions, nursing facilities and skilled nursing facilities.<sup>12</sup>

### ***4. Unique characteristics of the D-SNP population served***

Dual eligible members in the state of Arizona are in a mix of fee-for-service and Managed Care Organization programs, in either Medicare or Medicaid or both, which makes the access to and coordination of services and benefits and proper coverage for those needed services a very difficult, if not impossible task, for the member and/or caregiver who are often poorly educated, may not speak the language and don't have the knowledge or experience needed to navigate complex systems.

The Health Risk Assessment (HRA) data showed that 27% of D-SNP members reported they cannot shop for their own food and 29% of members reported that they cannot cook their food. Transportation is an economical factor that contributes to members being able to get to doctor appointments, pick-up prescriptions, and attend social events. About 34% of D-SNP members depended on friends for transportation. As a result, 64% of members reported that they are unable to participate in social activities on a regular basis. Dual eligible members that cannot afford the essentials or perform tasks on their own, such as food shopping and cooking, buying

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<sup>11</sup>[http://www.integratedcareresourcecenter.net/PDFs/ICRC%20WWM%20webinar%20Medicare%20101%20and%20201%20FINAL\\_508.pdf](http://www.integratedcareresourcecenter.net/PDFs/ICRC%20WWM%20webinar%20Medicare%20101%20and%20201%20FINAL_508.pdf)

<sup>12</sup> Medicare-Medicaid Enrollee State Profile. CMS/Medicare-Medicaid Coordination Office.

clothes, dressing themselves and securing housing, experience a social deficit that can impact their physical and mental health.

Furthermore, many members have comorbid medical and behavioral health conditions which brings challenges related to engagement, evaluation and assessment, access to culturally appropriate services, effective transitions between settings and ensuring adequate in-home support for those wishing to remain in the least restrictive setting of their choice.

This population requires a robust, integrated and well-coordinated program that does the following:

- Identify, coordinate and ensure access to all required covered and non-covered services
- Provide person-centered care managed by a Care Manager (CM) or Care Coordinator (CC) who coordinates with clinical (Primary Care Practitioner, Specialists) and behavioral health professionals, facilities and community resources, as well as LTSS providers as applicable
- Educate and support members and caregivers on the transition from institutionalized long term care to community based long term care, if applicable
- Monitor members at home after being discharged from the hospital, or other facilities, working closely with the caregivers and the integrated care team to prevent future hospitalizations or long term care to support their needs.
- Reconcile prescription drugs and educate member and their caregivers on medication purpose and proper consumption
- Ensure access to needed care and services in rural areas by providing health care professional house visits for the frail and home-bound
- Ensure availability of transportation
- Educate members on self-management, including self-management tools, and the signs and symptoms and appropriate management of their condition(s)

The program is culturally and linguistically appropriate in order to address barriers in accessing services, reduce disparities, and ensure compliance with medications and other therapies<sup>13</sup>.

## **Element B: Subpopulation—Most Vulnerable Members**

### ***1. Identifying our most vulnerable Members***

Allwell from Arizona Complete Health defines the most vulnerable members as those with clinical and behavioral conditions that place them at highest risk; disabilities such as developmental disability or other physical or mental disability; and/or complex psychosocial circumstances. As a D-SNP plan, a significant number will fall within the “most vulnerable” category.

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<sup>13</sup> M.K, Paasche-Orlow, M.S. Wolf, 2010 “Promoting Health Literacy Research to Reduce Health Disparities”. Journal of Health Communication, 15:S2, 34-41.

Allwell from Arizona Complete Health uses a variety of sources to identify its most vulnerable members, including the following:

- Internal data sources, such as historical and ongoing claims, encounters, healthcare utilization, pharmacy information, laboratory results and results of predictive modeling
- Health risk assessments results and comprehensive functional and home assessments
- Interdisciplinary Care Team observations
- Referrals from providers, Envolve People Care, members, caregivers, community partners and agencies

The defining variables for Allwell from Arizona Complete Health identification of high risk and most vulnerable members includes the following:

- Frail – may include the super elderly (> 85 years) and/or with diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty
- Disabled – members who are unable to perform key functional activities independently such as ambulation, eating or toileting, or who have suffered an amputation and/or blindness due to their diabetes or circulatory impairment
- Dementia – members at risk due to moderate/severe memory loss or forgetfulness
- ESRD post-enrollment – members with complex medical treatment plan for kidney failure
- End-of-Life – members with terminal diagnosis such as end-stage cancers, heart or lung disease
- Complex and multiple chronic conditions – members with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems

On average, vulnerable members are:

- Age: Based on the demographic data above, the average age of Allwell from Arizona Complete Health members is 71 years of age. Increased age typically signifies increased risk. However, our population's age reflects their Special Needs status, as many of our members qualify for Medicare due to condition(s) rather than age.
- Gender: Women make up 58.6% of Allwell from Arizona Complete Health membership. 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 are. In addition to routine screening for chronic diseases such as HTN, CAD and diabetes, men require regular screening for disorders of the prostate.
- Ethnicity: Allwell from Arizona Complete Health membership consists of 99.8% unknown ethnicity and 0.2% white/Caucasian. Culturally, Hispanics and African Americans may be less likely to obtain routine medical care.
- Urban poverty. All of our members (100%) are Low Income Subsidy Level 2 (up to or at 100% of the Federal Poverty Level). More than 84.2% of our members live within the city limits of Metropolitan Phoenix area.<sup>6</sup> Lower socio-economic status individuals in this urban setting have shown a variety of poor health outcomes, including: lower life

expectancy, lower perceived physical and mental health, lower mammogram rates, higher smoking rate, higher binge drinking rates, and higher obesity.

## ***2. Specially tailored services to be offered***

Specially tailored services and benefits for Allwell from Arizona Complete Health most vulnerable members are described below. These services and benefits include the following:

- Care coordination and complex care management for high risk and most vulnerable members
- Care transitions management
- Physician home visiting services
- In-home wound care
- Clinical management in long term care facilities as needed
- Medication Therapy Management and medication reconciliation
- Medicare and Medicaid benefit and eligibility coordination and advocacy

Our Care Management Care Plan is person **centered**, and employs an integrated approach that addresses health needs using plan benefits, social determinants, and community resources. Our “one point of contact

and accountability” model works across Medicare D-SNP, and Medicaid services provided by either Allwell from Arizona Complete Health, Medicaid FFS, or services provided by other MCOs.

In all instances, the Allwell from Arizona Complete Health “one point of contact” model coordinates care across the continuum to ensure full seamless care coordination.

Our model addresses the challenges our members face on a daily basis. CMs can perform a telephonic or home/onsite or a face-to-face assessment of their needs when the members’ condition warrants it. We use a health risk assessment tool that includes a review of prior medical/behavioral health history and medications to develop the member centric care plan. Meeting our members where they live is an important aspect of our Model of Care, especially for our most vulnerable members. Connecting at a personal level creates the important human bond that leads to engagement, partnership and trust to improve self-management, health and welfare.

## ***3. Health disparities in the most vulnerable population and correlation between demographic characteristics and unique clinical requirements***

The social determinants of health show that the most vulnerable members are generally older; approximately 8.2% are over the age of 85 with multiple chronic conditions including mental illness, mainly depression and dementia, and with serious ADL (dressing, eating, bathing,) and/or IADL (shopping, cooking, etc.) limitations. Among the most vulnerable younger members, below the age of 65, the majority will have some type of disability and/or cognitive/developmental issue paired with chronic conditions such as diabetes and behavioral

health conditions such as depression, bipolar disorder and anxiety/PTSD. All of them require a more intensive level of care management and benefit coordination. They live in either urban inner city areas or in rural areas of Arizona. More important, a great majority experience health disparities including poverty, poor health literacy and language and cultural barriers.

It has been demonstrated that low health literacy, which is “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions” leads to poor health outcomes <sup>6</sup>. Individuals may not understand the instructions or indications provided by physicians or nurses and, prescription drugs labels are often difficult to read. Furthermore, cultural and linguistic differences and the lack of an interpreter or of practitioners of the same culture limit communication effectiveness and create an access and regimen compliance deficiency. Overall, minorities and low income/low education individuals have shown less access to care, lower quality of care, increased preventable hospitalizations and overall poor health outcomes. <sup>14</sup>

In addition, most vulnerable members residing in rural areas tend to be more isolated, and have less access to the required services and providers that can help them manage their complex cases, thus contributing to overall poor health outcomes.

Finally, it has been demonstrated that members with comorbid medical and behavioral health conditions that are compounded by health disparities and social issues tend to have poor medical outcomes due to difficulty complying with treatment. It is fundamental to address co-existing behavioral health and social issues in order to achieve improvement in medical conditions.

The “one point of contact” person-centered program helps address the complex needs of the most vulnerable members by developing specific tailored outreach and services to respond to their particular health, behavioral health, social, geographic, cultural and linguistic barriers and requirements. The “one point of contact” receives multidisciplinary input and coordination support from our integrated care team to coordinate with the full range of providers serving the member, manage transitions in care, ensure appropriate medication reconciliation and signs and symptoms management, ensuring proper access to services by arranging transportation or sending healthcare professionals and/or services to the members’ homes, coordinate care and support with community organizations, assist members on their Medicaid recertification paperwork, and ensure proper coordination of benefits.

The following case study from one of our Centene affiliates illustrates the impact that a CM approach has on members:

“Cardio member was post discharge from SNF after a fall at home and a bout of cellulitis and debilitated state. Member was discharged home with her husband. Husband is able to help with provider for ADL’s. Home Health Care (HHC) had been ordered for PT/OT for strengthening and nursing visits. DME (walker and wheelchair) had been ordered through contracted provider. Walker was obtained same day and wheelchair was delivered next day.

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<sup>14</sup> National Healthcare Disparities Report 2012 – US Department of Health and Human Services



HHC initiated earlier than originally planned and member has since utilized resources to obtain in home assistance twice a week. Member reports gaining strength and making progress with no further falls or readmissions. Member was very grateful for assistance from CM with communication and coordination, post discharge.”

#### ***4. Establishing relationships with community partners***

To connect our members with established community partners, our referral process consists of Care Managers who provide the member with coordination of services to assist them with their needs. Care Managers maintain a good working knowledge of community resources within the member’s geographic location and conduct county-specific research to identify and connect members with the resources in their community to meet the unique needs of each individual. Services can range from assistance with home modifications (e.g. ramp installations) to financial assistance, support groups and in-home services.

Allwell from Arizona Complete Health collaborates with its participating provider groups in order to enhance member care. Actionable data is shared on a regular basis with providers, regarding; care gaps, member pharmacy issues, results of member surveys and other relevant data for providers to utilize with follow-up and outreach of members. Allwell from Arizona Complete Health also provides clinical practice guidelines and member educational tools around chronic heart failure and diabetes to provider partners for optimum disease management. The online provider portal offers access to member level data on the HRA, authorizations, claims and other information. This fosters continuity of community partnership and access. Ultimately, members benefit from partnerships with the following:

- All new members will be contacted within the first 90 days following enrollment.
- All members will be contacted for an assessment of needs and risks. Those identified, as at risk for medical, social or psychological gaps will be followed up with an in-home safety assessment within 14 days, if warranted.
- Providers will coordinate recommendations through the member’s PCP to order and facilitate coverage determinations for members who benefit from adjunct medically necessary therapies.
- Educate members on available community options, living wills, advanced directives; establish trust with members as point of contact, or in need of medical care.

Overall, D-SNP members face unique health needs including, but not limited to:

- Limited access to and availability of care due to constrained transportation and/or reliance on a working caregiver
- Social Determinants of Health
- Housing and income issues creating tenuous lifestyles, which causes the beneficiary to disengage with the health plan and providers
- Limited monetary resources to invest in a healthy lifestyle, such as nutrition, medication and gym memberships
- An inadequate social support system that heightens lifestyle vulnerability

- The complexities of having two sets of benefits (Medicaid and Medicare), with two systems to access, two sets of rules to follow, and two sets of coverage guidelines

These barriers lead to lack of obtaining preventative care, poor history of proactive health screening and increased hospital readmission rates. Because we acknowledge these limitations and barriers, our D-SNP plan focuses on contingency of care, care coordination, and increased access to providers. For example, our value added benefits may include services such as a fitness program that will provide physical exercise outlets and psychosocial interactions at no cost. We also may offer a monthly allowance for over the counter medications and/or supplies. Gaps in care for our members who are full duals will be addressed with coordination of benefits through education of the member and provider.

## MOC 2: Care Coordination

### Element A: D-SNP Staff Structure

Centene Corporation is the parent company of Allwell from Arizona Complete Health; within the corporate structure, the Corporate Executive Vice President oversees the Corporate Medicare CEO. The Medicare CEO oversees the Corporate Director of Compliance and Regulatory Affairs and at the Plan level, the Allwell from Arizona Complete Health structure includes the Senior Vice President of Government Relations and Compliance. Allwell from Arizona Complete Health has a dedicated Medicare Sales Team, as well as dedicated Marketing staff. The Medicare Medical Management staff is a separate multidisciplinary team receiving support from other plan departments such as Quality Improvement/Management, Pharmacy, Member Services, Provider Services and Claims.

Centene Corporation provides executive and operational support to Allwell Arizona Complete Health and offers specialty affiliates and contracted vendors that serves Allwell from Arizona Complete Health include affiliates who may participate in the care of Medicare members such as:

**Engage People Care:** afterhours call center services; disease management health coaching; behavioral health benefit management including claims payment, credentialing, utilization management, network management, case management, and crisis member outreach call support.

**Engage Pharmacy Solutions, Inc.:** pharmacy benefit management including claims processing, eligibility management, benefits administration, utilization management, pharmacy network management, call center services

**Engage Vision:** vision benefit management including provider credentialing and re-credentialing, network development, claims processing and payment

**National Imaging Associates, Inc. (NIA):** high-tech imaging/radiology; utilization management, credentialing, network development

To ensure a seamless operational integration of services, Allwell from Arizona Complete Health utilizes existing employed and contracted staff to oversee the administrative services noted throughout the Model of Care, in addition to hiring staff as needed to supplement any additional functions.

#### *1. Administrative staff's roles, responsibility and oversight functions*

The following describes the specific employed or contracted staff that performs administrative functions for the D-SNP program, by functional area. Each department has a VP/Director/Manager responsible for oversight of activities pertinent to their specialty area.

#### *Enrollment and Eligibility Verification*

Enrollment Specialist and Enrollment Supervisor from Corporate are responsible for the following:

- Verify Medicare and Medicaid eligibility
- Process enrollments and voluntary and involuntary disenrollment 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 Replay Report) and State Medicaid files
- Producing a Monthly Membership Report

### *Member Service*

Member Service Representative and Member Services Supervisor are responsible for the following:

- Inbound/outbound member call center activities
- Conduct new member welcome call to introduce the member to the Member Service unit, explains benefits, answers questions, assist with PCP selection
- Verify Eligibility
- Answer member inquiries

### *Claims*

Claims Specialist are responsible for the following:

- Process claims for contracted and non-contracted providers
- Assess payment accuracy and conducts recoveries of overpayment

### *Appeals and Grievances (A&G)*

A&G Coordinators are responsible for the following:

- Intake and resolution of member grievances according to CMS timelines
- Coordinates with the Quality Management department in the resolution of member quality of care complaints
- Intake of reconsiderations and coordination with the Medical Management department for resolution

### *Provider Services*

Provider Services Representative, Credentialing Specialist and Director of Network Operations are responsible for the following:

- Receive and resolve provider inquiries
- Manage Allwell from Arizona Complete Health website provider directory
- Setup & Contracting for Providers
  - Primary resource between providers and plan
  - Investigate and communicate resolutions to provider issues
  - Recruit new providers
  - Credential and re-credential providers
  - Manage providers' education
  - Ensure access and availability to providers to meet members' needs.

### *Marketing/Communications*

Marketing Manager and Marketing Team are responsible for the following:

- Develop communication articles and materials for distribution to stakeholders
- Develop and distribute member & provider educational materials
- Develop marketing materials

### *Finance*

Chief Financial Officer 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
- Manage risk management program
- Monitor HCC risk adjustment

### *Training*

Compliance VP, Medical Management VP, Director Network Management and Director Service Coordination are responsible for the following:

- Assess and identify individual and group training needs through key business indicators and develop various training curricula, materials and aids
- Coordinate training efforts to meet training demands through peer shadowing, classroom classes and online presence
- Oversee the auditing of team results and identify gaps in training and implement improvements in training programs

### *Regulatory & Compliance*

Compliance Director is responsible for the following:

- Assure statutory and regulatory compliance
- Maintain the storage and distribution of healthcare records
- Ensure compliance with HIPAA and Medicare guidelines
- Manage and implements the Compliance Program
- Monitor Fraud, Waste and Abuse
- Provides report to CMS

### *Contracted Vendors for Case Management Services*

Adobe Case Management vendor contracted to provide the following services

- Care Navigation/Data Gathering
- Transitions of Care
- Nurse Practitioner Services
- Case Management Services
- Telecommunication and Remote Monitoring
- Documentation EMR, Reporting and Data Exchange
- Participation in Joint Operating Committee meetings
- Participation in ICT meetings

- Communicating with Providers

### *US Health Systems*

- Transitional Care Services
- Intensive Care Management
- Care Coordination
- Palliative Care Services
- Emergency Room Care Coordination
- Post-Acute Care (PAC) Home Health and Skilled Nursing Facility (SNF) Network Management
- Participation in Joint Operating Committee Meetings

Directors/Managers of each function and the Vice President of Medical Management, Compliance, Chief Operating Officer and Chief Financial Officer oversees administrative functions.

## ***2. Clinical staff's roles and responsibilities and oversight functions.***

Allwell from Arizona Complete Health has an internal integrated team comprised of clinical and non-clinical staff with knowledge of and experience working with dual-eligible members. This includes knowledge of Medicare and Medicaid. Clinical leadership has monitoring and oversight of the Medical Management and Quality programs. The integrated Allwell from Arizona Complete Health team associates work collaboratively with the members to coordinate services. Associates such as: licensed physicians, nurse practitioners, registered nurses, licensed social workers, pharmacists, behavioral health specialists, and any other healthcare professionals. Members of these disciplines may also participate with the member's Interdisciplinary Care Team (ICT), which is involved in the planning, provision and monitoring of the member's care plan and services. The following are descriptions of clinical functions performed by Allwell from Arizona Complete Health staff.

### **Vice President Medical Management**

#### **Registered Nurse**

- Oversee clinical and administrative staff
- Direct and coordinate activities of the medical management department and aids the appropriate corporate staff in formulating and administering organizational and departmental policies
- Review analysis of activities, costs, operations and forecast data to determine department progress and staffing requirements to meet stated goals and objectives
- Serve as a member of management committees on special studies
- Administer and ensure compliance with National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, state and other activities, meetings and seminars

- Participate in provider education and contracting, as necessary
- Develop departmental objectives and organize activities to achieve success
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage, budget and forecast in support of strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, state and/or other accreditation processes
- Ensure compliance of D-SNP MOC training at hire and annually thereafter for clinical staff
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers, such as hospitals and state agencies, as required to facilitate plan goals and objectives and to ensure the appropriate use of clinical practice guidelines and integrate care transition protocols
- Coordinate with Medical Director to educate and communicate expectations with oversight of appeal and grievance operations

### **Sr. Director of Care Management**

Knowledgeable on Medicare regulations and special needs populations, in addition to being a Licensed RN or Nurse Practitioner

- Oversee clinical and administration of care management services provided to D-SNP and D-SNP members Develop department objectives and organizes activities to achieve objectives
- Evaluate and implements changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage budget and forecast for strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, State and/or other accreditations of the plan
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers such as hospitals and State agencies, as required, to facilitate the D-SNP plan goals and objectives
- Coordinate with Medical Director to educate and communicate expectations with providers
- Evaluate, managing best practices member engagement, in timely fashion

### **Director Quality Improvement**

Certified Professional in Healthcare Quality

- Oversee clinical and administrative staff
- Support corporate initiatives through participation on committees and projects

- Develop, review and implement QI activities in coordination with Medicare and State requirements
- Develop, implement, analyze and report Quality Improvement Projects (QIP) and Chronic Care Improvement Projects (CCIP) for the D-SNP population
- Analyze results of studies and initiate quality improvement projects/initiatives
- Evaluate and recommend performance improvement initiatives and program or process changes to all functional areas
- Research and incorporate best practices into quality improvement initiatives
- Monitor activities to maintain compliance with NCQA accreditation standards
- Coordinate development, documentation and implementation of the QI Program, QI Program Evaluation, and Work Plan including D-SNP Quality Improvement Program
- Oversee day-to-day operations of the QI Department (QI, Credentialing)



**Chief Medical Director**

Physician who holds an unrestricted license to practice medicine in the state of Arizona and is Board Certified with experience in direct patient care and long term care

- Oversee clinical and administrative staff
- Serve as a clinical resource for CM and members' treating providers
- Work with providers to ensure providers use nationally recognized clinical protocols developed by professional specialty groups or federally funded research (e.g., National Guideline Clearinghouse, Agency for Healthcare Research and Quality (AHRQ), American Medical Association (AMA), etc.)
- Facilitate multi-disciplinary rounds on a regular basis to discuss, educate and provide guidance on cases
- Monitor peer-reviewed medical journals to infuse research supported system and practices into Managed Health Service's care management model
- Provide a point of contact for providers with questions
- Oversee review and processing of clinical appeals.
- Communicate with practitioners as necessary to discuss care management and service coordination issues

**Director of Pharmacy (Pharmacist)**

Registered Pharmacists with active license and clinical expertise.

- Oversee clinical and administrative staff
- Ensure there is a consolidated pharmaceutical therapy plan, in conjunction with the members' provider
- Identify drug interactions to minimize side effects

**Care Manager II (CM II)**

Licensed RN (May also hold Certified Care Manager credential)

- Oversee clinical, non-clinical and administrative staff
- Manage D-SNP members, in particular, those belonging to the most vulnerable Support ongoing member engagement with an appropriate medical home
- Address the member's individual needs, strengths, preferences and goals
- Educate members on their conditions and promotes self-management skills including the understanding signs and symptoms that indicate a need to contact the PCP, and when it is appropriate to seek urgent or emergent care
- Support medication adherence
- Engage in member-centric discharge planning
- Ensure timely initiation of post-discharge services and care
- Link members to available community supports
- Participate in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers
- Coordinate with the behavioral health care managers and providers as needed for members receiving services through the BH MCO

- Communicate and coordinate with the member and their caregivers, practitioners, behavioral health providers, disease management staff and other members of the ICT to ensure that the member's needs are addressed and care transitions are communicated

### **Care Manager (CM I)**

- Works under direction of CM II, performing member outreach and care coordination of eligible members
- Manage D-SNP members, in particular, those belonging to the most vulnerable population
- Conduct/review HRA, participate in ICT, Identify needs and create a member centered care plan, with the help of the member and provider, to help the member achieve their goals
- Support ongoing member engagement with an appropriate medical home
- Address the member's individual needs, strengths, preferences and goals
- Educate members on their conditions and promotes self-management skills including the understanding signs and symptoms that indicate a need to contact the PCP, and when it is appropriate to seek urgent or emergent care
- Support medication adherence
- Engage in member-centric discharge planning
- Ensure timely initiation of post-discharge services and care
- Link members to available community supports
- Participate in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers, re-evaluate member service needs.
- Coordinate with the behavioral health care managers and providers as needed for members receiving services through the BH MCO
- Communicate and coordinate with the member and their caregivers, practitioners, behavioral health providers, disease management staff and other members of the ICT to ensure that the member's needs are addressed and care transitions are communicated

### **Sr. Director of Utilization Management**

- Develop Utilization Management department objectives and organize activities to achieve objectives
- Oversee operations for processing requests for both inpatient and outpatient services
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy objectives and policies
- Responsible for maintaining Prior Authorization List and communicating changes both internally and externally
- Coordinate with operating departments on research and implementation of best practices.
- Responsible for the statistical analysis of utilization data on programs
- Participate in NCQA, State, and/or other accreditations of the Plan
- Organize and present new concepts, programs and tools to staff and other plan departments

**Manager, Medical Management**

Registered Nurse with active license

- Implement changes to medical service functions and performance in relation to Medicare guidelines, company mission, philosophy objectives and policies
- Manage budgets and forecast for strategic planning and key initiatives and balance current future needs effectively
- Research and incorporate best practices into operations.
- Assure compliance of work processes with Medicare Advantage and CMS regulations.
- Responsible for the statistical analysis of utilization data.
- Participates in NCQA accreditation of the Plan.

**Program Specialists Social Workers (LMSW)**

Licensed Master's prepared social worker with a background in social services or other applicable health related field

- Works under direction of CM, performing member outreach and care coordination of dually eligible members
- Identify and facilitate access to community resources and social services coordination
- Advocate for the members
- Provide education on benefits and available social services
- Arrange for member transportation
- Assist the CMs in discharge planning and/or transitions to another level of care

**Program Coordinator (PC) I**

Non-clinical staff person working under the direction and oversight of a CM II.

- Provides administrative support to CC/CM team.
- Collects data regarding Health Risk Assessment.
- May participate in providing information to CM II for care plan.
- Supports scheduling of ICT
- Arrange for member transportation
- Assist the CMs in discharge planning and/or transitions to another level of care

**Program Coordinator (PC) II**

Highly trained, non-clinical staff person working under the direction and oversight of a CM II.

- Conduct Health Risk Assessment outreach with RN Review and oversight.
- Collect data for Health Risk Survey and other surveys
- Provide information to CM for Individualized Care Plan
- Provide educational promotion and member follow-up, arranges PCP visits and performs care coordination under direction of CM
- Support scheduling of ICT's
- Arrange for member transportation
- Assist the CMs in discharge planning and/or transitions to another level of care

**Behavioral Health Care Managers**

Licensed Master's or doctoral-level clinician in social work, psychology, or related field or equivalent experience with 3+ years of experience in a social service or health care related setting

- Complete behavioral health assessments with member/caregiver/provider to obtain information regarding client status, functional, cognitive capabilities, support system and need for services
- Coordinate chronic condition, disease and health management services
- Monitor delivery of services and follow-up with members/caregivers/providers through member face-to-face assessments and/or reassessments
- Authorize and coordinate referral for services
- Ensure provider services are delivered without gaps and identify functional deficiencies in plans of care
- Assist in coordinating the development of informal or voluntary services to integrate into the ICP
- Collaborate with discharge planners, physicians and other parties to ensure appropriate discharge plan
- Conduct reassessment and update the ICP
- Coordinate, behavioral health, services for members
- Assist members with filing and resolution of complaints and appeals

**Concurrent Review Nurse (RN Care Managers)**

Licensed RN, LPN or LVN

- Manage and monitor member's inpatient stay in coordination with the CM and Member's PCP to facilitate discharge arrangements
- Review and audit patient charts through on-site and telephonic review to ensure medical necessity and appropriate level of care
- Act as clinical resources to referral staff and make appropriate referrals
- Provide patient and provider education
- Enter data related to assessments, authorizations and reviews into the system
- Review and audit patient charts through on-site hospital visits

**Medical Management Trainer**

- Train all Medical Management staff
- Provide support to Provider Relations department on training and education of providers
- Provide training on systems and applications
- Determine further auditing and training support based on deficiencies

**Pharmacy Coordinator**

- Receive and respond to provider and pharmacy calls regarding the prior authorization and formulary process
- Perform review of pharmacy and override process in compliance with pharmaceutical related company and State guidelines

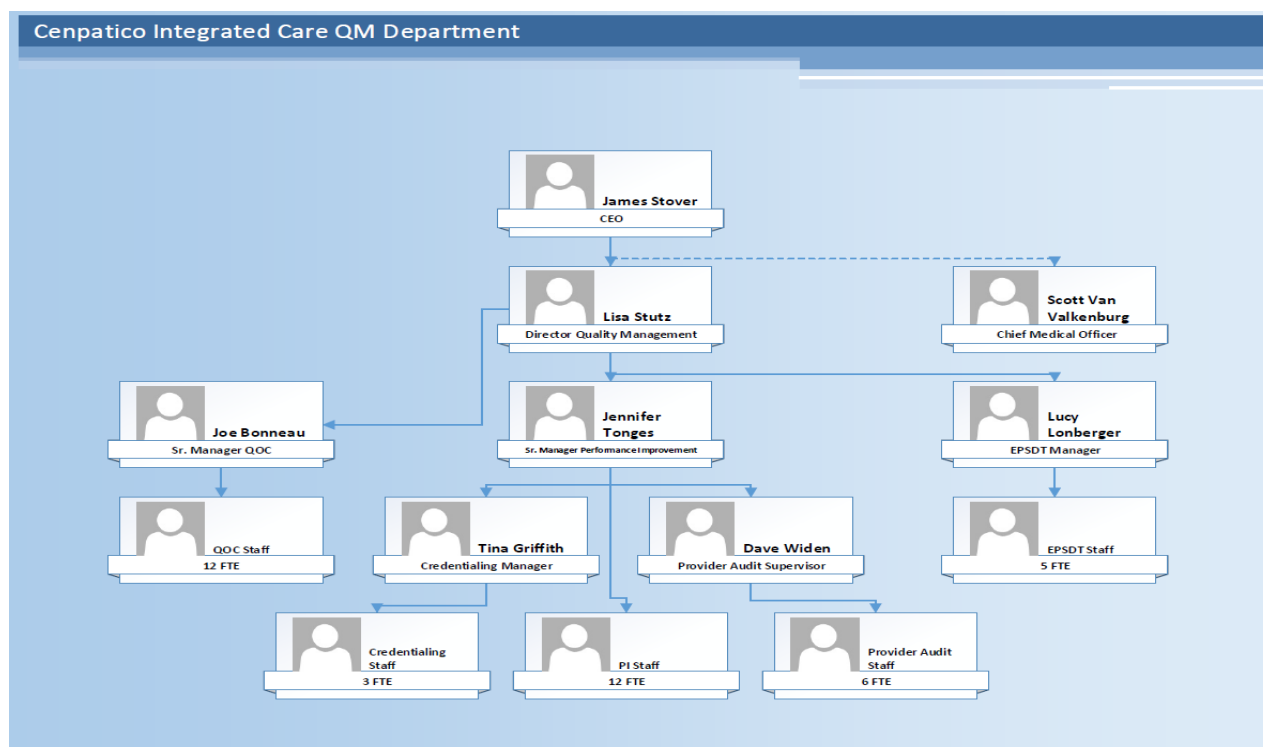
- Track and trend overrides to ensure criteria have been met, audit for prior authorizations, analyze cost and determine utilization patterns
- Resolve complaints and grievances related to the pharmacy network in conjunction with the Pharmacy team
- Assist Provider Relations and various departments with educating providers on the health plan's pharmacy process
- Assist with the pharmacy utilization review and reporting process
- Collaborate with Quality Improvement department with various meeting preparation and transcription of minutes
- Assist with member's inquiries related to the formulary process

### 3. Coordinating staff responsibilities with the job title

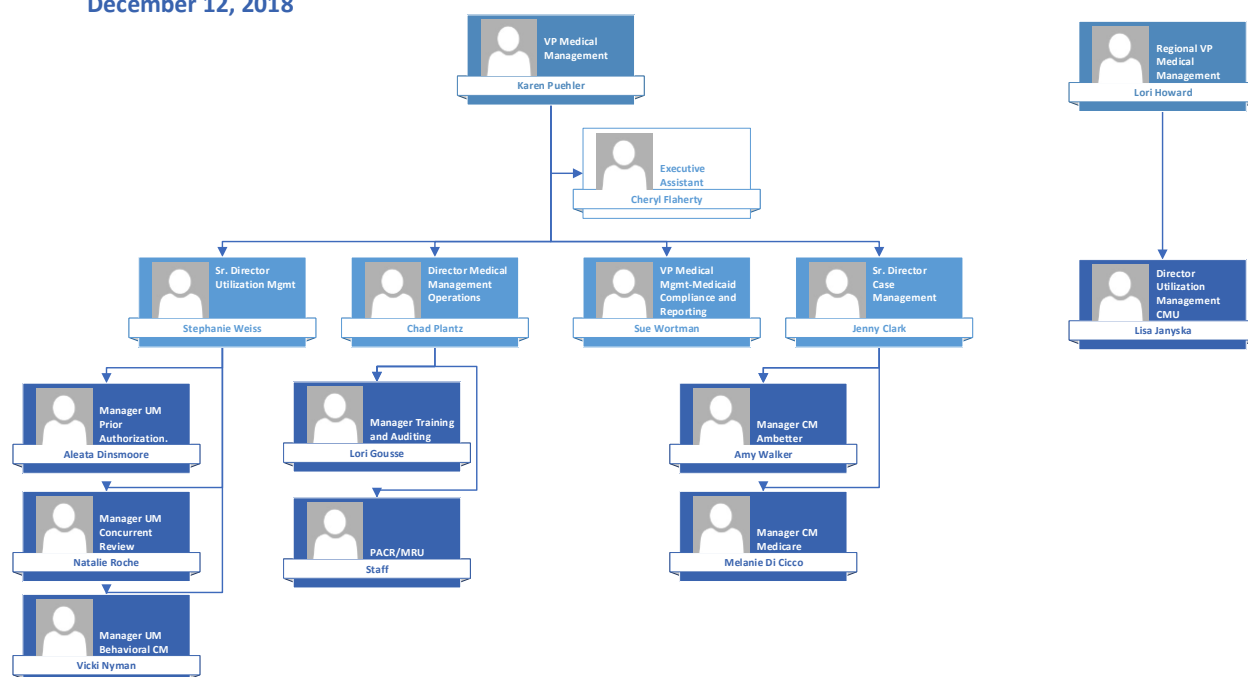
Allwell from Arizona Complete Health develops, reviews, approves and maintains role based job descriptions for every employee. These job descriptions create the foundation for all training, supervision, monitoring and feedback regarding employee performance. Job descriptions include roles and responsibilities, reporting structure, education and licensing requirements, as well as the skills and competencies necessary to effectively perform in the position. Initial orientation and training includes a detailed review of the individual's job description. Annual performance evaluations includes an assessment of the employee's performance compared to expectations delineated in the job description.

The following organizational charts summarize how Allwell from Arizona Complete Health integrates administrative and operational oversight with clinical care coordination for members.

#### Medical Management QI Department



## Medical Management December 12, 2018



### 4. Contingency plan used to address ongoing continuity of critical staff functions

Allwell from Arizona Complete Health has a contingency plan to avoid a disruption in care and services and ensure continuation of critical services for D-SNP members when existing staff can no longer perform their roles and meet their responsibilities.

If administrative or executive staff is unable to fulfill their roles, resources are diverted among corporate or regional offices within the Allwell from Arizona Complete Health network.

In the event of an absent employee, clinical employees are cross-trained to ensure continuity of operations, which equates to staff members having one successor. Additionally, remote access is available to Allwell from Arizona Complete Health applications for clinical staff if they cannot commute to the office due to a natural disaster or other impediments. Remote access consists of a web-based program on a secure network. Ultimately, remote access allows staff to continue services securely despite their physical location.

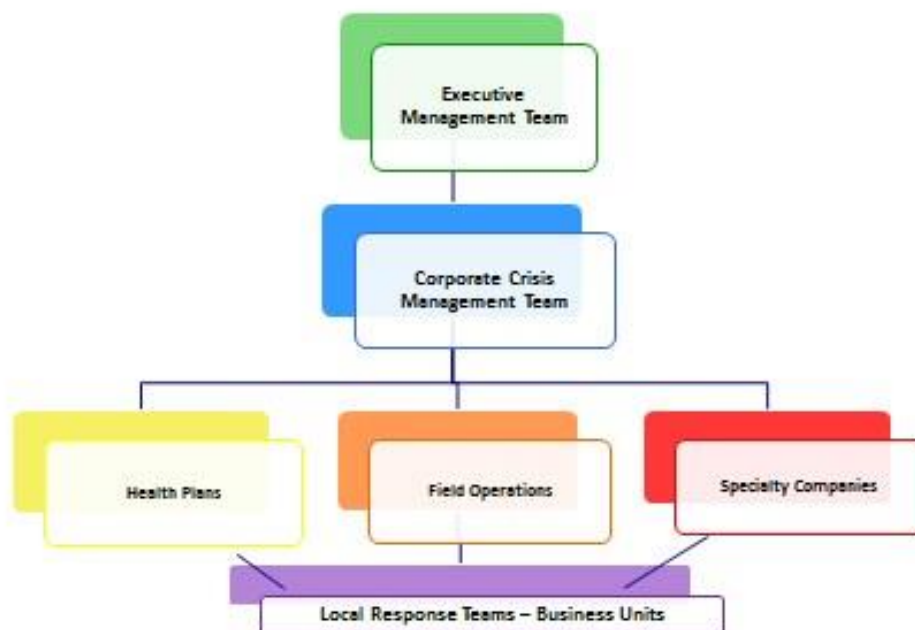
In the event of a natural disaster or an emergency, Allwell from Arizona Complete Health immediately implements Centene's business continuity plan, which involves diverting calls and services to other regional health plans within the Centene network. This plan ensures continuity of care and service for our members. Due to the sensitive nature of business continuity plans, the information below is a general overview.

### *Hierarchy for Decisions*

The local business units are organized into a local crisis response team. In the event of a disaster, the local response teams utilize the support of the Centene

Crisis Management Team in St. Louis. The Corporate Crisis Management Team reports to Allwell from Arizona Complete Health Executive Management Team.

## Business Continuity Governance



### *Chain or Recovery Options*

Options include forwarding our Call Center calls to the National Service Center, employees working from home if viable, utilizing other offices within the same State or other Allwell from Arizona Complete Health resources throughout the corporation, suspending or repurposing employees to assist as needed, and/or declaring a disaster with our recovery contractor to bring in mobile office trailers, or locate brick and mortar office space through Real Estate Investment Trusts (REITs). One or all of these measures are activated to maintain operations.



## Centene In-House Recovery Options



### 5. *Initial and annual MOC training for its employees and contracted staff*



Allwell from Arizona Complete Health requires that all employed and contracted staff involved with the D-SNP program undergo D-SNP MOC training within 90 days of hire, annually, and on an ad hoc basis when circumstances warrant (e.g., policy change, need for improvement, coaching). The Allwell from Arizona Complete Health Compliance Officer, in conjunction with the Director of Quality Improvement, are responsible for the oversight of the delivery of initial and annual web-based MOC training.

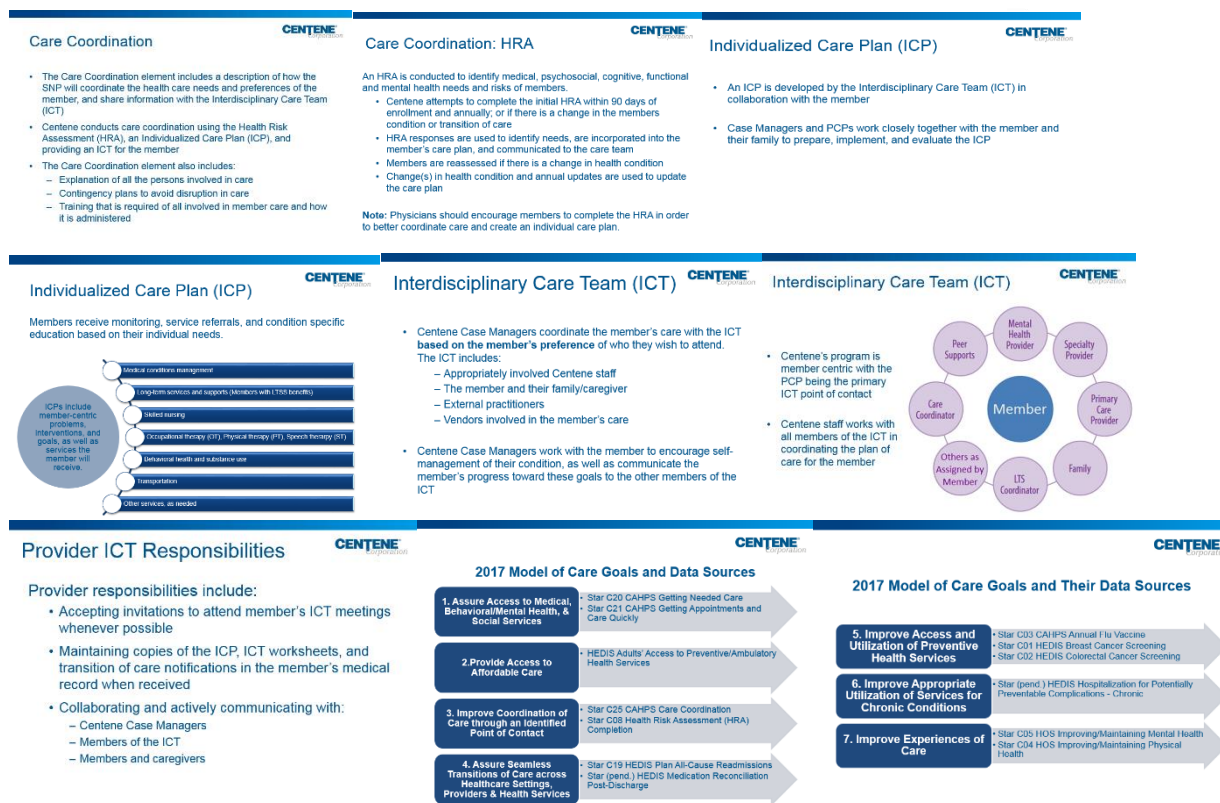
Additional mandatory training modules includes information on:

- Compliance Program
- Fraud, Waste and Abuse
- Code of Conduct
- HIPAA
- Cultural Competency
- Conducting administrative activities necessary for the operation of the Part D benefit
- Medicare Marketing
- Marketing the prescription drug benefit to Medicare beneficiaries
- Medicare Member Eligibility
- Medicare Medical Management Training:
  - Medicare Overview Medical Management Operations

- Medicare Utilization Management Process
- Medicare Model Of Care
- Medicare Guidance on Coverage Policy
- Medicare Jimmo v. Sebelius
- TruCare (clinical documentation software) Training
- InterQual Training
- Customer Service and Call Center Operations Standards
- Appeals and Grievance Process
- Administering the compliance program and operations, i.e., the Part D Officer and his/her staff
- Business Ethics and Conduct policy and other compliance related policies, procedures, standards

### Example of MOC Training Materials:

CENTENE	CENTENE	CENTENE
<p><b>Medicare: 2017 Model of Care Training</b> 01/2017</p> 	<p><b>Training Objectives</b></p> <p>This course will describe how Centene and its contracted providers work together to successfully deliver the Model of Care (MOC) program.</p> <ul style="list-style-type: none"> <li>After the training, attendees will be able to:           <ul style="list-style-type: none"> <li>Outline the basic components of the Centene Model of Care (MOC)</li> <li>Explain how Centene medical management staff coordinates care for Special Needs members</li> <li>Describe the essential role of providers in the implementation of the MOC program</li> <li>Define the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)</li> </ul> </li> </ul>	<p><b>Model of Care Training</b></p> <ul style="list-style-type: none"> <li>The Model of Care (MOC) is a quality improvement tool that ensures that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed</li> <li>The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNPs MOC using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS)</li> <li>This course is offered to meet the CMS regulatory requirements for MOC Training for our SNPs</li> <li>It also ensures all employees and providers who work with our SNP members have the specialized training this unique population requires</li> </ul>
<p><b>What is the Model of Care?</b></p> <ul style="list-style-type: none"> <li>The Model of Care (MOC) is Centene's comprehensive plan for delivering our integrated care management program for members with special needs</li> <li>It is the architecture for promoting quality, care management policy and procedures, and operational systems</li> </ul> 	<p><b>Model of Care</b></p> <p>The Model of Care is comprised of four clinical and non-clinical elements:</p> <ol style="list-style-type: none"> <li>Description of the SNP Population</li> <li>Care Coordination</li> <li>SNP Provider Network</li> <li>Quality Measurements &amp; Performance Improvement</li> </ol>	<p><b>Specific Services</b></p> <p>Centene provides members with services tailored to the needs of the SNP and MWP populations. These services can include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Care coordination and complex care management for high risk and most vulnerable members</li> <li>Care transitions management</li> <li>Physician home visiting services</li> <li>In-home wound care</li> <li>Disease management services</li> <li>Clinical management in long-term care facilities as needed</li> <li>Medication Therapy Management and medication reconciliation</li> <li>Medicare and Medicaid benefit and eligibility coordination and advocacy</li> </ul>



## Care Management and Service Coordination Staff Training

Allwell from Arizona Complete Health Care Management and Service Coordination staff receive, at time of hire and annually Medicare Boot Camp Training that includes, but are not limited to the following:

- Care Management and Service Coordination policies and procedures and regulatory requirements
- Member-Centered Care Planning
- Care Manager / Care Coordinator roles and responsibilities
- Motivational interviewing and readiness to change techniques
- Medicare Assessments
- Member Outreach
- Documentation
- ICP and ICT Processes
- Care Transitions
- Provider Relations
- Member Outcomes
- Care Management and Service Coordination (including appropriate documentation of tasks in TruCare)
- Behavior management strategies
- Behavioral health 101
- De-escalation techniques

Training to Ensure Alignment of D-SNP Models of Care. Allwell from Arizona Complete Health staff receive Medicare/Medicaid specific training that describes how the programs intertwine and their specific roles and responsibilities when a member is enrolled in the D-SNP Model of Care:

- Coordination and management of dual Members
- Specific characteristics of the population
- Services to meet specialized needs
- Medicare and Medicaid covered benefits
- Engagement techniques

In addition, training may be conducted to cover regional variances and/or specific indicators and/or needs of different areas of the state. Allwell from Arizona Complete Health measures effectiveness of education/training provided through audits and individual assessments. All trainers update materials as soon as new information and updated components become available.

Continuing education is provided to CM staff to support clinical competency as well as communication skills. Our Cornerstone web learning is available for both required and optional topics, and we provide lunch and learn opportunities for CM staff.

Methods for Delivering Training is provided using one or more of the following methods:

- Face-to-face training via a preceptor
- Peer shadowing/Preceptor support
- Web-based interactive training
- Group led training
- Telephonically
- Self-study through the use of print materials and electronic media (i.e., Centene's Cornerstone library of training classes)

Coordination of Benefits and Dual Appeals and Grievance Training. The Managers of Medical Management and Trainers provide additional training specific for integrated care team staff regarding coordination of Medicare/Medicaid, Members rights and responsibilities, appeal and grievance policies, procedures and processes.

***6. Maintaining training records as evidence that employees and contracted staff completed MOC training.***

Employees and contracted staff completion of class room trainings, group led training, and on-line MOC training is documented and maintained via *Cornerstone*, an internal web-based educational database that efficiently tracks training completion. Through *Cornerstone*, the Compliance Officer and the VP Medical Management are able to track and review completion of training.

## ***7. Actions if training is not completed***

If it is identified that an employee failed to complete MOC training, the employee and the employee's supervisor are notified and the employee is instructed to complete the course immediately. For those who fail to complete required MOC training after the first attempt of remediation, disciplinary actions are administered in accordance with Allwell from Arizona Complete Health Human Resources discipline policy.

### **Element B: Health Risk Assessment Tool (HRAT)**

#### ***1. How Allwell from Arizona Complete Health Contracts with case management companies to complete the HRAT using the HRAT to develop and update the Individualized Care Plan (ICP) for each Member***

Health Risk Assessment Tool (HRAT). The Health Risk Assessment (HRA) tool was designed by Corporate to identify the needs of D-SNP plan members by evaluating medical, psychological, functional, environmental, social and cognitive needs. The assessment also gauges the member's medical and mental health history to effectively coordinate care and identify any barriers that should be addressed to improve care outcomes. The HRA generates the initial list of problems based on the member's self-reported data, and based on a scoring methodology, determines the level of severity/risk.

Member Engagement and Initial Assessment. For the initial screening, the Care Team staff (outside vendor Adobe Case Management or US Health systems) (outside vendor or PCI or II, or CMI or II, or Envolve People Care) contacts the member to conduct the HRA and risk stratification within 90 days of the member's effective date. To conduct the HRA at least three phone attempts are made at different dates and times to engage the member to complete the HRA questionnaire. All outreach attempts (successful or unsuccessful) to complete the HRA are documented in a Care Management/Service Coordination Outreach note in the clinical documentation system (TruCare). When internal or contracted CM or other staff call members for other purposes and notice that the HRA has not been completed, they complete the assessment. Members unable to be contacted via telephone are mailed a letter requesting that they call the care management team. Attempts may be made on a site visit if risk indicators are identified. Outreach continues with member to complete the HRA or a paper copy is mailed to the member when we are unable to reach the member. If it is completed by the delegated Case Management Company, it is then entered into TruCare.

Risk Stratification and Development of ICT. Once the HRA is completed, reviewed and Care Management Prioritization has scored, the stratification is performed, so that the member is placed within one of the levels of risk/severity (low, medium or high/complex). The CM, based on the initial HRA results, assists the member in choosing the members of their Interdisciplinary Care Team (ICT). The member may include, their PCP and any healthcare professionals, the internal or delegated CM and other support individuals of their choice. The ICT helps develop the Individualized Care Plan (ICP).

## ***2. Dissemination of the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information***

Sharing the Results of the HRAT with the ICT and Creation of ICP. The CM contacts all selected members of the ICT and the member and/or caregiver and sets up an initial meeting. During the ICT meeting, which is held via phone or face to face, the various problems and member goals identified are discussed, treatment and service options are presented to the member/caregiver, and the ICP is developed/updated, which includes goals, interventions and time frames.

Using the HRAT Results to Update the ICP. Annually thereafter, or when the member's conditions or health status changes significantly, such as an inpatient admission or transition to a higher level of care, the HRA is completed by the CM or other assigned staff with CM oversight. Results of the new HRA are discussed with the members of the ICT. The member and/or caregiver is invited to participate in the ICT meeting, and the ICP is revised and adjusted to reflect member needs and preferences and any changes identified by the HRA. The renewal of HRA date is reset from the date of the last completed HRA. The member retains the right to change who participates on the ICT at any time. Copies of the ICP are sent to the member and their PCP.

Tools to be utilized are approved or determined by the state and based on our population characteristics.

## ***3. Initial HRAT and annual and as-needed assessments***

Initial HRA Allwell from Arizona Complete Health will attempt to complete an initial HRA for each beneficiary within 90 days of enrollment.

Triggered Reassessment Follow-up HRA is conducted to determine if adjustments to the ICP are necessary based on changes in the member's condition or health status, such as a recent hospitalization, multiple falls, reported changes in condition or functional level, or claims-based information provided by predictive modeling software. In those instances, the CM or designee contacts the member to complete the assessment and shares the results with the ICT.

Annual Reassessment Annual HRA is done within 12 months of the last assessment in order to evaluate the effectiveness of the ICP and collect data to measure outcomes. To ensure Allwell from Arizona Complete Health conducts timely reassessments, the internal or delegated case management CM or designee monitors and tracks the date by utilizing the HRA Tracking Report. The same contact protocol discussed above in the "Initial New Member" is utilized to reach out to members.

## ***4. The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results***



Once the HRA has been completed, it is reviewed as frequently as needed based on changes to the member's health, functional and environmental conditions, transition in care or increased risk for hospitalization based on information provided through predictive modeling. The HRA is used to stratify and determine risk, needs and to drive ICP creation.

All assessments are documented in TruCare with date/time stamps for each activity, including documentation of the internal or delegated Case Management Company CM or other staff completing the activity. Each HRA is scored based on an algorithm that weights members' responses. The total score places the member in a stratified risk category of low, moderate, or high. Members with comorbidities and other complex care needs are placed directly in the "high/complex" level.

Communicating Information to the ICT. The risk score indicators and the documentation collected in the HRA is shared and reviewed with the member/caregiver/PCP during the ICT scheduled meeting to adjust the existing ICP that includes interventions and goals, and the associated timeframes for completion based on the new assessment. The updated ICP is shared with the member/caregiver face-to-face in the member's home or setting, verbally by phone or sent via mail, mailing the ICP to member's PCP.

Using HRAT Results to Improve the Care Management Process. CM frequency of member contact to assess progress with the new ICP is determined by the level of the member's risk score and acuity level. Frequency of contacts is adjusted based on member's preference and progress based on CM clinical judgment.

- High – Including members identified as “most vulnerable”
  - Minimum continuous monitoring and review/outreach every 30 days; or more frequently as needed
  - Completion of an ICP no later than 120 days of enrollment
  - Telephone or face-to-face reassessment when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, his/her caregiver or provider
- Moderate – Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual
  - Minimum continuous monitoring and review/outreach every quarter; or more frequently as needed
  - Completion of an ICP no later than 120 days of enrollment
  - Telephone or face-to-face reassessment when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, his/her caregiver or provider
- Low – Member is stable but results of the Medicare CM Assessment/HRA indicate risk for a potential complication
  - Minimum continuous monitoring and review/outreach once a year or more frequently as needed
  - Completion of an ICP no later than 120 days of enrollment

- Telephone of face-to-face reassessment when there is a change in the member's health status or needs, a significant health care event, or as requested by the member, his/her caregiver or provider

## **Element C: Individualized Care Plan (ICP)**

### ***1. The essential components of the ICP***

Person-Centered Care Planning – Allwell from Arizona Complete Health person-centered approach focuses on the member's strengths, needs, preferences and develops individual goals and interventions in collaboration with the member and caregivers. To support the member safely, in the least restrictive setting of choice,

The internal or delegated Case Management Company CMs work with the member to develop an ICP that identifies barriers preventing the member from managing their current conditions and determines interventions to promote and maintain self-sufficiency.

Essential Elements of the ICP - The ICP includes self-management goals and objectives, a description of authorized services specifically tailored to the beneficiary's needs including type, duration, frequency, and provider, timeframe for reassessment, short and long-term goals for health promotion and prevention, referrals and interventions, barriers, the member's personal healthcare needs and preferences, and timeframes for completion.

An ICP typically includes the following:

- Prioritized goals – both short term and long term goals are determined with the member and are specific, measurable, attainable, realistic and timely
- 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
- Resources to be utilized, including appropriate level of care and member preference
- Interventions based on the member's identified problems, strengths, resources, barriers and agreed upon goals
- Self-management plans created to support members in managing their health, including specific technology supports, tools, and disease management/health education
- 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 manner in which progress is demonstrated



- Education provided to the member, 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.)

Interventions and Activities Included in the ICP - Interventions and activities may include care coordination for authorization of needed services such as transportation, home health care, equipment, supplies, ancillary services such as physical, occupational or other rehabilitation therapies, and referrals for preventive screenings. They also include health education needs, member self-management activities and goals, and evidence based disease management parameters such as HgbA1c every 6 months and annual dilated eye exam for diabetics. The ICP identifies barriers to achieving goals (financial, cultural, linguistic, lack of family support, cognitive impairments, etc.) and the strategies for overcoming these barriers. Finally, the ICP identifies gaps in care and services that require mitigation and the method for obtaining needed care and service, including collaboration and coordination of care and services provided by other health care and community based organizations, and supports (in-home meals, home repair, falls assessment, in-home support services, etc.). Interventions may include, but are not limited to the following:

- Guiding the member in achieving optimal health through the monitoring of specific clinical indicators
- Coordinating covered and non-covered benefits
- Coordinating inpatient and outpatient services
- Managing transitions in care settings.
- Educating member and supporting self-management activities
- Addressing barriers to care, including access to non-network providers as appropriate
- Assessing outcomes and updating the ICP on a regular basis
- Assisting with referrals to services appropriate for members nearing end of life such as Advanced Directives or hospice care
- Arranging for in-home visits to assess risk for falls and needed accommodations

## ***2. Developing the ICP and ICP modification in response to changes in members' health care 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, 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. Allwell from Arizona Complete Health employees empower members and/or caregivers through education, open communication, and partnership. Such empowerment encourages member and caregiver involvement, engagement and improved success in meeting established goals.

**CM as “One Point of Contact”** - In the course of developing the ICP, referrals are made, as needed, to the appropriate team members/providers of needed care. For example, if the individual indicated difficulty with housing, utilities, buying food or other financial concerns, the assigned CM would provide linkage to community resources if appropriate, and communicate the results back to the ICT. However, if behavioral health needs are identified, the CM coordinates with the BH providers to ensure a whole person approach towards care management. Wherever possible, the CM serves as the single/one point of contact for the member, but is responsible for introducing to the member and/or their caregiver to any new members of the team prior to any outreach by these individuals. The intent of this outreach is to ensure the member and/or their caregiver is aware of the role this new individual has, along with when they can anticipate outreach/contact. For example, the CM introduces the Disease Management (DM) Health Coach in cases where health education and outreach is included as an intervention in the ICP.

Assessment – During assessment, the CM collects information about the member’s mental and physical condition, functional status, and formal and informal social support system to identify their needs and develop the ICP. In addition to information collected during the assessment, supplemental information is gathered from other relevant sources (i.e. primary care provider, professional caregivers, non-professional caregivers, health records, and educational institutions/records, historical claims data, prior assessment, etc.), which are utilized to further refine the ICP. Ongoing reassessments occur when there is a change in the member’s health status or needs, a significant healthcare event, or as requested by the member, their PCP or their caregiver.

Identifying problems – The CM are trained in conversational interviewing, supporting the ability to obtain key information. They practice active listening to appropriately identify the member’s problems. In order to achieve the best possible health outcome, the CM collaborates with the member, their circle of support/caregiver, and the PCP to identify problems and barriers to meeting goals. Examples of identified problems/barriers may include but are not limited to:

- Lack of knowledge about disease process
- Lack of available resources
- Limited or no family support
- Psycho-social needs
- Low literacy/health literacy
- Language and culture
- No transportation or ability to schedule appointments

To overcome barriers and issues, the ICP includes a set of tailored services for each member, which includes preventive health services, preferences for care, chronic disease education, and other accommodations and services. The ICP is intended to increase self-management, independence and improved health status of each member.

Establishing goals – The CM collaborates with the member/caregiver, provider, and ICT members when establishing care plan goals and a member driven self-management plan. The

care plan includes the member's preferences and a description of the services tailored to the member's needs. The goals are specific and measurable.

- Long Term
- Short Term
- Consult with attending physician, other health care providers, client, family members, guardians etc.
- Obtain member buy-in for effective behavior modification and superior outcomes
- Determine how goals will be achieved and revise goals if necessary
- Be flexible
- Be creative
- Need for authorization
- Are the goals cost effective while maintaining quality of care?

Implementing Interventions – During implementation, the CM executes specific care management activities and/or interventions to accomplish the goals in the ICP. Selected interventions are usually inclusive of the member's willingness to participate, time sensitive and measurable. For example a CM may do the following:

- Implement a self-management plan which demonstrates:
  - Documentation of the action the member takes to improve the care
  - Documentation of member agreement to perform the action
- Document actions the CM takes in monitoring the ICP to ensure member compliance
- Identify/contract with providers needing to be involved
- Identify services or equipment which are not a covered benefit but may be a cost effective intervention
- Provide education based on health education needs
- Educate on medication
- Reinforce and explain why the member needs to be adherent to treatment plan
- Anticipate any obstacle to meeting treatment goals (e.g., transportation, ability to schedule appointments)
- Establish effective date for start of services
- Contact member and/or caregiver and initiate education and other activities

Evaluation and Reassessment - The delegated Case Management Company or internal CM performs ongoing assessments in order to evaluate the member's progress toward the goals or identify barriers impeding the achievement of such goals. The CM completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year.

Updating the ICP - The delegated Case Management Company or internal CM updates the ICP at least annually, at the time of a trigger event (inpatient hospitalization, change in level of care or care setting, etc.) and/or, as needed, in response to information obtained during the HRAT re-assessments; information obtained from providers, members and caregivers; claims data that may identify patterns of over or under-utilization including medication non-adherence; and any additional information related to health conditions, functional status, barriers to care, community supports and the member's response to interventions in the existing care. Updates are based on

the member's status, needs, and preferences including cultural and linguistic preferences. The CM and ICT rely upon evidence-based practices in developing appropriate interventions.

Changing Risk Categories - For example, a member who is stratified as low risk but has an unplanned admission, new diagnosis, or increased utilization is reassessed to determine if there are changes in their health and/or functional status that require them to be placed at a higher risk level with associated adjustments in the ICP. Members may temporarily move to a higher risk level during an acute phase of care (i.e. a member who has elective joint replacement surgery with full recovery) or from a higher level to a lower level as their health and functional status improves as a result of attaining self-management goals (i.e. a member with diabetes achieves stable blood glucose levels through medication adjustments and improved dietary habits). This often leads to a modification or change in the care management, care coordination plan in its entirety or in any of its component parts, as follows:

- Determine if treatment ICP goals have been attained (for long term cases, over 90 days, the goals are evaluated and refined based on member acuity)
- Measure member/caregiver/significant other's satisfaction with services

When goals are not met, the delegated Case Management Company or internal CM reassesses the member's situation and functioning as described above. The CM contacts the PCP and other members of the ICT as needed to discuss modifications and obtain an updated medical treatment plan. Based on the findings, the Care Manager provides supplemental resources or modify the goals. The CM engages the member, communicates any changes in the ICP to the member and other members of the ICT, and providers, as needed, via phone, email, mail, and fax and documents this in TruCare.

### ***3. Personnel responsible for development of the ICP, including how members and/or caregivers are involved***

The internal or delegated Case Management Company CM is responsible for the development of the ICP, in collaboration with the members and/or their family/caregiver, and the members of the ICT. The CM continuously attempts to engage the member/designee and provider(s) in care planning discussions related to goals, preferences, activities and interventions. Our CM is trained in motivational interviewing and member engagement strategies in order to maximize member engagement in care planning. Copies of the ICP are provided to the member/designee and PCP upon request and the document is used to guide discussion during telephonic contacts. Our goal is for the individual care plan to be a "living document" that provides a framework for managing the member's care and services. As a member's needs and preferences evolve over time, the care plan, along with the composition of the Integrated Care Team, also evolves and changes.

#### ***4. Documentation, maintenance, and updates of the ICP***

Documentation -All documentation of assessments, ICP and related follow-up communications are captured and updated in TruCare, our clinical documentation system. This system is only accessible by Allwell from Arizona Complete Health staff and the delegated Case Management Company; however, the ICP is shared via facsimile/mail/telephone to the primary care providers. Member records are maintained in accordance with HIPAA, state and federal privacy laws and professional standards of health information management.

Oversight - The CM 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 TruCare 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
- The ICP, including:
  - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers
  - Schedule for follow-up and communication with the member, member's family, providers, etc.
  - The member's self-management plan
  - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc.

Using Evidence Based Criteria - The CM is trained in the Medicare, Medicaid benefits, and supplemental benefits offered to the most vulnerable D-SNP population. Training enables the CM to facilitate care for the member through the prior authorization process and educating the member as to available benefits and community services and other supports. CMs have access to evidence-based clinical resources to help determine standards of care for this population. Allwell from Arizona Complete Health provides the following resources of medical criteria:

- InterQual® Care Planning Procedures Criteria
- National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) policies for Medicare Part A & B services
- Clinical coverage and practice guidelines

Communicating Changes in Member Status to the ICT - The internal or delegated Case Management Company CM is in a unique position to know and understand all facets of the member's condition and abilities. It is the responsibility of the CM, as a member of the ICT, to

inform other team members about any changes in the member's health status so that the team is able to 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 ICT, as the on-going evaluation of the ICP occurs, continues to change in order to include other members so as to ensure the member has access and coordination of all needed care. The ICT, led by the CM, are responsible for reviewing, analyzing and revising of the care plan with a multi-disciplinary 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 CM for any significant life/health event as needed, but no less than annually after the initial assessment. Modifications involve the entire ICT, including the member and/or their caregiver. The CM or a member of the ICT team completes the ICP changes after the review and with the assistance of the full ICT, and with the involvement of the member or member's caregiver. 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.

#### ***5. Communicating updates and modifications to the ICP to the member and other stakeholders.***

Members and their caregivers are engaged in any changes to the ICP and providers are notified anytime there is a change in the ICP. Communication may be verbal or in writing. All communication is documented in TruCare. 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 meeting 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) to discuss the member's ICP or change/revise the IC; CM may hand-deliver the ICP to members' homes
  - Telephonic – Direct calls with member/member's representative and/or providers
- Care reviews/rounds - Internal meetings with ICT

### **Element D: Interdisciplinary Care Team (ICT)**

#### ***1. Determining the composition of ICT Membership***

Allwell from Arizona Complete Health has an Integrated Care Team (ICT), which may utilize Program Specialists, Care Managers, Pharmacy Coordinators, Behavioral Health Coordinators, Program Coordinators, pharmacists and Medical Directors. The external team is 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. The member or his or her chosen representative also participate in the ICT.

ICTs are generally comprised of multidisciplinary clinical and nonclinical staff and are led by CM with support by Medical Directors. 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, works closely with the utilization management staff to coordinate care when members are hospitalized and assist with discharge planning and prior authorization activities. The teams utilize a common clinical documentation 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 Director as indicated, based on severity and complexity of the member's needs.

The following are the individuals who are involved in the Care Management functions performed by Allwell from Arizona Complete Health:

**Medical Director** The Medical Director oversees the care management program, ICTs and is responsible for managing the medical review activities pertaining to care and service coordination, utilization review, quality improvement, complex, investigational and/or experimental services. The Medical Director assures that providers use and adhere to appropriate clinical practice guidelines and integrated care transition protocols. In conjunction with the Vice President of Medical Management, the Medical Director evaluates the effectiveness of the care management and care coordination programs at least annually.

**Vice President of Medical Management** The Vice President of Medical Management is responsible for the day-to-day operations and clinical oversight of the care management program including compliance and preservation of MMP medical information in accordance with HIPAA and contractual requirements. The Vice President of Medical Management monitors the provision of services to assure there is a seamless transition of care across settings and providers and that clinical services are appropriate and timely. These functions are accomplished by regularly occurring audits and random attendance at ICT meetings.

**Care Managers** Care Managers (CM) are experienced RN care managers (preferably with CCM certification). CMs establish and implement the ICP/ICT for D-SNP members not receiving LTSS, 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. CMs work directly with the member and their support system to achieve an optimal level of health and function. Care Managers hold a key position in the ICT.

**Program Coordinators** The Program Coordinators have administrative and clinical support experience and are utilized to collect member and/or provider demographic information, completing data entry, establish case files, coordinate non-clinical services and provide

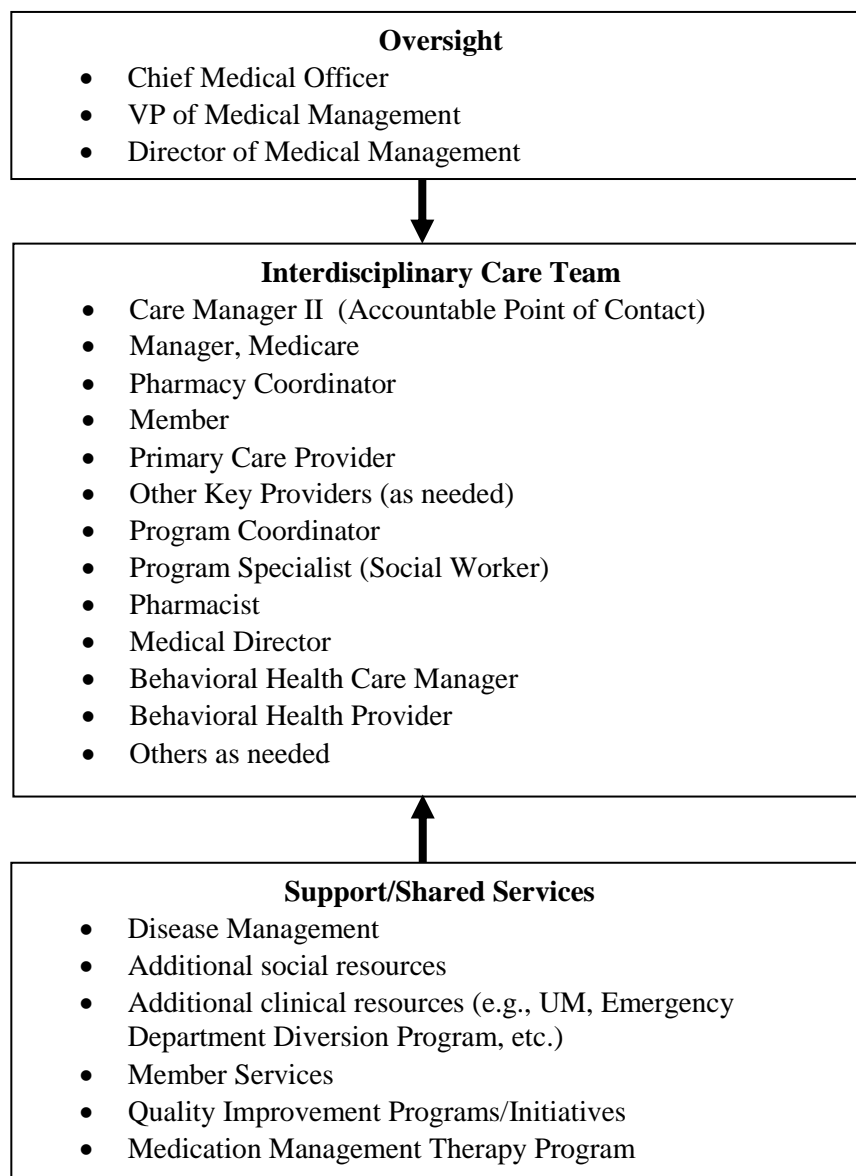
administrative support to the team as needed. Program Coordinators may also assist the CM in scheduling appointments and following up on services for the D-SNP member.

**Behavioral Health Care Manager** The Behavioral Health Manager is the team member with the primary responsibility of ensuring behavioral health needs are identified and addressed. In addition to participating on the ICT, the Behavioral Health Care Manager also attends the integrated care management rounds to facilitate identification of behavioral health issues for D-SNP members.

**Pharmacist/Pharmacy Coordinator** The pharmacist and/or pharmacy coordinator, in conjunction with the member's provider, ensures there is a consolidated pharmaceutical therapy plan, identify drug interactions, minimize side effects, and work with the D-SNP members to establish a pharmaceutical therapy program.

**Utilization Review (UM/CM) Nurses/Manager** The Utilization Nurse/Care Manager (RN) reviews the appropriateness of medical service requests to promote efficiency and maximize allocation of resources. The manager provides operational and administrative oversight to this department.





The Medical Director and the Vice President of Medical Management are responsible for articulating a clear vision for Allwell from Arizona Complete Health Care Management and Care Coordination Programs and ensuring the appropriate Allwell from Arizona Complete Health staff is available to participate in the ICT.

Challenges around member access to providers, care and/or services are communicated directly to Provider Services. The Director of Medical Management is responsible for semi-annual review and reporting of ICT activities to the Utilization Management Committee (UMC).

Interdisciplinary Care Review Rounds - In addition, the internal or delegated Case Management Company CM participates in weekly interdisciplinary care review rounds. The interdisciplinary

rounding teams are led by a Medical Director who is board certified and licensed in an appropriate discipline.

Each team includes, but is not limited to:

- Care Manager
- Pharmacist
- Program Specialists
- Utilization review (UM) nurses (as needed)
- Behavioral Health Case Manager/Mental health specialist
- PCP and Specialty providers

Member Engagement in the ICP Development - The ICT facilitates the participation of the member and the member's caregiver or other members of their circle of support in the development of the ICP. The member may participate in person, via telephone or through written information provided by the member/caregiver, depending on the status and/or the member's preference. Allwell from Arizona Complete Health may attempt to engage members during home assessments, during concurrent review and discharge planning, via telephonic contacts, and through follow up outreach letters targeting specific members and more generically through the use of a member newsletter. Our goal is to ensure the member/caregiver is able to actively participate in the development of an ICP that increases self-management, improves mobility and functional status, addresses limitations and barriers, establishes reasonable goals and creates an improved satisfaction with health status and healthcare services that result in improved quality of life. In compliance with CMS regulations, Allwell from Arizona Complete Health may offer member incentives to increase the member's participation in self-management.

Additional Sources of Information - Information from the primary care provider, specialists, non-professional caregivers, health records, specialist records, pharmacy data and predictive modeling aids in the full development of the ICP. The member's involvement is critical as this allows the member to be engaged in their own care and service management

Documentation of the ICP - The CM assigned to the member is responsible for the facilitation of communication among the team and documentation of the ICP in TruCare.

ICT Role in Transitions of Care - In our efforts to maintain an ongoing partnership and to improve a member's status/condition, we have staff (i.e., Transition of Care Nurses, Utilization Management Nurses) available telephonically for all facilities, to promote transition of care. Our goals and objectives are below:

- Early identification of members not engaged in care/service management services
- Increase identification, coordination and member awareness of discharge planning needs
- Ongoing partnership/relationship with area providers

To achieve our objectives, we may also conduct onsite health risk assessments of members and provide education regarding health options, community resources, member diagnosis/condition,

and plan benefits (Nurse Advice Line, transportation, meals, etc.). The CMs and the onsite staff also serves as liaisons between the facilities, PCP and the ICT. CMs assist members that were a “no show” for their scheduled follow-up appointments with rescheduling. All staff document interactions in TruCare.

Allwell from Arizona Complete Health Member Handbook includes clear description of the Care Management program.

***2. How the roles and responsibilities of the ICT members (including members and/or caregivers) contribute to the development and implementation of an effective Interdisciplinary Care process***

Roles and Responsibilities of ICT Members - Each member of the ICT, including the member, caregivers, PCP and CM contribute to the development and implementation of an effective interdisciplinary care process by offering personal, professional and cultural knowledge and perspectives.

- Clinical Staff, including physicians, registered nurses, pharmacists, nutritional and rehabilitation specialists provide input on evidence based clinical guidelines and standards of care, specific disease states and medical conditions and available therapies.
- Social Workers contribute knowledge of the bio-psychosocial and financial impacts of chronic illness and disability as well as the social supports available to our members.
- Behavioral Health Care Managers, and Licensed Social Workers lend expertise on integrating physical and behavioral care and services and linking members to the appropriate behavioral health providers.
- Primary Care Providers share the member’s medical history, including both successful and unsuccessful treatments, the member’s level of health literacy and understanding of their disease, their ability to self-manage and any issues of non-adherence to prescribed treatment. Our primary care providers are trained on conducting assessments, including the types of information that should be forwarded to the ICT for inclusion in the care planning.
- Members and their caregivers are able to interpret the member’s personal experience for the team, including cultural context, health care and functional goals, perceived needs, barriers and preferences, and choice of least restrictive setting, allowing the
- Team to customize a care and service plan of activities and interventions to meet the needs of the individual member.

Leveraging Information to Improve Member Outcomes – Allwell from Arizona Complete Health CMs 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 D-SNP members. In-home assessments often identify acute as well as chronic issues of concern. The CM 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.

### ***3. How ICT Members contribute to improving the health status of D-SNP Members***

Member-Centric Team Approach - The composition of the ICT is member-centric and is designed to improve the health status of dual D-SNP members by offering an integrated, person centered approach to care planning and service coordination. Team members are selected based on the individual needs and preferences of the member and their ability to offer knowledge and expertise in developing an ICP that best meets the unique needs of an individual member. The ICT is responsible for the following:

- Developing and implementing individualized care plan with the member 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 care review meetings
- Detecting possible 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 using the "Interdisciplinary Care Team" note type in TruCare

### ***4. How the D-SNP's communication plan to exchange member information occurs regularly within the ICT, including evidence of ongoing information exchange.***

It is the responsibility of the internal or delegated Case Management Company CM to facilitate communication among the member/caregiver and applicable team members and to ensure documentation of ongoing information exchange. All Allwell from Arizona Complete Health staff involved in the member's care has access to the TruCare record and document all interactions with the member, including authorizations and care plans.

ICT Communication - Care review rounds 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 provide 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 available on the member/caregiver and Provider portals, along with care gap alerts. The Provider portal also includes a Member Health Record.

Communicating Health Information to Members and Providers - In addition to developing, implementing, and communicating the ICP, Allwell from Arizona Complete Health develops educational newsletters intended for both the members and contracted providers that address

general health information, and introduce standards of care and services in addition to 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
  - Visual language systems (telecommunications device for the deaf TDD)
  - Interpreters
- Language barrier:
  - Allwell from Arizona Complete Health utilizes translation services when no staff is available to provide translation services.
  - Members may request to have 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 important elements; use pictures
  - Choose 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 Grievance and Appeals department for resolution and tracking.

Ongoing Communication Strategies - The success of the ICT in developing, maintaining, and updating a person centered ICP depends on strong communication. To that end, Allwell from Arizona Complete 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 ICT staff in TruCare. To ensure complete and consistent documentation Allwell from Arizona Complete Health documents all ICT reviews and activities in TruCare. Allwell from Arizona Complete Health's joint operating committee supervisory staff meet at least quarterly with the delegated Case Management Company's management to ensure smooth and complete communication and that all work is completed to the health plan's satisfaction.

## **Element E: Care Transition Protocols**

## ***1. Using care transition protocols to maintain continuity of care for D-SNP Members***

Allwell from Arizona Complete Health uses comprehensive, member-centric discharge planning policies and procedures to ensure seamless, safe transitions and to reduce the risk of readmissions. CMs conduct discharge planning and post-discharge follow-up using policies, procedures and processes described in the D-SNP Transition of Care/Post Hospital Discharge Call work process.

The Transition of Care Work Process coordinates care for members moving from one care setting to another to ensure continuity of care, reduce any potential risk to member safety, and facilitate a controlled plan so that the member receives care in the least restrictive care setting. Transitional care settings include the member's home, active home health care, acute care facilities, nursing facilities (skilled and custodial), and rehabilitation facilities. Transitions from one care setting to another involve both planned and unplanned transitions

Below we describe:

- Key elements of discharge planning policies and procedures
- Pre-discharge activities, including collaboration with the member/family and community resources involved at discharge and thereafter. Including ensuring service needs such as home health, DME, and other services for continuity of care.
- Follow-up activities after discharge to support a successful transition and reduce readmission risk.
- Integrated care team, to support a seamless transition process through collaborative care and discharge planning.

### Discharge Planning Policies and Procedures

Allwell from Arizona Complete Health uses an integrated, person-centered model of health, behavioral health in discharge planning activities to ensure a person-centric, holistic perspective. We consistently review and adopt best practices related to reducing readmissions, which support efficient and effective care coordination, and contribute to improved quality outcomes.

## ***2. Personnel responsible for coordinating the care transition process***

Collaborative, Comprehensive Assessment and Planning - Effective discharge planning involves our concurrent review staff collaborating in person or via phone not just with the facility discharge planning staff, but also the member/caregiver, the PCP, treating physical and behavioral health (BH) providers and CMs to comprehensively assess and develop interventions to address physical, behavioral, psychosocial, environmental, financial, cultural, and linguistic needs and barriers, including functional limitations that indicate a need for dual eligible members. The CM coordinates communication with the member, caregiver and/or family and between the discharging provider, the PCP and other applicable treating and providers. They also provide education related to available covered services, health options, and recommended care according to clinical practice guidelines. Cases are reviewed, as needed, with Allwell from Arizona Complete Health own integrated care team, which includes nurses and BH clinicians,



care managers, care coordinators, licensed social workers, behavioral health care managers, pharmacist, UM nurses, and disease management staff.

The concurrent review nurse/ Transition Care Manager, delegated Case Management Company or internal care managers ensures that the member's discharge plan includes referrals to appropriate post-discharge supports, including services such as home care, DME, transportation, prescriptions, and supplies, as well as community resources needed to support a safe discharge and reduce readmission risk. For example, care managers identify community resources such as the need for meals post discharge, and utility assistance programs, and incorporate them as applicable into the transition plan. The care manager contacts these resources prior to discharge to arrange for timely initiation of services when the member returns home.

Member/Family Engagement and Education - Timely communication of information to the member/caregiver or family and assisting the member to understand their condition and needs are important tools in reducing readmission risk. The concurrent review nurse/care manager attempts to contact the member/caregiver or family in person or via phone while they are inpatient to discuss diagnoses, test and procedures, pending tests, medication lists, rationale for medication changes, contact information for the discharging physician, and all instructions and recommended follow-up care on the discharge plan. The concurrent review nurse/care manager also ensures that the member is knowledgeable about "red flags," which are indications that their condition is worsening or that they are experiencing a medication side effect, and how to respond, including self-management strategies and when to call their provider. They utilize the "teach back" method to verify that the member/caregiver understands by having the member/caregiver restate the discharge instructions and self-care concepts in their own words.

### ***3. Transferring elements of the member's ICP between health care settings***

Communication of Information to the Next Care Setting - The CM ensures that all treating providers have full information about the member's care history and current needs as well as the context for planned care. The CM also ensures that they know whom to contact with questions regarding the member's care history or follow-up care. For admissions, the CM provides information to the facility regarding the member's ICP, authorized services and providers to support assessment and discharge planning. The concurrent review nurse/care manager alerts the PCP of any transition in care setting. The concurrent review nurse or the CM collaborates with the facility treating physicians and BH providers, as appropriate, to facilitate discharge planning and follow-up as needed. The concurrent review nurse, transition care manager or the internal or delegated Case Management Company CM coordinates and facilitates provider communication, and ensures that the PCP and all treating providers, including formal and informal community supports, as appropriate, are involved in the planning for the anticipated transition. The concurrent review nurse or the CM sends the discharge plan to the PCP (and, for discharges from inpatient psychiatric facilities, to the BH Provider as well). The discharge plan is incorporated by the internal or delegated Case Management Company CM into the ICP.

### ***4. Providing members with access to personal health information to facilitate communication with providers in other healthcare settings***

All D-SNP members are provided their Individual Care Plan that can be shared with providers in other care plan settings and/or health specialists outside of their primary care network. Any member may request that he or she be allowed to inspect and/or obtain a copy of any of their Protected Health Information that is maintained by or for Allwell from Arizona Complete Health a designated record set. The member, or any other person who is qualified to act as the member's personal representative under state or federal law, may make the request.

Arranging timely and Appropriate Primary Care and Specialist Follow-up Prior to Member Discharge - Prompt follow-up with the PCP or other outpatient specialty provider after discharge is critical in preventing readmission. The concurrent review nurse/care manager takes steps prior to discharge to ensure that the member receives timely and appropriate follow-up care. These steps include but are not limited to scheduling follow-up appointments and transportation, as needed; verifying anticipated start date/time for community based care and services and working with the CM and the member/family to fill any gaps between discharge and initiation of community services.

### ***5. Educating Members and/or caregivers about the Member's health***

Post-Discharge Outreach, Education, and Assessment - The assigned CM conducts post-discharge follow-up with the member within 72 hours of notification of discharge to verify that they have been able to get prescriptions, equipment, and supplies. They review with the member/caregiver the discharge plan to ensure they understand the importance of accessing recommended follow-up care, address barriers to accessing follow-up care, and review red flags and the process for contacting the PCP or other providers when complications arise. The CM educates the member/caregiver about how to use Envolve -- NurseWise, our after-hours nurse advice line.

The goal of the post-discharge outreach assessment is to assist members in closing identified healthcare gaps and barriers during transitions from an inpatient hospital to home. We focus on care coordination, health education, medication adherence, and follow-up appointments in order to promote healthy behaviors and reduce the risk of readmission, and ensure that the member can remain in a least restrictive setting of their choice.

Medication Reconciliation - Medication reconciliation is a critical element of care transitions and preventing readmission due to medication error or adverse event when a member has poly-pharmacy, low health literacy, or communication barriers. The CM ensures that the member is able to safely use medications in accordance with their discharge plan and confirms that the member has picked up their medications. Medication reconciliation may be done in person by the internal or delegated Case Management Company CM, telephonically by a RN care manager, pharmacist, or by a home health agency RN. This includes checking the accuracy of medication lists; identifying changes in medication regimen, duplication of therapy and/or potential interactions with medications in the home; and assuring that the member/caregivers understands changes and side effects that should be reported to their PCP. It also includes communicating the discharge medication regimen to the PCP, if they were not the treating physician during the inpatient admission.



Pre-Discharge Activities - When Allwell from Arizona Complete Health identifies that a member has been admitted or has a scheduled admission, the concurrent review nurse, care manager begins working with the facility staff, providers, and the member to coordinate care, ensures a safe discharge, and reduces readmission risk. Discharge planning of an inpatient admission starts as early in the admission as possible. The concurrent review nurse, internal or delegated Case Management Company care manager conducts onsite or telephonic reviews and outreaches to facility staff to obtain clinical information, assesses members' conditions, needs, and potential discharge. The concurrent review nurse and/or the CM participates in facility care conferences to identify barriers, discuss the member's progress, and help develop and coordinate the discharge plan. They also notify and share information with the PCP and other treating providers, such as BH providers to ensure an integrated approach to services and discharge planning, and ensures necessary authorizations are in place for ordered services such as home care services. Nurses conducting telephonic concurrent review and discharge planning ensures that transition plans are person-centered, meet the members clinical needs, consider the members' goals and preferences, and supports them in achieving desired health outcomes, including being able to safely reside in the least restrictive setting of their choice, while preventing readmission.

The CMs use information from the facility, treating providers, and the members to identify members' at risk for readmission. This includes but is not limited to members with complex medical and social needs, co-existing medical and BH conditions, and members with a history of non-compliance or poor community supports. CM supports concurrent review nurses as follows:

- Participate in interdisciplinary rounds when possible
  - Identify and attempt to resolve barriers to care
  - Coordinate initiation of services such as home health and DME
  - Encourage medication adherence and follow-up care
  - Assist with scheduling follow-up appointments
  - Assist with scheduling transportation to scheduled appointments
  - Complete referrals to appropriate community agencies
  - Discuss "red flags", and when to contact the PCP, the use of the Emergency Room and Urgent Care Centers and what is considered a true emergency

For members with complex needs, Allwell from Arizona Complete Health conducts multi-disciplinary rounds to support the concurrent review nurse/care manager. This care review process brings a holistic look at members' needs, risk factors, preferences, goals, and barriers to achieving desired goals, and develops recommendations for the discharge plan and post-discharge services to successfully support the member's transition out of the hospital and prevent readmission.

Collaborating with the Member/Family - Following admission, the delegated Case Management Company, concurrent review nurse, or internal CM attempts to talk in-person or via phone with at-risk members, their provider(s), and family/supports as appropriate, to the following:

- Assess health status, care plan changes, any needs such as unmet education or psychosocial needs, reasons for unplanned admissions and ED visits, and potential risks

and barriers in their environment which potentially will, or in the case of readmission, have interfered, with a successful recovery. Assessment also includes the evaluation of the member's functional status, health literacy, self-management skills, social and community supports and culture and language needs

- Provide education about the member's condition, red flags, and other topics (as described above)
- Conduct medication reconciliation
- Involve the member in discharge/service planning
- Assist the member as needed with choosing providers of post-discharge services
- Educate the member and their caregivers about available Allwell from Arizona Complete Health support to help connect caregivers to support groups and other community resources

Collaborating with Community Resources to be Involved at Discharge and Thereafter - The goal of Allwell from Arizona Complete Health Transition of Care is to provide whole health management across the continuum of care as well as to identify and address social determinants of health, which impact the member's health outcomes and ability to remain in the least restrictive setting of their choice. To accomplish this, the concurrent review nurse/CM go beyond a purely clinical approach to developing discharge plans by identifying and addressing barriers related to physical, behavioral, socioeconomic, functional status, and other needs such as food, housing, or other assistance.

#### ***6. Fostering appropriate self-management activities through education and follow-up.***

Pre-Discharge Education - The CM attempts to discuss the final discharge plan and instructions with the member (and applicable family/informal supports). This includes assisting the member with developing actions to prevent avoidable ER and inpatient utilization, if the member's condition and cognitive status permits such interaction at that time.

#### ***General Discharge/Post-Discharge Procedures***

The concurrent review nurse or internal or delegated Case Management Company CM handling discharge planning collaborates with facility staff to ensure that these appointments are scheduled before the member is discharged from the facility. The CM contacts the member via telephone within 72 hours of discharge.

During the follow-up home visit or phone call to members, the CM does the following:

- Review and reinforce discharge instructions, and provide additional education to ensure the member understands his/her condition, needed follow-up, and the importance of adherence and timely follow-up. This activity is critical because discharge instructions typically provide limited information, and the member's health literacy level may limit their understanding. Additionally, the member may not retain any education received in the hospital due to such issues as stress, pain, or medications.
- Complete a medication reconciliation of newly prescribed medications and all others the member may be taking to identify any potential issues, such as duplication or contraindications; identify any barriers to the member's compliance in taking the

medications, provide education on why the medication is needed and the appropriate way to take the medication.

- Ensure a follow-up is scheduled, and assist as needed with scheduling follow-up appointments, arrange transportation if needed, and address any other barriers to timely access.
- Confirm initiation of home care and the delivery of medical equipment/supplies.
- Assist the member in determining if they understand what symptoms they should look for, what to do when they have those symptoms, and how to contact their PCP in order to reduce avoidable ED visits and readmissions. The CM educates the member on how to contact the Care Manager or, after hours, how to use our 24/7 Nurse Advice line if they have any questions.

Ensuring Members Are Connected With Community Resources - During the post-discharge contact described above, the delegated Case Management Company or internal CM confirms whether the member has accessed the community resources in the transition plan. If not, the CM follows-up directly with the community resources to discuss the member's needs and ensure services are available and are provided timely.

For members whose hospitalization resulted from a BH issue, the CM collaborates with the BH Coordinator for continued behavioral health needs.

Post-Discharge Monitoring - The CM follows the member's progress throughout the post-discharge transition period. Typically, follow-up for members extends 30 days from discharge, but may extend beyond 30 days depending on the member's needs and condition. Any member identified as needing more intensive education and support following discharge may receive a Face-to-Face visit by the CM or home health provider to ensure the member understands the importance of, and is accessing follow-up care appropriately, and adhering to medication regimens. Once the member is stable, the CM assesses the member for ongoing care management needs and referral for disease management education and health coaching.

Integrated Care Management for Ongoing Needs - Members who continue to need monitoring and support is supported by Allwell from Arizona Complete Health own integrated care team. This team includes a social worker, BH clinician, pharmacist, health coach and non-clinical supports. Furthermore, the CM, which constitutes the "one point of contact" for the member and the providers, communicate the newly updated ICP to the ICT. The ICT collectively reviews and provides interdisciplinary input on the member's needs and care. Team members, regardless of background, receive training on basic information about detecting and appropriately referring for potential medical and behavioral needs. Clinical staff receives more in-depth training on the causes, evidence-based treatment, components of care, potential barriers to care, and expected outcomes of both medical and BH conditions, particularly those that often occur co-morbidly. This approach helps to avoid unnecessary readmissions by ensuring an integrated approach to each member's ongoing needs and care.

## MOC 3: Provider Network

### Element A: Specialized Expertise

#### *1. Ensuring a specialized network to meet the unique needs of the population*

Allwell from Arizona Complete Health provides member access to a wide range of credentialed and contracted providers to meet the healthcare needs of each member. In instances where in-network services are not available within the Allwell from Arizona Complete Health network or as part of continuity of care, members are granted access to out-of-network providers, coordinated by the CM or ICT. Allwell from Arizona Complete Health establishes access and availability standards consistent with CMS standards and evaluates performance against those standards on a quarterly basis. As part of the annual network analysis, we evaluate the needs of our D-SNP members with the composition of the network using a number of data sources. For example, members' complaints and specialty/geographic referrals are reviewed upon receipt. Quest Analytics GEO Access Reports<sup>15</sup> are generated and reviewed on, at least, an annual basis to compare performance against access standards. Providers are surveyed annually regarding availability and corrective action plans are initiated as needed.

#### Specialized Expertise/Special Needs of Target Population

Allwell from Arizona Complete Health continually monitors its provider network to ensure that members have access to needed care. The following are examples that demonstrate how we address the needs of the population:

- Allwell from Arizona Complete Health contracts with providers who accept both Medicare and Medicaid. Allwell from Arizona Complete Health expects providers to be able to bill for the Medicare and Medicaid portion of members' covered services
- Overall, D-SNP members have multiple chronic conditions and may have established providers who are not in-network. Through the initial HRA, face-to-face member home assessment and other initial conversations with the member/caregiver and/or provider, it is often determined that it is in the member's best interest to remain with that provider, even though they are not contracted with Allwell from Arizona Complete Health. Allwell from Arizona Complete Health outreaches to out-of-network providers to determine if they will contract with the plan, and, if not, at least continue to see the member under a single case agreement through the continuity of care period.
- In general, the D-SNP population is elderly and has a higher prevalence of comorbid conditions, as well as a higher number of medications taken for these conditions. As noted in the "Description of the overall D-SNP Population", there is a high concentration of Behavior Health diagnoses along with Chronic Obstructive Pulmonary Disease, Diabetes, Obesity and Congestive Heart Failure. Due to the higher prevalence of comorbid conditions, Allwell from Arizona Complete Health spends significant time collaborating with Cardiology, Behavioral Health and Pulmonary Specialists to facilitate

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<sup>15</sup> Quest Analytics software generates a report that has analysis related to our provider network composition and accessibility.

care, conduct medication reviews and authorize appropriate services for this medically complex population.

- Since there is a high incidence of D-SNP members who are likely to have mental health disorders, these issues often result in barriers to receiving physical care, we connect these members with a primary care provider/medical home. Additionally, Allwell from Arizona Complete Health works collaboratively with on-site behavioral health coordinators and care managers and the contracted Behavioral Health provider to ensure care is coordinated and both the medical and behavioral conditions are being addressed.
- Providers are also surveyed individually if complaints are received. For example, if a complaint states that the provider's office was not accessible, even though the office certified that it was accessible and was listed as such in the Provider Directory, Allwell from Arizona Complete Health Provider Relations & Provider Contracting Representative reviews the complaint and follows-up with the provider, as necessary.

### Network Distribution

Allwell from Arizona Complete Health utilizes quantifiable and measurable standards for the number and geographic distribution of network providers. Provider type and availability are analyzed, at least annually, by the Provider Services Department using Quest Analytics GEO Access Reports. Member data regarding satisfaction with physician availability are collected and analyzed, at least annually, by the Quality Department. The Quality Improvement Committee (QIC) reviews these reports. The QIC, or designated subcommittee, analyzes the reported data and makes recommendations to address deficiencies in the number, distribution or type of providers available to the members.

### Cultural Needs and Preferences

At least annually, Allwell from Arizona Complete Health assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within the network, if necessary. Allwell from Arizona Complete Health utilizes all available resources to gather ethnic, racial and linguistic data about its members including, but not limited to the following:

- Data provided by the state enrollment
- Data collected voluntarily through member contacts and outreach efforts (e.g., new member welcome call, health risk assessment, care management assessments, reminder calls, etc.)
- Data collected through enrollment forms

Allwell from Arizona Complete Health collects cultural, ethnic, racial and linguistic data about practitioners on a voluntary basis during the credentialing process. Allwell from Arizona Complete Health then facilitates linking of members with practitioners who can meet members' cultural, ethnic, racial and linguistic needs and preferences through its Member Service Representatives or via the on-line Provider Directory. In order to address the members' needs, analysis of member surveys and/or member complaint data are reviewed at least annually to identify potential areas for improvement.

### **Provider Specialties:**

The following list of providers includes but it is not limited to:

Practitioners

Primary care providers  
Geriatricians  
Nurse Practitioners  
Physician Assistants  
Dietitians  
Oral/dental specialists  
Vision specialists  
Cardiologists  
Nephrologists  
Orthopedists/Orthopedic surgeons  
Rheumatologists  
Urologists  
Dermatologists  
Pathologists  
Pulmonologists  
Endocrinologists  
Optometrists  
Ophthalmologists

Podiatrists  
Neurologists  
Hematologists  
Obstetrician and Gynecologists  
Oncologists/Radiation oncologists  
Radiologists  
Gastroenterologists  
Thoracic surgeons  
Audiologists/hearing aid specialists  
Physical Therapists  
Speech Therapists  
Occupational Therapists  
Psychiatrists  
Psychologists  
Social workers  
Dentists  
Allergist/Clinical Immunologists  
Oral and Maxillofacial surgeons





### Facilities and Services

Hospitals and Emergency departments  
 Urgent care centers  
 Long-term care hospitals  
 Inpatient mental health facilities  
 Alcohol and drug specialty agencies  
 Patient Centered Medical Homes (PCMH)  
 Laboratories/pathology sites  
 Skilled nursing facilities  
 Federally Qualified Healthcare Centers (FQHCs)  
 Rural Healthcare Centers (RHCs)  
 Local and national Pharmacies  
 Radiography facilities  
 Rehabilitative facilities  
 Dialysis centers  
 Outpatient surgery centers  
 Home health agencies

Home infusion providers/Infusion centers  
 Durable medical equipment suppliers  
 Hospice providers  
 Medical transport providers  
 Personal attendant services  
 Day activity and health services  
 Adaptive aids and medical supplies  
 Adult foster care  
 Assisted living and residential care services  
 Emergency response services  
 Home delivered meals  
 In-home skilled nursing care  
 Minor home modifications suppliers  
 Respite care  
 Consumer directed services  
 Transition assistance services  
 Other LTSS specific providers

## ***2. Credentialing process for providers and facilities and maintaining an accurate provider directory***

Allwell from Arizona Complete Health credentialing program is built on Centene's extensive experience with credentialing providers and includes comprehensive policies and procedures for the process of provider selection and retention. These policies and procedures include practices of credentialing, re-credentialing and ongoing monitoring in full compliance with applicable federal and state requirements and National Committee for Quality Assurance (NCQA) standards.

Application process - To participate in the health plan network, providers must submit a completed application and applicable supporting documentation and meet the participation requirements of Allwell from Arizona Complete Health. Applications are reviewed to determine if all required fields are completed and required documentation is attached. Providers are promptly notified if applications are incomplete and are instructed to provide missing information before the application can be processed. Allwell from Arizona Complete Health Credentialing Department conducts three documented attempts to collect any missing information with the last attempt involving certified registered mail. If there remains no response to the request for the missing information, the application review process is withdrawn. Providers may receive information and assistance at any time from our Credentialing staff.

Board certification is a preferred accreditation, but it is not a requirement for network participation. If a practitioner claims to be board certified, the Credentialing staff verifies current



board certification through the American Board of Medical Specialties (ABMS) or other approved services. For non-board certified practitioners that have completed medical school, we complete a query to the facility where the highest level of training program was completed. For facilities, we verify federal and state licensure through queries of the licensing agency or obtain a copy of the actual license. We seek to ensure that medical and behavioral health care organizational providers and service providers are in good standing with state and federal regulatory bodies and that they were reviewed and accredited by the appropriate accrediting body. If the provider is not accredited, Allwell from Arizona Complete Health staff obtains the most recent CMS or state survey in lieu of conducting an onsite assessment visit.

Credentialing process – Allwell from Arizona Complete Health Credentialing staff ensures all provider-specified data elements and documents are included and have been verified, are consistent with established thresholds and are valid within 120 days of the Credentialing Committee meeting. A contracted delegated vendor completes the Primary Source Verification for Arizona Complete Health.

Applications meeting the following established thresholds for “clean files” are presented to the Medical Director for review:

- No past or present suspensions or limitation of state licensure within a 5 year look back period
- No past or present suspension or limitation of DEA or state controlled substance registration within a 5 year look back period
- Current malpractice coverage in the amount required for provider type
- No past or present Federal or State sanction activity
- Absence of information that practitioner has opted out of receiving Medicare funds, as applicable to plan requirements
- No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff in a 5 year look back period from date of settlement
- No gaps in relevant work history of 6 months or longer for a minimum of 5 years; if provider has practiced less than 5 years, the work history review starts at the time of licensure
- No current hospital membership or privilege restriction and no history of hospital membership or privilege restrictions within a 5 year look back period
- No history of current use of illegal drugs or alcoholism
- No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
- No criminal/felony convictions, including a plea of no contest
- No involuntary terminations from a HMO or PPO
- Passing site visit score, if applicable





Credentialing files not meeting the “clean file” requirements are submitted to the Credentialing Committee for review, which reviews the application information and makes approval or rejection determinations.

#### Primary Source Verification (*PSV*)

- Primary Source
  - National Practitioner Data Bank (NPDB) query
  - Medicare/Medicaid sanctions query through Office of Inspector General (OIG) or List of Excluded Individuals and Entities (LEIE)
  - Medicare Opt-out query
  - Medical school and residency verification
  - Evidence of professional training (Mid-level practitioners)
  - Board certification query through AMBS via Certifacts, AMA profiles (American Medical Association) or any other NCQA approved site if applicable. If not board certified, highest level of credential attained
  - Current state license within the state of practice
  - Drug Enforcement Agency (DEA) certification, if applicable
  - Malpractice insurance including a minimum five-year history of professional liability claims resulting in judgment or settlement
  - Professional peer references, for physicians that are not board certified
  - Hospital privileges, if applicable
- Documentation: In addition to performing primary source verification by a credentialing specialist, we ensure that all of the following documentation is present and valid:
  - Proof of professional liability coverage in compliance with State regulations regarding professional liability coverage
  - Curriculum Vitae / Work history for the past 5 years, with no unexplained gaps greater than 6 months
  - Education Certificate for Foreign Medical Graduates (ECFMG) – if applicable
  - Privileges at a hospital or evidence of arrangements with another practitioner to assume coverage of the practitioner’s patients (if applicable)
  - For mid-levels practitioners, proof of collaboration agreement with a physician

Credentialing Committee review and decision – The Allwell from Arizona Complete Health Quality Improvement Committee (QIC) has direct responsibility for the credentialing program, activities and policies. The Credentialing Committee reports to the QIC, which in turn, reports to the health plan Board of Directors. The Medical Director has direct responsibility for the health plan credentialing program and participate in monthly credentialing meetings and other activities related to the credentialing and re-credentialing programs. The Credentialing Committee includes network physicians, oversees the credentialing process and evaluates each applicant’s credentials and professional conduct and is responsible for acceptance, deferment, or denial of a provider’s application based on CMS, State, NCQA and other requirements for participation in the health plan network. The Credentialing Committee is also responsible for reviewing monthly reports to measure compliance with credentialing standards.



Credentialing/re-credentialing cycle time – Allwell from Arizona Complete Health concludes the initial credentialing process following receipt of a complete credentialing application for each applicant within 30 days for all applicants. To accommodate periods of heavy demand, such as prior to or immediately following a new plan implementation, Credentialing utilizes additional staff typically dedicated to other markets. To ensure ongoing compliance with required timeframes, the QIC monitors key credentialing indicators quarterly to ensure that initial credentialing and re-credentialing are completed within required timeframes.

Allwell from Arizona Complete Health also formally re-credentials practitioners at least every thirty-six (36) months.

Ongoing monitoring – Allwell from Arizona Complete Health Credentialing staff conducts ongoing monitoring and reporting to ensure continued compliance with credentialing and re-credentialing timeframes and compliance with all credentialing standards and policies. Credentialing staff ensures that initially credentialed and approved providers have not incurred sanctions, illegal activity, or other negative indicators in between or prior to their standard re-credentialing through routine monitoring of all providers in the network. This ongoing monitoring includes the System for Award Management (SAM), OIG, LEIE (available on the internet) and applicable State Board and/or Medicaid Agency reports on a monthly basis. This review helps identify excluded parties that are banned from participation in federal healthcare programs.

Acceptance of CAQH application submissions – Allwell from Arizona Complete Health also accepts credentialing applications submitted via the standard Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing Data Source, which simplifies the administrative process for providers who choose to participate. Providers may contact CAQH or Allwell from Arizona Complete Health for assistance with submitting through CAQH. Applications submitted through CAQH are subject to the same review and data verification process as application submitted directly to Allwell from Arizona Complete Health.

Using quality and utilization measures in the re-credentialing process – Allwell from Arizona Complete Health D-SNP Credentialing Department receives, from various departments in the organization, information related to provider performance. Such information includes the following:

- Member quality of care complaints against a practitioner
- Member complaints against a practitioner due to access issues
- Potential Quality of Care issues identified during the concurrent review process
- Members in a practitioner's panel with significant gaps in care
- Practitioner requesting unusual numbers of a given test or procedure
- Practitioner non-compliant with appointment availability

This information is stored in the provider file and is reviewed at time of re-credentialing prior to approving re-credentialing. Additional information may be requested by the committee before making the decision for re-credentialing.

Data storage – Allwell from Arizona Complete Health Provider Data Management Department is responsible for the entry and maintenance of provider data into the Provider Database. It includes all provider credentialing and re-credentialing information, ongoing monitoring of provider quality and utilization measures. Network Operations is responsible for monitoring the provider directory and updating it for accuracy.

Credentialing delegation - Delegated credentialing partners are held to the same credentialing standards and documentation requirements. Allwell from Arizona Complete Health credentialing staff performs oversight and due diligence to monitor delegated entity provider's credentialing on an annual basis. An audit is done annually on delegated vendor credentialing and re-credentialing files. Delegated entity is required to report all initially credentialed, re-credentialed practitioners, determinations, demographic changes and notification of any de-credentialed and denied re-credentialed providers as they occur.

After initial providers are credentialed, their information is loaded in our internal systems (Provider Database), sent to our online provider directory and used to create our print and web-based directories.

Allwell from Arizona Complete Health performs annual reviews of the provider network to confirm our continued compliance with CMS access and adequacy standards and ensure data accuracy. The Provider Data Management Team continually validates provider data, including changes or updates and makes the current data available via the member and provider portals.

Providers are able to update their demographic information at any time by completing and submitting the form available on Allwell from Arizona Complete Health website.

Delegated credentialing partners are required to send us monthly rosters, which are used to update provider information in all of our directories.

Updates to the provider directory are done upon referrals from Member and Provider Services. For example, if a member informs us that they called a provider and the number is disconnected, we contact the provider, find the correct number and update our directory information accordingly. The Allwell from Arizona Complete Health Provider Relations Department also audits contact information by randomly calling providers to verify triage timeframes and provider address/phone information.

***3. Engaging providers in collaborating with the ICT and contributing to a Member's ICP to provide necessary specialized services.***



Allwell from Arizona Complete Health Care Managers and the delegated Case Management Company successfully engage our provider network to participate in and work with the ICT and to contribute to the ICP through the following steps:

- Sharing the identification of health care and service needs and risks
  - CM review the HRA conducted by a delegated vendor and saved in TruCare.
  - By completing such an assessment, the CM will determine the specialty providers, allied health or support services (durable medical equipment, home health services, meals and other home and community-based services) needs of the member
  - CMs share results and analysis of the Medicare CM Assessment/HRA with the member's PCP and with all other healthcare providers and other staff, "the ICT", identified by the CM as necessary to handle the member's identified needs and preferences
- Developing the member's individualized care plan with the member and/or caregiver, PCP and other external ICT members based on the member's health care, social and functional needs
  - Care Managers lead the initial ICT meeting, as well as all subsequent meetings, where the member's specific needs are addressed; proposed course(s) of action are presented to the member/caregiver by the members of the ICT and based on the member's desires, an ICP is developed with specific goals and steps to follow
- Providing the PCP and other members of the ICT with one point of contact at Allwell from Arizona Complete Health to coordinate care and ensure service delivery
  - Members of the ICT receive a single "one point of contact": the member's CM
  - CMs help educate the provider network in general and the ICT, in particular, on services and benefits available to the member
  - Provider relations educates the PCP's on their responsibilities in the ICT process as new provider orientation and throughout the year as needed.
  - CMs serve as the point of contact to the members of the ICT to facilitate and authorize all needed benefits and services, provide appropriate information about the UM rules and monitor timely delivery of services
- Notifying the PCP and other members of the ICT of care transition and/or significant clinical, behavioral, functional or social status change that their assigned health plan member may encounter to ensure smooth transition of care with the proper adjustment of services
  - CMs, for example, provide members of the ICT documentation related to a member's transition from home care to a nursing facility, a discharge from the hospital to a nursing facility, a visit to the emergency room
  - CMs are responsible for communicating to the ICT, the participants' change in health status, the need for modification to the member's ICP, and for coordinating and obtaining approval from the ICT of an updated ICP and implementing the updated ICP.
  - CMs request, from the ICT, information related to preventative health screenings being completed or remind them of gaps in care that need to be closed



- CMs share, with the ICT, a daily turn-around report that lists all in-process prior authorizations to ensure proper and timely delivery of services, and inpatient census to ensure proper discharge planning and transition of care by working with concurrent review nurses
- CMs assign tasks to other members of the ICT such as scheduling appointments, obtain lab results, schedule transportation for the member, arranging for special services, etc.

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

### ***1. Communicating and monitoring compliance with clinical practice guidelines***

Clinical Practice Guidelines (CPGs) assist providers, members, medical consenters and caregivers in making decisions regarding health care in specific clinical situations. Allwell from Arizona Complete Health adopts CPGs in consultation with network providers (including behavioral health, as indicated) based on the health needs and opportunities for improvement identified as part of the Medicare QI Program Description. Allwell from Arizona Complete Health decisions regarding utilization management, member education, coverage of services, and other areas included in our practice guidelines are consistent with Allwell from Arizona Complete Health clinical practice guidelines.

These practice guidelines are comprehensive, addressing both quality of clinical care and the quality of non-clinical aspects of service, such as, but not limited to availability, accessibility, coordination and continuity of care. Our guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals practicing in the relevant field and the needs of our members.

Allwell from Arizona Complete Health updates clinical and preventive health guidelines upon significant new scientific evidence or change in national standards, or at least every two years. We distribute guidelines to affected providers and, upon request, to members, potential members, medical consenters and caregivers. Additionally, we maintain a listing of adopted clinical practice and preventive health guidelines on the health plan web site with links and/or full guidelines available to print, noting that hard copies are available upon request.

Practitioner adherence to Allwell from Arizona Complete Health adopted preventive and clinical practice guidelines is encouraged in the following ways: new provider orientations include the practice access standards with discussion of Allwell from Arizona Complete Health expectations, measures of compliance is shared in provider newsletter articles and on the provider web site, targeted mailings that include guidelines relevant to specific provider types underscore the importance of compliance and Allwell from Arizona Complete Health Physician Profiling program.

In addition to the credentialing and verification process for network providers, Allwell from Arizona Complete Health influences the overall medical quality of provider decisions and care transitions by endorsing evidence-based practice guidelines and nationally recognized protocols.

Adoption of Clinical Practice Guidelines Allwell from Arizona Complete Health adopts preventive and clinical practice guidelines (CPGs) from recognized sources for the provision of acute, chronic and behavioral health services relevant to the populations served. Clinical Practice Guidelines are systematically developed statements based on accepted medical evidence that assists provider and patient decisions about appropriate health care for specific clinical circumstances. They are used to objectively evaluate clinical and health service delivery issues, as well as, guide care delivery. Clinical Practice Guidelines are available from a number of sources, including but not limited to:

- The American Medical Association, Directory of Practice Parameters;
- Medical Specialty Societies;
- The National Institutes of Health;
- The Agency for Healthcare Research and Quality; and
- U.S. Preventive Services Task Force's Guide to Clinical Preventive Services.

Although nationally developed guidelines can serve as the foundation, Allwell from Arizona Complete Health QIC obtains input from network providers to ensure that regional variations are considered. Service performance standards related to these initiatives are routinely reviewed and analyzed by the QIC.

As needed, Allwell from Arizona Complete Health obtains advice from board-certified consultants in various specialty areas to assist with development of clinical policies, procedures and educational programs. The Quality Management Committee is responsible for the revision and approval of Clinical Practice Guidelines.

Examples of the Allwell from Arizona Complete Health Clinical Practice Guidelines are below:

- Adult Immunization Schedule
- Adult Preventions Guidelines
- Asthma
- Diabetes
- Major Depression Disorder
- COPD
- Cardiovascular Disease

Upon approval by the QIC, network providers are notified of adopted Clinical Practice Guidelines via Provider Handbook, Provider Resource Center on our Provider Portal, Provider Newsletters and fax blasts.





## ***2. Identifying challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable D-SNP members***

Allwell from Arizona Complete Health recognizes that nationally developed procedures and guidelines are often designed for standard medical cases, but may not apply to members with complex needs. Such cases include challenges related to medication, prescriptions, facility placement, surgical intervention and other medical treatments.

In a broad context, all standard criteria/guidelines (e.g., NCD, LCD, InterQual, Clinical Practice Guidelines) and Allwell from Arizona Complete Health developed clinical protocols/standards are reviewed at least once a year and adopted in consultation with network providers. Adopted or revised guidelines are then distributed via online postings, faxes, portals and/or newsletters to network providers. Network providers are also able to request updates via mail. General revision challenges, such as changes in member population, new scientific evidence, or evolving industry standards, dictate when updates are needed on an ad-hoc basis. In addition, revisions are also considered and/or implemented annually. For example, changes to cancer screening protocols necessitating guideline revisions.

## ***3. How decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT***

Process to Modify CPG and/or Clinical Protocols - More specifically, when a member with complex needs fails to meet applicable medical criteria/guidelines during the UM process for prior-authorization, the case is referred to Allwell from Arizona Complete Health Medical Director. The Medical Director reviews all pertinent clinical information, including applicable peer review literature. He/she considers relative information during the review, such as member's age, comorbidities, complications, current treatment, psychosocial factors and home environment. Once the Medical Director concludes a clinical decision, such decision is communicated to the ICT, the member's PCP and the member/caregiver as needed, to ensure medically appropriate care or service is provided and within the allowed benefits. The Medical Director makes him/herself available to discuss his/her decision with the ICT, at the team's request and convenience. Lastly, the ICP is adjusted according to the final decision and the new adjusted ICP is distributed to the ICT members, and verbally shared with the member/caregiver. The Care Managers (CM) monitor the timely delivery of the requested services to the member.

When network providers identify challenges/don't agree based on their own experience with clinical protocols, they are able to do the following:

- Request a change in Allwell from Arizona Complete Health guidelines by submitting evidence to be considered on an individual prior authorization request
- Request a revision of the overall guideline
- Request a peer-to-peer review



- Submit an appeal form for any adverse determination/denials

In all instances, providers are encouraged to submit additional clinical evidence for consideration or information about a particular case.

Overall, these methods help Allwell from Arizona Complete Health revise and address challenges/exceptions to clinical practice guidelines for the unique health needs of members.

#### ***4. How D-SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E***

Allwell from Arizona Complete Health Care Coordination provides crucial connections when members transition from one care setting to another. This activity is critical to providing a safe and smooth transition. Allwell from Arizona Complete Health CMs mediate member transitions to/from the hospital, home, nursing facility or to a totally new care setting and involve the member/caregiver as well as all care providers responsible for the services and supports in the new setting.

Transition protocols include the following:

- Addressing the member's individual needs, strengths, preferences, and goals
- Educating the member/caregiver on his/her condition
- Supporting medication adherence and reconciliation
- Ensuring timely initiation of post-discharge services and care such as post-discharge office visits and other services, home health care services, etc.
- Linking member to available community supports

These protocols are implemented and managed by Allwell from Arizona Complete Health clinical resources.

CMs ensure that the member's PCP receives notification within 24 hours of care transition. They request the documentation related to the transition in care, e.g., completed discharge summary, history and physical, specialty consultation reports, and any pertinent information such as main issues, post-discharge required services, and provide such information to the member's PCP and other members of the ICT. CMs, in conjunction with the PCP, update the ICP and provide updates to the ICT members and the member/caregiver. Finally, they follow-up on all outlined tasks with the member, providers and ancillary services to ensure that all activities outlined in the transition plan and in the updated ICP are completed in a timely fashion. This process ensures a seamless transition for the member and reduces readmission risk.

In the event that a provider is non-compliant or resistant to working with the CM, the network team mediates the conflict by providing outreach and facilitating compliance discussions. They





also deliver training to providers if there is an educational gap related to the care transition protocol.

## **Element C: MOC Training for the Provider Network**

### ***1. Initial and annual training for network providers and out-of-network providers seen by members on a routine basis***

Allwell from Arizona Complete Health Vice President of Network Development & Contracting and Compliance Officer are responsible for the oversight of the health plan Medicare MOC training for network providers and out-of-network providers seen by members on a routine basis.

Training methods – Allwell from Arizona Complete Health uses a variety of training and communication methods via multiple modalities to conduct MOC training including, but not limited to the following:

- Initial review of MOC and Medicare Fraud, Waste & Abuse training requirements during the face-to-face provider orientation conducted by Allwell from Arizona Complete Health staff
- Online webinar training
  - Provider completes attestation that Allwell from Arizona Complete Health utilizes to monitor and track provider training
- Given our wide geographic area and sheer volume of providers, print materials are critical to MOC education. Consequently, we use mailing services to send updates and annual reminders to providers. For example, annually, we post an article in the provider newsletter explaining that the MOC training is available on our website and encourage participation. More general information, such as articles about facilitating members' transitions between care settings or other information about MOC elements are included in provider newsletters and other self-study documents.
- Care Management staff disseminate information verbally or in writing on an ongoing basis about the MOC as it applies to specific members. This method is most often used with non-contracted providers seeing individual members. All CM/CC-to-provider communication is documented in the members' patient records in our clinical documentation system.
- Additionally, Allwell from Arizona Complete Health utilizes various methods to communicate updates and changes to our providers:
  - The Provider Contracting and Provider Relations representatives conduct regular meetings with our hospitals, health systems, and large medical groups, Patient Centered Medical Homes, Physician Hospital Organizations and Independent Practice Associations to review network updates and changes and reinforce training on the D-SNP MOC.
  - Information related to the MOC is included in the Provider Manual on the provider site of the Allwell from Arizona Complete Health website.

Training content includes pertinent information, such as our overall care management model, transition of care notice requirements, medication reconciliation monitoring, how to contact care management, etc.

Example of Provider MOC Training Materials: Please reference MOC 2

## ***2. Documenting MOC training.***

All MOC training for providers are tracked via provider attestation submission. This documentation enables Allwell from Arizona Complete Health to track MOC training for providers.

## ***3. Explaining challenges associated with the completion of MOC training for network providers.***

There are a number of challenges associated with completing MOC training for network and out-of-network providers that include the following:

- Providers lack time to complete MOC training due to the demands of patient care
- Providers are asked to complete MOC training from multiple managed care plans resulting in lost productivity and duplication of effort
- Providers have variable MOC knowledge. Newly participating providers may benefit from the training whereas an established network provider may be very familiar with the various Allwell from Arizona Complete Health clinical programs and care management processes detailed in the MOC
- Out-of-network providers have no contractual responsibility to complete MOC training

## ***4. Actions taken when the required MOC training is deficient or has not been completed.***

If a provider fails to support Allwell from Arizona Complete Health model of care training, Provider Contracting and Provider Relations representative's follow-up with the provider on an individual basis and provide the necessary education. If the provider education related to the MOC is found to be deficient by a CM during a routine contact, the CM addresses those deficiencies and conducts a quick refresher while he/she is talking to the provider and documents such education on the member record. The CM forwards such information to the Provider Relations team.

In serious non-compliance cases, Allwell from Arizona Complete Health may pursue contractual options up to, and including, termination.

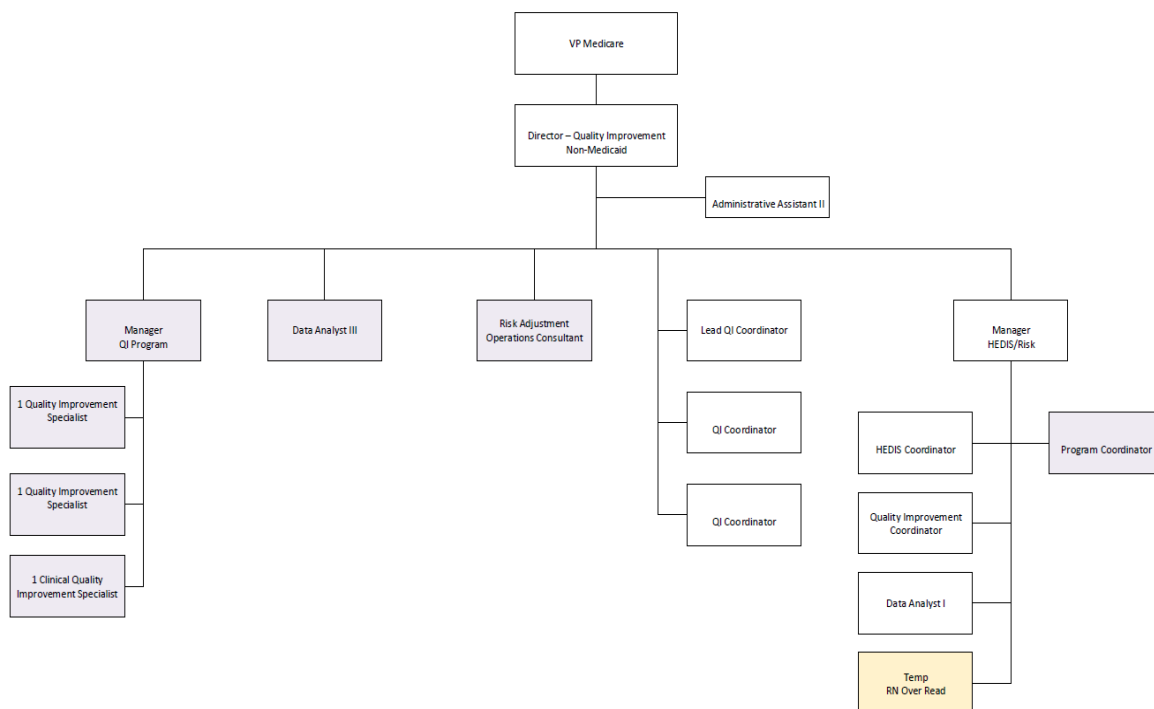


## MOC 4: MOC Quality Measurement and Performance Improvement

### Element A: Quality Performance Improvement Plan

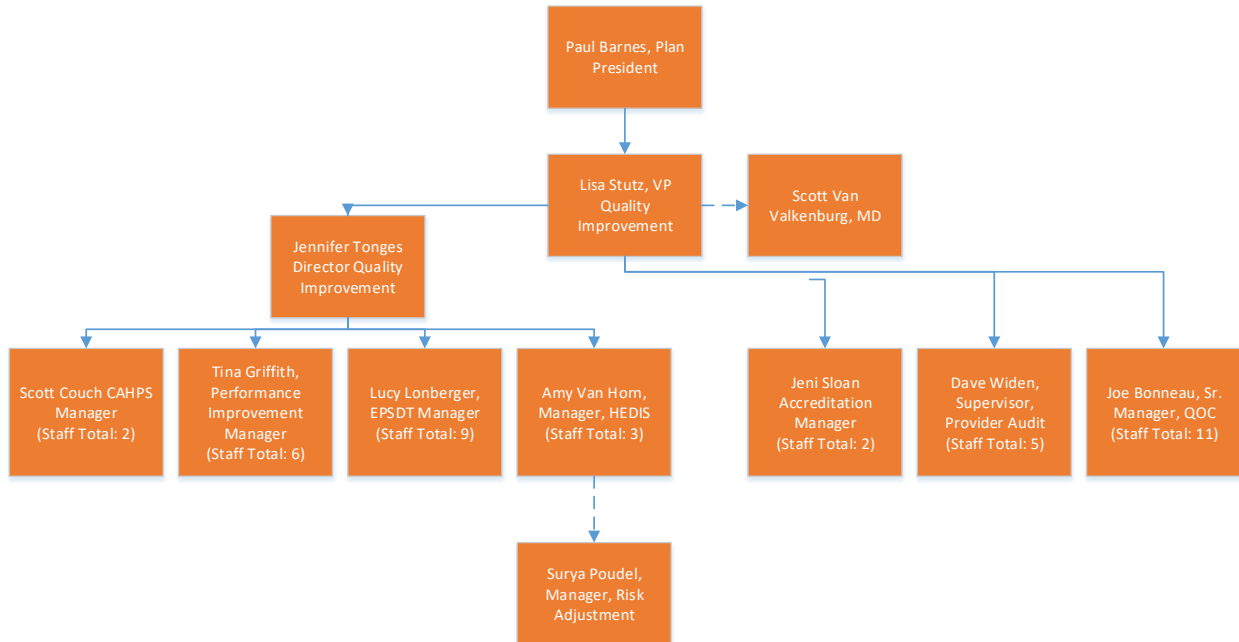
***1. Overall quality improvement plan and how the organization delivers/provides for appropriate services to D-SNP members, based on their unique needs.***

Continuous Quality Improvement (CQI) is Allwell from Arizona Complete Health core business strategy. Our primary goals are to maintain and improve our members' health, functional status, and quality of life, as well as to prevent deterioration. As such, Allwell from Arizona Complete Health has built a Culture of Quality and Service Excellence focused on achieving the "Triple Aim": simultaneously improving the well-being of our members, enhancing members' and informal caregivers' experience of care and service, and lowering the per capita cost of their health care and services. The organizational chart below is the Quality Improvement team managing this D-SNP plan.





## Allwell from Arizona Complete Health Quality Improvement Organizational Chart



### Quality Improvement Process

On a regular basis, our Senior Leadership Team (SLT) uses data-driven decision-making methodologies and demonstrates, by their own example, the value and applicability of improvement methodologies. The SLT is intimately involved in and accountable for our Quality Improvement Program (QIP). Every employee in the organization is an advocate for quality regardless of their specific job function and have performance goals related to organizational quality improvement as part of their individual performance management plans.

For each aim, Allwell from Arizona Complete Health identifies appropriate interventions and outcome measures that are included in our Quality Improvement Program and Program Evaluation.

Our SLT serves as QI Champions and drives our strategic planning process to set up annual QIP goals. The SLT conducts a comprehensive analysis of demographic and epidemiological data from our members, historical data, prior year's QIP evaluation results, and qualitative information about external environmental factors such as economic, technological and social ones. Allwell from Arizona Complete Health consults with members and community stakeholders to confirm that the goals and strategies set forth for the dual SNP QIP are in alignment with the physical, behavioral, functional and social needs of our members.

Allwell from Arizona Complete Health understands the importance of the continuous measurement of the quality and appropriateness of care and services that our members receive. Thus, the Arizona Stars Workgroup operationalizes the identification of improvement opportunities and specific objectives, and the selection and implementation of improvement activities. The Arizona Stars Workgroup meets monthly and includes cross-functional leaders



(e.g., Compliance, Member Services, Utilization Management, Contracting, Provider Services, Medical Management, Quality Improvement), as well as employees who conduct or directly supervise the day-to-day activities related to clinical and operational improvement initiatives. A primary responsibility of the Arizona Stars Workgroup is to ensure that Allwell from Arizona Complete Health complies with, and achieves optimal performance on all required and identified performance measures

In addition, Allwell from Arizona Complete Health with the support of the SLT, and the Arizona Stars Workgroup continuously monitors claims and other available data for cost and quality variance that may indicate unusual practice or service patterns, aberrant coding or billing. Arizona Stars Workgroup staff initiate trials of process changes targeting identified issues related to member's care or services and hand-off successful interventions to them for ongoing control of these programs.

#### Attention to D-SNP appropriate services

The Arizona Stars Workgroup gives focused attention to potential barriers members may experience, such as the lack of accessible care (e.g. accessible exam rooms and exam tables), the availability of care and services (e.g. behavioral health professionals, radiology centers, appropriate transportation), the lack of information provided in a manner that meets their unique needs (e.g., materials in large print or braille, or in translation) and the respect of cultural health beliefs. The Arizona Stars Workgroup then develops processes to eliminate those barriers, whether there are related to Allwell from Arizona Complete Health internal processes, to external factors either due to geography, the network or the member him/herself. Allwell from Arizona Complete Health thus ensures that all dual members receive the right care and services that they need, at the right time, in the right setting, and that the severity of their conditions are addressed.

### ***2. Specific performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance***

Allwell from Arizona Complete Health uses a wide range of data and our sophisticated analysis and reporting capabilities available through Centelligence™, our data integration, decision support, and health care informatics solution that facilitates our analysis by receiving, integrating, and continually analyzing transactional data. Centelligence™ provides expansive intelligence support with “drill down” capability, and the predictive modeling capability to determine the predicted risk for members for utilizing future health care services.

#### Data sources

The following sources will be utilized to collect and analyze data as part of the annual evaluation of the SNP Model of Care to evaluate outcomes in each of the domains as specified in 422.152(g)(2)(i)-(x) of the Code of Federal Regulations (CFR):



- **Health Outcomes And Use Of Evidence Based Practices** – Health Care Effectiveness Data and Information Set (HEDIS®) measures, including utilization metrics for inpatient, emergency and readmission
- **Access to Care** – member medical and behavioral health surveys, appeals and grievances re: access, monitoring of provider network, utilization metrics, HEDIS® preventive care metrics
- **Improvement in Health Status** – related HEDIS® measures, responses to HRA questions re: health status, pain, functional status, self-management
- **Implementation of Model of Care** – process reports from medical and behavioral health case management and delegation oversight
- **Health Risk Assessment** – initial and annual completion rates
- **Implementation of Care Plan** – audits of case management records and Care of Older Adults (COA) HEDIS® measure
- **Specialized Provider Network** – delegation oversight audits, availability of providers and facilities including behavioral health providers and specialists, member surveys, HEDIS® clinical measures
- **Continuum of Care** – related HEDIS® measures such as Medication Reconciliation, Plan All Cause Readmissions and Follow up after Hospitalization for Mental Illness and response to HRA question regarding transitions
- **Delivery of Extra Services** – utilization for transportation, Decision Power, Complex Case Management, Medication Therapy Management program, dental and vision benefits
- **Integrated Communications** – Customer Call Center (service level, abandonment rate), satisfaction survey

Allwell from Arizona Complete Health collaborates with the Centene Corporate IT team, who loads new claims data and updates provider and member information into the data warehouse/data integration platform at least weekly or more frequently as required by the business needs. The IT team ensures data are normalized, scrubbed and validated for accuracy and, with the support of the Reporting team, reviews data for accuracy, completeness, logic, and consistency. Data received from vendors are reviewed and historical files are compared to verify the accuracy of reporting or transmissions. Deficiencies identified in reported data are addressed through provider education, or other corrective action processes.

Allwell from Arizona Complete Health uses Centelligence™, a comprehensive family of integrated decision support and health care informatics solutions, to support quality performance. The Centelligence™ enterprise platform integrates data from multiple sources, and provides actionable population and member level information to the right person for the right task at the right time, with the ultimate goal of improving clinical, operational, and financial outcomes. Allwell from Arizona Complete Health D-SNP will focus on Diabetes, preventative care, medication adherence and improving member satisfaction.

Centene is in the process of developing an enhanced, comprehensive dashboard of performance measures for all Dual SNP plans. This dashboard includes MOC goals covering Care



Management, Service Coordination, Utilization, Cost of Care, Operations, Clinical Quality and Member Satisfaction. Allwell from Arizona Complete Health is able to select those MOC goals that best represent our D-SNP MOC population. The Arizona Stars Workgroup uses this data to assess performance on measures related to each goal, compare it to established benchmarks, and develop objectives and steps to achieve each goal. Benchmarks are established based on available state and national data, goals are determined based on internal objectives.

#### Performance and Outcome Measures

Allwell from Arizona Complete Health uses nationally recognized measures such as HEDIS, CAHPS, and AHRQ, as well as internally developed measures to monitor the effectiveness of the MOC. Data is reviewed at established intervals, presented to the QIC no less than quarterly and used to inform the annual evaluation of MOC effectiveness, which is submitted to the Board Of Directors (BOD).

The MOC goals and outcome measures that Allwell from Arizona Complete Health uses to monitor and assess the quality of care and services provided to our members may include, but are not limited to the following:

Measures monitored specifically for the D-SNP population are bolded below.

- Physical and Behavioral Health
- HEDIS®
- Assessment of BMI
- Colorectal cancer screening
- Breast cancer screening
- **Persistence of beta-blocker treatment after a heart attack**
- **Pharmacological management of COPD exacerbation**
- **Controlling high blood pressure**
- **Diabetes management**
- Osteoporosis management in women who had a fracture
- Antidepressant medication management
- Follow-up after hospitalization for mental illness
- Screening for clinical depression
- **Medication reconciliation post-discharge**
- Use of high risk medication in the elderly
- Potentially harmful drug-disease interaction in the elderly
- **Care for older adults**
- Advanced care planning
- Medication review
- Functional status assessment
- Pain assessment
- **Plan all cause readmissions**
- **Pneumococcal vaccination (CAHPS)**





- **Flu vaccine (CAHPS)**
- Medical assistance with smoking cessation (CAHPS)
- Managing urinary incontinence (HOS)
- **Reducing the risk of falls (HOS)**
- **Improving or maintaining physical health (HOS)**
- **Improving or maintaining mental health (HOS)**

#### Agency for Healthcare Research and Quality – Preventive Quality Indicators

- Diabetes short-term and long-term complications – admission rate
- Uncontrolled diabetes – admission rate
- COPD or Asthma in older adults – admission rate
- Hypertension – admission rate
- CHF – admission rate
- Dehydration – admission rate
- Bacterial pneumonia – admission rate
- UTI – admission rate
- Angina without procedure – admission rate
- Rate of lower extremity amputation among patients with diabetes – admission rate

#### Utilization measures

- Hospitalization rates (medical and mental health)
- ED utilization rates (medical and mental health)
- 30-day readmission rate (medical)
- SNF readmission rate

#### Care Management/Care Coordination

Percent of Members with the following:

- Completed HRA within 90 days of enrollment
- Completed annual HRA
- Developed ICP within 30 days of the initial comprehensive assessment
- Utilization of choice/interest in the composition of their ICP
- Identified PCP
- Transition in care
- Transition of care/were discharged and were contacted by their CM/CC within 72 hours
- Discharged from the hospital and had a medication reconciliation completed

#### Operations measures

- Grievances rate
- Quality of care complaints rate
- Appeals rate
- Percent of fully/partially favorable appeals



- Percent of upheld appeals
- Percent of overturned appeals by IRE
- Percent of claims paid within 30 days
- Percent of claims paid within 60 days
- Percent of calls answered within 30 seconds (Member Services)

#### Satisfaction measures

- CAHPS composite scores

Allwell from Arizona Complete Health monitors the performance results of these measures and report on them at the Stars Workgroup meeting where the current initiatives are discussed and adjusted based on root cause analysis.

### ***3. Involving leadership, management groups, other D-SNP personnel and stakeholders in the internal quality performance process***

Allwell from Arizona Complete Health Board of Directors has delegated decision-making authority for the quality improvement program to the Quality Improvement Committee (QIC). The QIC provides reports to the Board of Directors on activities, findings, recommendation, actions and results on a scheduled basis and no less than once a year. Plan leadership are included on committees, while all leadership, management and individual personnel have quality metrics for which they are responsible. We communicate results of quality metrics to all staff and make the results of the Quality Improvement Program available to providers, members and other stakeholders.

The QIC coordinates the activities of all subcommittees, oversees the strategic planning process by the Senior Leadership Team (SLT) to establish annual MOC program goals, and approves the annual MOC program evaluation.

Subcommittees include, but are not limited to the following:

- Medical Management Committee
- P & T Committee
- Credentialing Committee
- Stars/HEDIS Committees
- Vendor Management Oversight Committee

The QIC involves Leadership, Management Groups, and other D-SNP personnel. Leadership, management, and individual personnel has quality metrics for which they are responsible and results are communicated to all personnel. The QIC also shares results with, providers and stakeholders (see table in Element E).



The QIC reviews all reports presented by the Arizona Stars Workgroup including the MOC Work Plan, prioritize identified initiatives focusing on those with the greatest need or expected impact on health outcomes, service performance and member satisfaction. Performance improvement projects, focus studies, and other QI initiatives are designed to achieve and sustain significant improvement over time in clinical and non-clinical care and service areas in accordance with principles of sound research design and appropriate statistical analysis.

The Arizona Stars Workgroup determines whether current interventions are effective and should therefore be continued, modified or discontinued and will present such reports to the QIC for review and final approval. Data is re-measured at least quarterly to monitor progress and make changes to interventions as indicated. Once a best practice is identified, process control reports will be implemented to monitor for changes in the process and need for re-intervention.

The QIC is chaired by the Allwell from Arizona Complete Health Chief Medical Officer (who may delegate such functions to the Quality Director or designee) who provides overall direction and support to the Quality program and is responsible for the oversight of all clinical and service quality improvement operations initiatives. Other members of the QIC are leaders from the Quality Management, Medical Management, Member/Provider Services, Network Management/Contracting, Behavioral Health, Pharmacy Services and other internal staff members whose roles are essential in supporting the MOC.

Representatives from our community actively participate as members of the Allwell from Arizona Complete Health Board of Directors where their specific needs, cultural characteristics and personal views are key to our ability to achieve the Triple Aim.

All QIC members are appointed for one year, but can continue to serve after the first year; the QIC meets no less than quarterly.

#### ***4. Integrating D-SNP-specific measurable goals and health outcomes objectives in the overall performance improvement plan***

As noted above, Allwell from Arizona Complete Health overarching quality goal is to achieve the Triple Aim of simultaneously improving the wellbeing of our members, enhance members' and caregivers' satisfaction with their experience of care and services, and lower the cost of care. We collect and analyze data to determine where the problems are, design and implement interventions and measure outcomes.

Numerous performance and outcome measures selected to monitor and evaluate the MOC are utilized to monitor the quality of care and services among Medicaid and Medicare members and the process for continuous quality improvement is built into all operations.

The QIC agenda, on a regular basis, includes a section dedicated to the MOC performance measurement goals, where current status of MOC goals, trends over time and implemented



and/or proposed interventions is presented and discussed. The annual evaluation includes a summary of all MOC activities, the impact the program has had on members' care, services and satisfaction, an analysis of the achievement of stated goals and objectives, barriers to achieving such goals and objectives, trended data (as available), the need for program revisions and modifications and “lessons learned.” The MOC program evaluation is shared with the Board of Directors for final approval. The findings of the annual MOC program evaluation are used by the SLT to develop the annual MOC Program and Work Plan for the subsequent year. This process allows for a more dynamic, efficient and effective way of regular monitoring of the MOC performance.

## **Element B: Measureable Goals and Health Outcomes for the MOC**

### ***1. Measurable goals and health outcomes used to improve the health care needs of D-SNP Members.***

The success of improving a member’s health and the effectiveness of the MOC is measured through the evaluation of measurable outcomes associated with HEDIS, CAHPS, and AHRQ measures, as well as through, at a minimum, the 7 goals indicated below:

- Assure Access to Medical, Mental Health and Social Services
- Provide Access to Affordable Care
- Improve Coordination of Care through an Identified point of Contact
- Assure Seamless Transitions of Care across Healthcare Setting, Providers and Health Services
- Improve Access and Utilization of Preventive Services
- Improve Appropriate Utilization of Services for Chronic Conditions
- Improve Experiences of Care

The selection of benchmarks/goals has been based on (i) Medicare 2016 Part C and D Star Rating Technical Notes – 9/30/2015; (ii) CMS contractual requirements; (iii) internally developed goals and measures. Timelines have been selected based on availability of fully certified reported data and/or availability of data. All of these 7 goals are geared towards achieving the “Triple Aim” of simultaneously improving the wellbeing of our members, enhancing our members’ experience of care and services and lowering the cost of their health care and services.



## 2. *Specific member health outcome measures used to measure overall D-SNP population health outcomes at the plan level*

### Assure Access to Medical, Mental Health, and Social Services

As part of the annual SNP evaluation, data is collected from HEDIS®, CAHPS®, surveys, HRA, audits, appeals and grievance, utilization, customer service and other sources for a comprehensive set of metrics in each healthcare domain. Outcomes are compared to applicable and available benchmarks from internal and external sources such as NCQA, CMS, Medicare Advantage and SNP member data. A subset of metrics is identified for each of the program objectives that are relevant to the SNP population and re-evaluated each year. Measureable goals are determined on baseline performance and reference values within a certain timeframe (Table 4.1). The current Star cut-points and CMS National Part C Average are utilized as goals when applicable. Results will be compared year to year and to measure specific benchmarks that are available. With the goal of obtaining 4 Star rating within the next three years.

The table below identifies goals by focus area. Each goal includes relevant data sources, methodology, targets, and monitoring.

Focus:	Ensure Access to Medical, Mental Health, and Social Services	
MOC Goal	CAHPS Getting Needed Care	CAHPS Getting Care Quickly
Data Source	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
Methodology	i. In the last 6 months, how often was it easy to get appointments with specialists? ii. In the last 6 months, how often was it easy to get the care, tests or treatment you needed through your health plan?	i. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? ii. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? iii. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Target	Meet or exceed the CAHPS Getting Needed Care (Star C202) measure 4 Star benchmark, which is $\geq 84\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.	Meet or exceed the CAHPS Getting Care Quickly (Star C213) measure 34 Star benchmark, or $\geq 79\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.



Comments	The baseline measurement will reflect calendar year 2018 activity. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	The baseline measurement will reflect calendar year 2018 activity. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.
<b>Focus:</b>	<b>Provide Access to Affordable Care</b>	
MOC Goal	Adults' Access to Preventive/Ambulatory Health Services	
Data Source	Healthcare Effectiveness Data and Information Set (HEDIS)	
Methodology	i. The HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP) measure assesses the percentage of enrollees 20 years and older who had an ambulatory or preventive care visit during the measurement year. Without a visit with a medical care provider, enrollees do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. A low rate indicates there may be systemic barriers to access that need to be addressed.	
Target	Meet or exceed the 2017 NCQA Medicare Quality Compass National HMO Average 75th percentile for the CMS National Average for the HEDIS measure AAP (Total).	
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	
Comments	The baseline measurement will reflect calendar year 2018 activity. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	
<b>Focus:</b>	<b>Improve Coordination of Care through an Identified Point of Contact</b>	
MOC Goal	CAHPS Care Coordination	
Data Source	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys	
Methodology	i. In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? ii. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? iii. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? iv. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? v. In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? vi. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	
Target	Meet or exceed the CAHPS Care Coordination (Star C257) measure 4 Star benchmark, $\geq$ 87%, based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.	
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	



Comments	The baseline measurement will reflect calendar year 2018 activity. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	
<b>Focus:</b>	<b>Ensure Seamless Transitions of Care across Healthcare Settings, Providers and Health Services</b>	
MOC Goal	Plan All-Cause Readmissions	Medication Reconciliation Post-Discharge
Data Source	Healthcare Effectiveness Data and Information Set (HEDIS)	Healthcare Effectiveness Data and Information Set (HEDIS)
Methodology	i. The HEDIS Plan All-Cause Readmission (PCR) measure assesses the number of acute inpatient stays during the year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for enrollees 18 years of age and older.	i. The HEDIS Medication Reconciliation Post-Discharge (MRP) (Star C20) measure assesses the percentage of discharges for enrollees 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge.
Target	Meet or exceed the HEDIS Plan All-Cause Readmission (PCR) (Star C19) measure 4 Star benchmark, $\leq 9\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.	Meet or exceed the HEDIS Medication Reconciliation Post-Discharge (MRP) (Star C20) measure 4 Star benchmark, $\geq 55\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.
Comments	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	The baseline measurement reflects performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.
<b>Focus:</b>	<b>Ensure Seamless Transitions of Care across Healthcare Settings, Providers and Health Services (Cont.)</b>	
MOC Goal	Breast Cancer Screening	Colorectal Cancer Screening
Data Source	Healthcare Effectiveness Data and Information Set (HEDIS)	Healthcare Effectiveness Data and Information Set (HEDIS)
Methodology	i. The HEDIS Breast Cancer Screening (BCS) measure assesses the percentage of women 52 to 74 years of age who had a mammogram to screen for breast cancer.	i. The HEDIS Colorectal Cancer Screening (COL) measure assesses the percentage of enrollees 50 to 75 years of age who had appropriate screening for colorectal cancer.





Target	Meet or exceed the HEDIS Breast Cancer Screening (BCS) (StarC01) measure 4 Star benchmark, which is $\geq 78\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points	Meet or exceed the HEDIS Colorectal Cancer Screening (COL) (Star C02) measure 4 Star benchmark, which is $\geq 72\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points 2017 RY cut points
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.
Comments	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.
<b>Focus:</b>	<b>Ensure Seamless Transitions of Care across Healthcare Settings, Providers and Health Services (Cont.)</b>	
MOC Goal	Annual Flu Vaccine	
Data Source	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys	
Methodology	i. The Annual Flu Vaccine measure evaluates the percent of plan enrollees who received an influenza vaccine prior to flu season. This measure asks the following question. ii. Have you had a flu shot since July 1, of the prior year	
Target	Meet or exceed the <i>CAHPS Annual Flu Vaccine</i> (Star C03) measure 4 Star benchmark, which is $\geq 74\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points	
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	
Comments	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	
<b>Focus:</b>	<b>Improve Appropriate Utilization of Services for Chronic Conditions</b>	
MOC Goal	Hospitalization for Potentially Preventable Complications	
Data Source	Healthcare Effectiveness Data and Information Set (HEDIS)	
Methodology	i. The HEDIS Hospitalization for Potentially Preventable Complications (HPC) measure assesses the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 enrollees and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions, for enrollees 67 years of age and older.	
Target	Meet or exceed the HEDIS Hospitalization for Potentially Preventable Complications (HPC) (Star DMC24) measure 4 benchmark national average, $\leq 43\%$ based on the most current Medicare Star Display Ratings Technical Notes	
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	



Comments	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	
<b>Focus:</b>	<b>Improve Experience of Care</b>	
MOC Goal	Improving or Maintaining Mental Health	Improving or Maintaining Physical Health
Data Source	Health Outcomes Survey (HOS)	Health Outcomes Survey (HOS)
Methodology	i. This measure evaluates the mental health of enrollees using a core set of survey questions from the Veterans RAND 12-Item Health Survey (VR-12). It is suitable for self-administration and has been successfully administered to older populations with specific diseases, with a high degree of member acceptability and data quality.	i. This measure evaluates the physical health of enrollees using a core set of survey questions from the Veterans RAND 12-Item Health Survey (VR-12). It is suitable for self-administration and has been successfully administered to older populations with specific diseases, with a high degree of patient acceptability and data quality.
Target	Meet or exceed the HOS Improving or Maintaining Mental Health (Star C05) measure 4 Star benchmark, which is $\geq 84\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.	Meet or exceed the HOS Improving or Maintaining Physical Health (Star C04) measure 4 Star benchmark, which is $\geq 69\%$ , based on the most current Medicare Part C & D Star Ratings Technical Notes rating year (RY) cut points.
Monitoring	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.	Monthly, quarterly and yearly reporting is monitored to ensure if progress is being made or a correction is necessary.
Comments	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.	The baseline measurement will reflect performance for calendar year 2018. Taking into account the timing and availability of fully certified reporting, the timeframe to achieve this goal is within the next three years, by the end of calendar year 2021.

### ***3. How the D-SNP establishes methods to assess and track the MOC's impact on D-SNP health outcomes.***

Relevant measures are selected that will have an impact on the health outcomes of D-SNP members, such as improvement in cardiovascular and diabetic health outcomes, preventive care and coordination of care. Allwell from Arizona Complete Health has established processes and contracts with vendors when appropriate to collect D-SNP health outcome data through HEDIS® and annual HRAs, member experience and access to care through CAHPS® and internal surveys, and data from provider network, delegation oversight, utilization of services, customer service, 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 monthly, quarterly or annually as with HEDIS® and CAHPS®. Medicare rates, of which D-SNP is a subset, for select HEDIS® measures are also reported to providers monthly for more current monitoring of performance.

The D-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 D-SNP MOC. Annual data and progress towards goals is collected, analyzed and reported to the QIC and stakeholders. Electronic and print copies of the evaluation of the D-SNP Model of Care are prepared annually, reported to the QIC and as requested, to 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.

#### ***4. Processes and procedures the D-SNP uses to determine if health outcome goals are met.***

Allwell from Arizona Complete Health develops a specific MOC Quality Work Plan to monitor and assess the progress of the MOC and all identified outcome metrics related to the 7 major goals. The work plan is a dynamic document that reflects quarterly ongoing progress on outcomes. The work plan is approved yearly by the QIC and monitored quarterly. It includes the following:

- Planned activities for improving quality and safety of care, quality of service, and member experience
- Timeframes
- Departmental leaders responsible for the activities
- Results/Analysis

The QIC identifies the activities for improvement based on the Institute of Healthcare Improvement model that starts with the following three questions:

- Setting aims: What are we trying to accomplish?
- Establishing measures: How do we know that a change is an improvement?
- Selecting changes: What changes can we make that will result in an improvement? In order to determine those changes a thorough root-cause analysis is conducted.

The Arizona Stars Workgroup continuously monitors all MOC goals and, in particular, the MOC specific outcome measures. They do so by the following:

- Identifying the appropriate population based on age, gender, date of enrollment, diagnosis, health care and risk status
- Identifying the appropriate time period i.e. last month, last 3-6 months, and
- Calculating rates by utilizing:
  - Centelligence™ to run queries based on claims
  - Monthly audit reports
  - Customer Relationship Module to assess grievances



- QSI-XL to obtain intermediate HEDIS measures
- In-house survey results and other proxies to monitor member satisfaction

#### Meeting health outcomes goals

MOC specific outcome measures are tracked and trended against benchmarks to determine if the selected and implemented interventions by the Arizona Stars Workgroup are rendering the desired outcome and if benchmarks are achieved. Results of the analysis are compared to benchmarks/goals by utilizing statistical tests of significant difference. The following situations are encountered when comparing performance against goals or benchmarks:

- The goal/benchmark is not reached and the trend is either on the negative direction or remains flat
- The intervention is ineffective, or
- The intervention requires more time (in the case of a flat trend)
- The goal/benchmark is not reached and the trend is in the positive direction
- The intervention requires more time in order to reach desired outcome
- The goal/benchmark is reached or exceeded
- The intervention has been successful

Based on results, the Arizona Stars Workgroup initiates processes for enhancing or modifying interventions. By reviewing and updating the work plan at least quarterly, it provides the Arizona Stars Workgroup with the opportunity to develop new interventions and change the course of action before the annual assessment must be completed.

#### ***5. Steps the D-SNP takes if goals are not met in the expected timeframe.***

Allwell from Arizona Complete Health Senior Leadership Team (SLT) reviews all metrics against the established performance goals or benchmarks. In the event that desired outcomes or benchmarks are not achieved in the established time periods of 6 months, 1 year or 2 – 3 years, they ask the Arizona Stars Workgroup to conduct a barrier analysis and develop a strategy to meet the goals. The steps in the process are the following:

- Identify the barriers that impeded the ability to meet the objective
- Determine strategies for overcoming the barriers
- Establish a plan for implementing the strategies, including specific action items and timeliness
- Implement the plan
- Re-measure

This process is documented in the annual MOC program evaluation that is presented to QIC for review, recommendation and approval and the Board of Directors.



## **Element C: Measuring Patient Experience of Care (D-SNP Member Satisfaction)**

### ***1. Specific survey used: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)***

#### **CAHPS®.**

Allwell from Arizona Complete Health conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey every year to determine the level of members' satisfaction with Allwell from Arizona Complete Health Customer Services, access to care, provider communication, coordination of care, as well as pharmacy services. The CAHPS® survey responses are used to identify areas of member experience in need of improvement.

#### **Methodology:**

- Allwell from Arizona Complete Health follows NCQA methodology of selection of a random sample of 600 and up to 1,040 D-SNP members by an NCQA certified survey vendor
- Survey is conducted between February and May every year
- Official results are available in September

#### **Measures to be considered:**

- Overall rates: Rate of Healthcare Quality, Rate of Drug Plan, Rate of PCP, Rate of Specialist seen more often – represents an evaluation of the care the member receives which is a reflection of the performance of the Care Management team, Transitions in Care and physician members of the ICT, as well as the access to services.
- Composite scores:
  - Customer Services and How Well Doctors Communicate - measures of effective service and communication provided by our Customer Services and the provider network
  - Getting Care Quickly and Getting Needed Care - measures that reflect the access to services, which represents an evaluation of the Care Management team and its effectiveness in setting up appointments and follow-up visits
  - Care Coordination - a measure of the clinical skills and cultural competency of our network
- Individual questions: the individual questions allow for the specific drill down within each composite score

### ***2. Why we selected this tool***

Our goal is to collect, analyze and use as much information as possible to inform our quality improvement process as we strive to achieve the Triple Aim. The CAHPS® survey ensures use of standardized measures with a clear score value that allows for easy tracking over time. CMS



cut-points and NCQA Quality Compass percentile rankings provide Allwell from Arizona Complete Health with benchmarks for comparison and goal-setting.

### ***3. How results of patient experience surveys are integrated into the overall MOC performance improvement plan***

Allwell from Arizona Complete Health monitors member satisfaction through CAHPS®, which is done annually, and the quarterly analysis of member grievances.

Member satisfaction is an important component of our performance improvement plan. It represents the members' perception of the care and services they receive. Based on that perception, as long as it is positive, the member is more likely to comply with a given treatment and/or appointments, thus avoiding unnecessary hospitalizations, and have an overall personal feeling of wellbeing.

For example, if the member is satisfied with the CM/CC and the way the CM/CC interact with them, the member is more likely to follow recommendations. A CM/CC empowers the member to engage in an active role in their care, and facilitates access to providers and home and community based resources, services and supports, hopefully improving member satisfaction with their ICP and CM/CC, and ultimately with Allwell from Arizona Complete Health.

Member satisfaction with Care Management and Allwell from Arizona Complete Health is a reflection of the MOC goals of:

- Improved access
- Improved access to preventive health
- Improved access to home and community services
- Improved coordination
- Improved transitions of care
- Improved health outcomes

Member satisfaction is reflected in the achievement of five of our measurable goals since a satisfied member is more likely to be compliant with treatments that are going to keep them out of the hospital and have a perception that their quality of life has improved or at least stayed the same over time.

### ***4. Steps to be taken to address issues identified in surveys***

#### **Steps to address identified issues**

Results from the CAHPS® survey are analyzed by comparing to regional benchmarks. Any measure at or below the 50th percentile of the distribution is submitted to the Quality Improvement Committee (QIC) in order to understand and identify root causes for dissatisfaction.



To complete the picture of member satisfaction, member grievances will be analyzed in order to identify particular patterns in association with survey results. The grievances will be reviewed monthly and analyzed for trends. When trends are identified, they are reviewed by the Stars workgroup for a root cause and process for improvement. The QIC provides recommendations to the Senior Leadership Team and the QIC and, upon approval, initiates implementation of corrective actions. Those corrective actions are monitored mainly through analysis of members' grievances and existing surveys.

## **Element D: Ongoing Performance Improvement Evaluation of the MOC**

Allwell from Arizona Complete Health Quality Improvement, Operations and Medical Management, Departments, represented through the Senior Leadership Team (SLT), is responsible for the ongoing monitoring and evaluation of the MOC performance improvement program. Detailed processes and methodologies are utilized for the ongoing monitoring and evaluation of the MOC.

### ***1. How the D-SNP uses the results of the quality performance indicators and measures to support ongoing improvement of the MOC.***

#### Ongoing Improvement

With the support of the SLT, selected interventions are implemented and MOC goals continue to be monitored by the Arizona Stars Workgroup. After sufficient time has elapsed since implementation of an intervention, for example: (a) if we encourage diabetic members via phone to get an eye exam, we would likely re-measure 3-6 months later, whereas (b) if we work with providers that are non-compliant with appointment availability, we would likely re-measure 6-12 months later; or the MOC goal is due for assessment, a re-measurement will take place and an analysis of change and/or trend will be carried out via statistical procedures. This analysis is shared with the QIC, which determines the steps to follow based on the findings.

Several outcomes are possible below:

- There is no change, thus no improvement, which may be indicative that either:
  - Not enough time has elapsed to register change and the indicator needs to continue to be monitored;
  - The intervention is not working;
- There has been a change in the wrong direction, and then the intervention(s) and the barrier need to be re-evaluated. Either the intervention is ineffective, or not appropriate, provided that enough time has elapsed to assert change, and the intervention may need to be suspended; or
- There has been a change in the desired direction, which leads to a continuation of the intervention(s).

In any case of an observed improvement, whether the goal or benchmark is met or there is a positive trend, we try to isolate the activity/intervention that created that change using time of





implementation and controlling for environmental factors. Sometimes it is not a single intervention but a combination of interventions and other factors. All the components of this analysis of changes constitute our “lessons learned”.

## ***2. How the D-SNP uses the results of the quality performance indicators and measures to continually assess and evaluate quality.***

### Continuous Assessment

The Arizona Stars Workgroup and QIC utilizes a dashboard developed by Centene, and adjusted according to Allwell from Arizona Complete Health population and programs, which covers the care and services provided to our D-SNP members. This dashboard includes MOC goals covering Care Management, Utilization Management, Operations, Service Coordination, Clinical Quality, Member Satisfaction, and Network Management. Those MOC goals are objective, measurable, based on current scientific knowledge and clinical expertise, broadly recognized in the industry and are structured to produce statistically valid performance measures of care and services provided. Each MOC goal has industry benchmarks or internally developed goals against which performance is measured.

The Arizona Stars Workgroup, with support of the IT Department, runs queries in Centelligence™, TruCare, and QSI, conducts chart audits, and utilizes other data sources to clearly identify:

- Proper population or sample to be considered based on age, gender, enrollment date, ethnicity, medical condition, etc.
- Time period that the query or analysis must cover
- Data sources, specifications, codes, algorithms to be selected.

Once the outcomes for all or a group of MOC goals are obtained, results are compared to benchmarks and/or goals. Analysis of change and trending are conducted and when possible statistical tests are run to assess significance. The frequency of this process is dependent on the nature of the individual MOC goals. It may be run weekly as MOC goals relate to claims performance or authorizations; monthly as they relate to Care Management and utilization of services measures, quarterly as they relate to clinical outcomes such as HEDIS® measures or annually as it relates to some member satisfaction measures and provider geo-access.

Results of the analysis are shared with the Quality team, who in turn engages additional teams with expertise in specific areas. They review the results of the analysis and identify barriers through a root-cause analysis utilizing a set of tools such as Pareto Charts, Ishikawa Cause and Effect Diagram, and Process Mapping. Based on identified barriers, actions for improvement will be selected, and priorities will be set.

## ***3. Ensuring timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation***

### Reports and Monitoring



This analysis is reported quarterly to the QIC as part of the MOC work plan. It is the expectation of Allwell from Arizona Complete Health that the members of the QIC, which include senior leadership, providers, and community representatives, provide suggestions and approves necessary improvement activities. These quarterly reports are the source for the annual MOC effectiveness evaluation.

Through the production and presentation of quarterly reports to the QIC, Allwell from Arizona Complete Health creates a dynamic and rapid monitoring of the MOC performance without having to wait until the annual evaluation to determine what worked, what didn't work and what needs to be done next. The ongoing monitoring is critical to ensure that members are receiving the care and services they need and deserve, that they are satisfied, and their care is clinically appropriate and cost effective, with the ultimate goal of improving members' wellbeing and quality of life.

#### ***4. How the performance improvement evaluation of the MOC is documented and shared with key stakeholders***

Allwell from Arizona Complete Health shares the outcomes of our quality program, including evaluation of the effectiveness of our D-SNP Model of Care (MOC) with internal and external stakeholders. We have multiple ways we communicate these findings, including:

- Presentation at the Quality Improvement Committee (QIC)
- Notice to all Allwell from Arizona Complete Health employees via e-mail or intra-net, to our providers, members and caregivers, and general public through our web site and at member, Provider, and Community Advisory Committee meetings, and
- Articles in Allwell from Arizona Complete Health provider and member newsletter

The process for notification would be as follows:

1. Arizona Stars Workgroup and QIC communicate outcomes to the SLT
2. Once an improvement is identified and confirmed, and the intervention activity or activities are isolated, the SLT discusses a communication plan that will be developed and implemented. Depending on how widespread the work to achieve the improvement is (e.g. a large number of providers, agencies etc., vs. only internal staff, or all members vs. a specific subpopulation) the notification will involve more widespread public information as well as notice to the involved stakeholders

Examples could be an improvement in one of the MOC elements, such as expansion of needed specialties in the provider network, additional new services or benefits, increased access, new programs, or the development of specialized ICTs

Other examples could be improvement in a MOC performance measure and outcome, such as reductions in ED visits for our high risk members receiving intensive care management, improvement in one of the HEDIS® measures, or improvement in the quality of life of high risk members receiving LTSS services.



## Element E: Dissemination of D-SNP Quality Performance Related to the MOC

- 1. How performance results and other pertinent information are shared with multiple stakeholders*
- 2. Frequency of communications with stakeholders*
- 3. Methods for ad-hoc communication with stakeholders*
- 4. The individuals responsible for communicating performance updates in a timely manner*

The following table sets forth the process for sharing performance results with stakeholders, including the frequency and methods of such communication, and the individuals responsible for communicating the information:

Stakeholders Targeted for Dissemination of Quality Performance Information	Method and Frequency of Communication	Individuals Responsible for Communication Activities
D-SNP Leadership D-SNP Board of Directors D-SNP Management Groups D-SNP Personnel & Staff	On an annual basis, Allwell from Arizona Complete Health communicates the model of care standards and program and quality improvement performance results to all employees (including executive management and temporary employees), subcontractors, members of its Board of Directors, and other significant agents by requiring participation in training programs or disseminating publications that explain specific requirements in a practical manner.	Director, Medical Management Director, Quality
Cross-Functional QI Committee	The MOC work plan is presented to the QIC on a quarterly basis where major metrics are tracked and interventions proposed and/or described for QIC suggestions and approval. The Quality Improvement/Model of Care Plan evaluation is presented to the QIC annually for the QIC to determine if implemented initiatives to improve health outcomes were met. If goals are not met in the expected timeframe, the QIC re-evaluates the initiatives and identify additional opportunities for improvement and actions.	Director, Medical Management Director, Quality QIC
Regulatory Agencies	QI Program and Model of Care evaluations are reported as required to CMS, NCQA, and other regulatory entities. The timing and method of this reporting varies.	Director, Compliance



Members, Caregivers, & Providers	When requested or at least annually, Allwell from Arizona Complete Health provides information, including a description of the QI MOC Program and a report on progress in meeting QI Program goals, to members and providers. Examples of communication content includes information about QI Program goals, processes and outcomes as they relate to member care and services, plan/MOC specific data results such as HEDIS, CAHPS, and progress accomplished in the QIP and CCIP projects. Primary distribution sources include the member /provider newsletter, plan web site and direct mail. Information about how to obtain a hard copy description of the program is included on the web site, in the Member Handbook and Provider Manual.	Vice President, Medical Management Director, Medical Management Director, Quality
General Public	Information about the QI Program and Model of Care Plan is posted on our website.	Director, Medical Management Director, Quality
Ad-Hoc (non-calendared) Communication	Ad hoc day-to-day communications are done based on the particular needs of individual stakeholders. For example, care managers outreach to members regarding care gaps that tie to clinical goals in the MOC. This outreach is conducted via phone, mail, or other methods.	Care management staff Quality or utilization management staff Other Allwell from Arizona Complete Health staff