



IMPERIAL HEALTH PLAN
OF CALIFORNIA

SPECIAL NEEDS PLAN MODEL OF CARE 2023

Contract H5496

Imperial Health Plan H5496 C-SNP

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SUMMARY

Target Population

Imperial Health Plan of California C-SNP serves a target population of current SNP members in California: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura and Yolo county.

Imperial Health Plan intends to offer the C-SNP Plan in the following chronic conditions: Cardiovascular disorders including Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic disorder; Chronic Heart Failure; Hypertension; and Diabetes Mellitus. Imperial performs a population assessment to build a Model of Care that will best serve the needs of the members.

Provider Network

Imperial Health Plan contracts with a comprehensive network of facilities and providers to serve the needs of the dual population. Facilities within the network include but are not limited to acute hospitals, emergency facilities, diagnostic/surgery centers, skilled nursing, rehabilitation, and psychiatric centers. The provider network includes various PCPs and specialty providers in but not limited to Cardiology, Endocrinology, Nephrology, Neurology, Psychiatry, and Pulmonology.

Care Management and Coordination

The Initial Health Risk Assessment (HRA) is conducted within 90 days of enrollment, and an annual reassessment is conducted for each member within 365 days of the last assessment. In the event of a hospitalization or a change in health status, prescribed medications or utilization of services, reassessments occur more frequently. The initial health risk assessment (HRA) to members is conducted by phone, mail, or in-person if necessary. The standardized health risk assessment (HRA) questionnaire evaluates the physical, psychosocial, cognitive, and functional needs of the SNP members. In addition to the HRA, Imperial will be deploying a comprehensive risk assessment solution that will integrate claims, clinical and population data to comprehensively assess the risk of its SNP members. Thus, this 360-degree assessment provides the member's health status and acuity level,

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including both vulnerability/care gaps and resilience factors which, in turn, guides clinical interventions and the development of the individualized care plan (ICP). The case manager develops and discusses the ICP with the member and the interdisciplinary care team to ensure that the goals are agreed upon mutually. The interdisciplinary care team consists of but is not limited to Primary Care Physicians, Specialists, care managers, administrative management staff, community resource specialists, behavioral health specialists, pharmacists, and family members. The case manager utilizes the ICP to accomplish, track interventions and document progress towards set goals. With each member contact, the case manager assesses the member's progress towards the goals. The Case manager defines and discusses the barriers in achieving the identified goals and modifies the goals based on member and caregivers needs. The ICP is saved on an online portal hosted by Imperial's servers and is accessible to the care management team.

This Model of Care (MOC) summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides a general overview of how Imperial addresses SNP member needs. For more information about this health plan refer to the Special Needs Plan's website at: <https://www.imperialhealthplan.com/>.

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1A Description of the SNP Population

1A Factor 1: Determine, Verify, and Track Eligibility of SNP Beneficiaries.

Imperial Health Plan of California C-SNP serves a target population of current SNP members in California: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura and Yolo county.

Imperial Health Plan performs a population assessment to build a Model of Care that will best serve the needs of the members. Additionally, this population assessment assists in identifying existing community resources and gaps in services, including clinical, case management, social services, long term care services, and hospice services in the areas that it serves. Imperial offers C-SNP in the following chronic conditions: Cardiovascular disorders including Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic disorder; Chronic Heart Failure; Hypertension; and Diabetes Mellitus. As members are enrolled into Imperial's C-SNP, the enrolling agents present the benefits of the C-SNP and reviews a qualifying questionnaire that has been approved by CMS. Upon identification of this qualifying condition, beneficiary is enrolled in the C-SNP. Within 90 days, an HRA is performed to confirm qualifying condition. Incremental files received in a 2- way methodology from CMS via Imperial's contracted submission vendor ensure that an updated enrollment and disenrollment file is obtained. The eligibility file uploads to the IT platform, which makes available to the health plan staff the eligibility, verification and tracking of SNP beneficiaries.

On a monthly basis, Imperial receives pertinent demographic information, enrollment effective date and benefit status indicators. Imperial utilizes this information to assign service coordination activities and determine eligibility for Case Management. To determine eligibility for Case Management, Imperial takes into consideration social, cognitive, and environmental factors, living conditions and comorbidities associated with the SNP population. The enrollment data analyst receives enrollment applications directly from beneficiaries via the sales agent. The enrollment data analyst reviews the application and

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checks eligibility via the Medicare system. The information tabulated below reflects the demographics and disease prevalence targeted by the SNP in the service areas¹

CALIFORNIA

	ALAMEDA, CA	CONTRA COSTA, CA	FRESNO, CA	KERN, CA	KINGS, CA	LOS ANGELES, CA	MADERA, CA	MERCED, CA	ORANGE, CA	PLACER, CA	RIVERSIDE, CA
BENEFICIARIES	244,026	175,882	117,777	94,712	150,063	1,335,978	21,431	29,956	455,105	73,772	340,575
HISPANIC or LATINO	11.00%	11.10%	30.40%	26.80%	34.00%	29.40%	26.30%	34.40%	15.20%	6.50%	22.50%
WHITE	51.0%	70.30%	75.6%	80.70%	78.70%	58.50%	81.20%	69.70%	71.00%	89.90%	76.70%
AFRICAN AMERICAN	11.6%	7.40%	3.90%	4.10%	4.00%	8.90%	2.70%	3.80%	1.20%	1.10%	5.30%
ASIAN	29.50%	15.80%	9.10%	5.90%	5.70%	19.30%	3.00%	7.50%	21.20%	5.60%	6.80%
NATIVE HAWAIIAN & PACIFIC ISLANDER	0.75%	0.30%	0.10%	0.10%	0.0%	0.20%	0.00%	0.30%	0.20%	0.20%	0.20%
HYPERTENSION	17.7%	13.0%	9.3%	0.0%	0.0%	17.6%	25.0%	13.6%	50%	9.6%	22.7%
TYPE 2 DIABETES	17.7%	15.3%	17.3%	16.7%	0.0%	7.0%	0.0%	12.0%	0.0%	3.8%	22.7%
CHF	48.2%	0.0	48.6%	66.7%	66.7%	52.9%	100%	43.4%	50.0%	34.6%	16.7%

	SACRAMENTO, CA	SAN BERNARDINO, CA	SAN DIEGO, CA	SAN FRANCISCO, CA	SAN JOAQUIN, CA	SAN MATEO, CA	SANTA BARBARA, CA	SANTA CLARA, CA	STANISLAUS, CA	TULARE, CA
BENEFICIARIES	209,596	241,961	454,089	134,981	93,081	120,877	66,563	254,174	69,679	51,531
HISPANIC or LATINO	10.60%	30.90%	17.20%	9.10%	21.10%	12.60%	19.60%	13.70%	22.60%	36.00%
WHITE	70.10%	71.40%	79.30%	43.70%	68.60%	62.20%	87.40%	57.40%	83.60%	81.80%
AFRICAN AMERICAN	7.90%	7.90%	3.50%	5.60%	6.10%	2.80%	1.70%	2.00%	2.40%	1.20%
ASIAN	15.50%	9.20%	12.00%	44.40%	15.60%	27.50%	4.40%	33.40%	5.60%	4.20%
NATIVE HAWAIIAN & PACIFIC ISLANDER	0.70%	0.20%	0.40%	0.20%	0.50%	0.90%	0.20%	0.30%	0.80%	0.10%
HYPERTENSION	19.2%	14.8%	11.8%	18.4%	13.8%	17.4%	7.7%	15.5%	10.2%	0.0%
TYPE 2 DIABETES	15.3%	14.8%	13.2%	19.2%	12.6%	16.5%	11.5%	8.5%	11.7%	0.0%
CHF	38.6%	15.4%	24.0%	25.9%	34.6%	39.1%	22.2%	25.0%	44.0%	50%

¹POPULATION 65 YEARS AND OVER IN THE UNITED STATES. United States Census Bureau. (n.d.). Retrieved February 11, 2022, from <https://data.census.gov/cedsci/table?g=0500000US04005,04013,04019,04021,04025,06001,06013,06019,06029,06031,06037,06039,06047,06059,06061,06065,06067,06071,06073,06075,06077,06081,06083,06085,06099,06107,06111,06113,48029,48085,48091,48113,48121,48141,48157,48201,48209,48339,48355,48439,48453,48491,48497&tid=ACCS5Y2019.S0103>

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	VENTURA, CA	YOLO, CA
BENEFICIARIES	127,628	26,396
HISPANIC or LATINO	20.70%	17.60%
WHITE	85.30%	82.70%
AFRICAN AMERICAN	1.60%	2.00%
ASIAN	8.20%	8.90%
NATIVE HAWAIIAN & PACIFIC ISLANDER	0.20%	0.20%
HYPERTENSION	11.1%	6.7%
TYPE 2 DIABETES	0.00%	16.7%
CHF	20.0%	16.7%

Enrollment process for SNP verification:

For enrollments into a chronic special needs plan (C-SNP), Imperial Health contacts the provider or provider's office to confirm that the enrollee has the qualifying condition to enroll into the C-SNP.

Imperial utilizes a CMS-approved pre-enrollment qualification assessment tool prior to enrollment and obtain verification of the condition from the provider or provider's office on a post-enrollment basis. Verification from the provider can be in the form of a note from a provider or the provider's office, or documented telephone contact via Wipro M360 with the provider or provider's office confirming that the enrollee has the qualifying condition. Upon completion of the signed qualification assessment form from the member and member's provider; form is scanned and stored in member's record within Wipro M360.

Disenrollment process for SNP:

Imperial Health has until the end of the first month of enrollment to confirm that the member has the qualifying condition necessary for enrollment into the SNP. If Imperial Health cannot confirm that the

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member has the qualifying condition within that time, the plan has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the member notice of his/her disenrollment at the end of that month for not having the qualifying condition. Members are informed via correspondence advising they do not have the condition to remain enrolled or Imperial Health was unable to obtain medical information from their provider. Members will be provided with guidance within the notice of their special election period.

Disenrollment is effective at the end of the second month of enrollment; however, Imperial Health retains the member if confirmation of the qualifying condition is obtained at any point during the second month of enrollment. In the event the plan submits a disenrollment request to CMS prior to confirming the qualifying condition, a reinstatement request must be submitted to CMS (or its designee).

CMS provides a Special Enrollment Period (SEP) for members enrolled in the C-SNP who are no longer eligible for the C-SNP because they no longer meet the required special needs status for enrollment or wish to disenroll from Imperial. When such an event occurs, Imperial Health sends appropriate notice(s) to the member explaining the disenrollment. The member has an SEP that begins with the month of notification and continues through the two following months to enroll in another MA organization for a prospective effective date. This SEP allows a member time to find a new plan while reducing the potential for incurring a late enrollment penalty.

Imperial's member retention department works assiduously to ensure membership remains enrolled. This involves a welcome call by the department, outreach by member services for any post enrollment needs the member may have, coordinating appointments and medication refills, arranging for any continuity of care if necessary, and resolving member-initiated concerns expeditiously.

Enrollment/Eligibility Process:

Imperial Health verifies a patient's special needs status by contacting the member's existing provider or provider's office to verify that the member has the qualifying condition to enroll in the special needs plan. Imperial reconfirms a member's eligibility at least annually. To obtain eligibility verification from the existing provider, Imperial sends a fax or other dated document that allows the existing provider to select the member's diagnosed chronic condition(s) from the C-SNP list of qualified conditions.

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1A Factor 2 and 3: Describe the social, cognitive, and environmental factors, living conditions and comorbidities associated with the SNP population. Identify and describe the medical & health conditions impacting SNP beneficiaries?

The Imperial SNPs serves a diverse population, ranging from urban to rural, with different socioeconomic levels and varying access to healthcare and social supports. Additionally, Imperial SNPs serve a diverse range of racial and ethnic populations, with varying age and gender ratios. According to the United States Census, there is a large population of 65 years of older living below the poverty line.

Please see the table below²:

State	Percent of 65-year-old and older living below poverty
California	10.5%

The gender breakdown is roughly even across the states and counties. The most prevalent chronic diseases in these states and counties are hypertension, hyperlipidemia, coronary artery disease, diabetes, and congestive heart failure (CHF).³

Behavioral Health

Adults with Serious Mental Illness and children with Serious Emotional Distress (SED) face a variety of barriers to achieving and maintaining physical, mental, and emotional health. Persons with SMI have diagnoses of psychotic disorders, bipolar disorders, major depressive disorder with psychosis or treatment-resistant depression, and can also include anxiety, eating and personality disorders if the functional impairment is severe enough.⁴ During 2019, 51 million US adults reported any mental illness, while 7.7% of the population reported a substance use disorder.⁵ While approximately 4% of adults have a diagnosed

² <https://data.census.gov/cedsci/table?t=Poverty&g=0400000US04,06,12,13,26,31,32,35,37,39>

³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF

⁴ Evans TS, Berkman N, Brown C, et al. Disparities Within Serious Mental Illness [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 May. (Technical Briefs, No. 25.) Background. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK368430/>

⁵ Evans TS, Berkman N, Brown C, et al. Disparities Within Serious Mental Illness [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 May. (Technical Briefs, No. 25.) Background. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK368430/>

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SMI, only 65% of patients diagnosed with SMI received mental health care.⁶

Imperial is committed to providing services for this vulnerable population by providing integrated care that promotes improved population outcomes, improved patient satisfaction and reduced costs through comprehensive primary, secondary, and tertiary preventive measures. Imperial recognizes that people with SMI face increased burdens of morbidity and mortality, as well as reduced quality of life. It has implemented evidence based direct services and case management, including social determinants of health, to achieve better patient self-activation, self-determination, and quality of life. Progress to these goals will be measured both individually and on a population basis. Imperial collaborates with behavioral health resources such as psychiatrists, psychologists, adult day centers, nurses, social workers and community organizers to reach these beneficiaries who may not be able to advocate for themselves and are at risk of being overlooked.

Additionally, people with Severe Mental Illness (SMI) constitute a vulnerable population, as they face increased morbidity and mortality compared to the general population, and generally receive lower-quality and higher cost care. Moreover, SMI and substance use disorders (SUDs) can lead to increased housing instability, incarceration, difficulties with employment, poor social support, and repeated hospitalizations.⁷ SMI may also lead to a co-diagnosis of one or more SUDS. People with SMI/SUD may also encounter inequities in the distribution of healthcare, particularly when there is intersectionality of SMI/SUD with race or ethnicity, gender, sexual orientation, economic disadvantage, and limitations in English language proficiency.⁸ There are also disparities in the prevalence of SMI/SUDs among different populations.

The following table details the Mental Illness population representative of the states. An overall ranking 1-13 indicates lower prevalence of mental illness and higher rates of access to care. An overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care⁹.

ly Rep 2021;70:162–166. DOI: <http://dx.doi.org/10.15585/mmwr.mm7005a3>^{external icon}

⁶ American Psychiatric Association. Mental health disparities: diverse populations. Available at: <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf>. Accessed April 26, 2021.

⁷ Evans et al 2016.

⁸ Evans et al 2016.

⁹ <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>

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Ranking of States who need Mental Health Services	
California	24
Adult Prevalence of Mental Illness	
California	19.49%
Adults with Cognitive Disability who Could not see a doctor due to costs Prevalence by State	
California	25.54%
Adults with Mental Illness who did not receive Mental Health Services Prevalence by State	
California	64.5%

C-SNP members have multiple chronic and complex medical and behavior conditions and can lead to multiple re-admissions. This may lead to functional issues and other social issues that limit their access to medical care. Patients with chronic conditions and those who are dually eligible often share common vulnerabilities as has also been validated by Imperial’s analysis of its current membership. The prevalence of multiple co-morbidities is particularly high among D-SNP members, which CMS measured in 2014 as 60% having at least three physical and mental health diagnoses, and 25% having five or more diagnoses.¹⁰ Partially because of these co-morbidities, D-SNP members are consistently among the highest cost groups of Medicare and Medicaid expenditures.¹¹ This membership has limited social, economic, and family resources. Poverty worsens the health and special needs of D-SNP beneficiaries.¹² They tend to fall through the gaps since there is limited care coordination for this cohort of patients. The patients with diabetes, chronic heart failure, and cardiovascular disorders frequently experience avoidable readmissions. Often their clinical conditions co-exist with other comorbidities such as dementia, depression, advanced renal disease, or cancers. These issues contribute to a significant impact on their quality of life. The members often need help with Activities of Daily Living (ADLs), assistance within their homes and with transportation. A large portion of our membership tends to have a lower health literacy level compared to other Medicare beneficiaries.

¹⁰ Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees. Centers for Medicare & Medicaid Services, September 2014.

¹¹ CCEHI, 2017

¹² CCEHI, 2017

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Imperial's current experience with the Medicare beneficiaries, reveals the following: Almost 25% of the population has diabetes, 25% has chronic heart failure and 20% of the membership has a cardiovascular disorder. Diabetes, cardiovascular disorders, and chronic heart failure are often correlated, through the mechanism of cardiometabolic disease. Members tend to have other comorbidities including neurological disorders (3%), psychiatric disorders (8%), cancers (3%), renal disorders (10%), and pulmonary disorders (7%). In addition, Cardiovascular conditions are inclusive of the following: coronary heart disease, cardiomyopathy, hypertension, stroke, syncope, vascular disorders, stroke, and arrhythmias.

Language Barriers

SNP membership include populations with limited English proficiency. Amongst Imperial's population served in these counties, the most commonly spoken languages are Spanish, Chinese, Tagalog, and Vietnamese. This is also a barrier for the members since it may limit their access to care.¹³ Additionally, members of minority and disenfranchised communities may also face discrimination based on race and ethnicity, and English proficiency.¹⁴

To address language needs for our SNP membership, Imperial contracts with Connect TransPerfect, an interpreter services vendor, who provides language assistance services. These specific interpreter services are provided to our SNP members and include the following 10 threshold languages: Arabic, Armenian, Chinese, English, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese. Additionally, Imperial's vendor provides language services for multiple languages to meet the needs of our SNP membership.

By providing interpreter services, this ensures the SNP members can comprehend medical information from their care plan team. This service prevents any gaps in care and acts as a facilitator between the member and provider, allowing members to ask questions about their treatment plan.

Cultural Beliefs

SNP members come from different cultural and religious backgrounds and their beliefs play a role in

¹³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

¹⁴ Center for Consumer Engagement in health innovation, SNP Alliance. Special Needs Plans: Focusing on Social Determinants of Health among Duals. Washington, DC 2017.

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their healthcare decisions. This can include decisions about medication adherence, medication management, blood transfusions and out-patient treatment. Cultural beliefs can also include adopting specific diets created for their health risks, and the gender of their provider ¹⁵.

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

C-SNP and D-SNP population are members who have co-morbid chronic conditions that are considered disabling or life-threatening. The chronic conditions include Cardiovascular Disorder, Chronic Heart Failure and Diabetes¹⁶. These members require specialized care plans that address their health concerns. SNP members have multiple chronic conditions and face many challenges which require monitoring and assistance, however, many lack the support needed from family or a caregiver to assist them in their activities of daily living. SNP members live in low-income neighborhoods where there is limited access to basic human needs including household supplies, running water, electricity, and fresh foods. They have limited access to phone and/or internet, creating another challenge for members to communicate with their providers if they are unable to visit in-person. With their limited finance, SNP members face the challenges of paying rent, resulting in homelessness or living in shelters. Members also have limited mobility and living in shelters and moving around becomes more difficult because of the crowded environment.

SNP members also live in areas with limited access to transportation or they have limited access to funds to afford transportation. The result of this, members face missing medical appointments with their providers, picking up their medications and lack of access to grocery stores. In addition, many members are faced with relying on fast food to budget their monthly income. Due to these barriers, it affects not only the SNP members emotional mental health, but also affects their overall quality of life. Additionally, SNP members require specialized health plans developed to address their health risks but many with low literacy and low education background may not fully comprehend the severity of their health conditions and other information from their Primary Care Physician (PCP), making them hesitant

¹⁵ Swihart DL, Yarrarapu SNS, Martin RL. Cultural Religious Competence In Clinical Practice. 2021 Nov 17. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan---. PMID: 29630268.

¹⁶ *Chronic Condition Special Needs Plans (C-SNPs)*. (2021, December 12). Retrieved February 10, 2022, from <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs>

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to ask questions about treatment plans and medication adherence instructions. The result of this, the members will miss continuous care tracking with their primary provider, out-patient treatments and instead, require medical emergency treatment due to the advanced stages of their co-morbid diseases.

For D-SNP members, if a service is not covered by Medicare but it is covered by Medi-Cal or Medicaid, a plan will be coordinated to provide coverage for the requested service, resulting in a gap of coordination.

1 B Subpopulation- Most Vulnerable Beneficiaries

Imperial strives to deliver tailored services to its most vulnerable members through the various methods delineated in this section.

1B Factor 1: Define and identify the most vulnerable beneficiaries within the SNP population and provide a complete description of specially tailored services for such beneficiaries

Our most vulnerable members include the dual-eligible and individuals with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple comorbid conditions, and so are more challenging and costly to treat. Dually eligible members are also more likely to be female, non-White race, have limitations in ADLs, lack a high school diploma, have incomes at or below 200% of the Federal poverty level, live in an institution, and to be single. In fact, dual status itself is a risk factor for increased morbidity and mortality.¹⁷ Dual-eligible populations are often underserved with respect to prevention and wellness, access to care, and chronic disease management resulting in unnecessarily high costs for the health system and poor health outcomes for beneficiaries. These members have multiple chronic and complex medical and behavioral conditions which may lead to multiple hospital re-admissions or complex medication regimens. They may experience functional, social, and environmental issues that limit their access to medical services. Each members care plans are created for their unique health needs but depending on the severity and health needs, additional services can provided to provide the most appropriate care coordination and care management services.

Our membership in the C-SNP exhibits certain characteristics, including sensory or communication issues such as language, hearing, or cognitive difficulties, disability, and related issues that impact access

¹⁷ CCEHI, 2017

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to health care services or create specific health challenges such as minimal physical activities, lack of appropriate transportation or impaired mobility, which may increase fall risks. These members may also experience caregiver issues including loss of a caregiver, vulnerability to abuse or neglect and an unstable home environment, low literacy levels resulting in difficulty understanding health issues or how to access care. The most vulnerable members in the C-SNP tend to be older (over 70 years of age), female, minority population with a middle school level of education. They tend to live alone with limited access to transportation, communication devices or social support.

This membership is identified through the enrollment data using the health risk assessment, and the annual wellness visit (G0438 and G0439). The encounter data that is submitted for RAPS and EDPS submission is used to risk stratify the membership based on ICD-10 and CPT codes to identify members with chronic conditions that include but are not limited to chronic respiratory disorders, coronary artery disease, congestive heart failure, chronic kidney disease, diabetes, diabetic manifestations and complications, neurological disorders, vascular disease, major depressive disorder, and dementia. These assessments are performed by a physician (MD or DO), Nurse Practitioner or Physician Assistant. The evaluations assess, address, and document all chronic conditions being treated by the primary care provider, or referred to outside physician specialist, including complications, treatment plans, and follow-up instructions. The evaluation also is used to assess, address, and document all status conditions such as paraplegia, hemiplegia, ostomies, amputations, organ transplant, respiratory dependence, and renal dialysis.

Populations at risk are identified. This identification is facilitated by a software solution that incorporates social risk with clinical data to derive a score. The risk stratification process allows Imperial to direct resources towards the patients with the greatest need for case management services. Based on clinical assessment, claims data, utilization management review and input from case managers, disease managers and clinical records, members are identified according to the following categories:

- **Frail:** This subpopulation may include the elderly over 85 years. These patients may have a diagnosis such as osteoporosis, rheumatoid arthritis, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), as well as Diabetes. These chronic conditions increase frailty.
- **Disabled:** This subpopulation may include patients who are unable to perform key functional

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activities independently such as ambulation, eating or toileting. This category includes members who have suffered amputation and blindness due to their diabetes.

- **Dementia:** This subpopulation may include patients at risk due to moderate/severe memory loss or forgetfulness.
- **End-of Life:** This subpopulation may include patients with terminal diagnosis such as end-stage cancers, heart, or lung disease.
- **Complex and multiple chronic conditions:** This subpopulation may include patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems.

In addition to Health Risk Assessments, Imperial uses claims and utilization data to distinguish certain codes to identify the most vulnerable SNP members with poor outcomes and high utilization. Imperial also identifies at risk characteristics through chart reviews to capture non-structured data that may not have been submitted through encounter data. This analysis provides a more layered and textured understanding of a beneficiaries clinical, social, and behavioral milieu. These members tend to suffer from neglect and lack skills on how to access care. Imperial uses community resources such as health centers which help in providing services that reduce barriers to care that these members face. To address these needs, Imperial realizes that simply addressing the physical and mental health of the C-SNP members is not enough. Instead, we collaborate with community partners to address needs such as English-language, health and technology literacy, food, income, housing insecurity, and transportation needs. For example, Imperial will partner with services to provide fresh fruits and vegetables, or pre-cooked meals to members with reduced incomes or transportation barriers. As part of the HRA process, Imperial case managers coordinate social services which the member may not be aware are available to them.

1B Factor 2 and 3: Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries. Shows the relationship between the demographic characteristics of most venerable beneficiaries and their unique clinical requirements.

These members are the most vulnerable and at risk of poor outcomes, increase service utilization related

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to clinical comorbidities and limited social support. Members may not seek timely care which could help eliminate the need for emergent clinical attention. These members may need care beyond what would be needed for an average Medicare beneficiary. For example, they may need help with creating appointments with their primary care physician, visits from clinical and social workers at their residence, frequent telephonic contact, assistance with diet planning and physical activity. We use reports from our utilization management department, case management department, pharmacy, claims, and chart reviews to create a composite of each vulnerable patient. This information is ingested by a proprietary data warehouse that incorporates asynchronous and disparate data elements to provide a composite picture of the patient. This composite also helps predict resource utilization and clinical deterioration in the near term (3-6 months). Additionally, Imperial is leveraging technological solutions that aid in risk assessment, taking not only claims and chart data but social risk factors to construct a more comprehensive, predictive score for its members.

The clinical team then deploys resources to aid this cohort. Data from the health risk assessment and pharmacy utilization allows us to determine patients who may need prescription refill reminder, frequent visits to address worsening depression signs, or providing transportation services to their primary care physician and their specialist providers. Our most vulnerable membership suffers from multiple clinical and behavioral comorbidities, often having increased social risk. This leads to avoidable hospitalization and readmissions. Members also have complex medication regimens, and polypharmacy that impairs overall quality of life and health. Their functional, social, and environmental issues limit their access to medical services. They have minimal physical activity, poor transportation, impaired mobility, and a high fall risk. They have limited caregiver access, poor literacy level and an unstable living situation. They are also vulnerable to abuse and neglect. They have limited understanding of their underlying health issues and are unsure about the process to access proper care.

The vulnerable patients have multiple chronic conditions, social isolation, cognitive impairments, and challenges to accessing care e.g., language or cultural barriers and frail conditions. Imperial has an established policy and procedure that facilitates the identification of these members. The coordination process refers and links members into helpful community programs and resources that address special needs, including but not limited to economic, legal, housing, psychosocial and medical services. These

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services are integrated into the member's individual care plan and may be coordinated with the assistance of community health centers, advocacy groups and Imperial's care coordination team. Imperial works with county protective services, home health agencies and it's the clinical teams to leverage relationships with community and clinical partners to provide care in areas of concern. Home visits by providers allows for an accurate assessment of the member's living condition and determining what services are beneficial for them. Transportation through local services vendors ensures patients can visit their providers. Mobile phone use, mail, in home visits all reduce social isolation. Ensuring that patients frequently visit their community senior centers and take part in activities is an important strategy in achieving this goal.

Language barriers also affect health outcomes of members of the vulnerable members. Many members come from low literacy backgrounds and face challenges comprehending medical terminology and treatment plans recommended by their care team. Some members with Limited English Proficiency rely on family members and/or minors to translate on their behalf which can result in improper translation or misinterpretation of given medical instructions.

Imperial Health Plan employees are trained in Cultural Awareness and Competency and Language Assistance. In addition, we provide resources for our providers on how to access trained interpreter services for members. This helps reduce chances in miscommunication of instructions and ensures members effectively understand their treatment plans.

Member's education level also affects their health outcomes. Most SNP members are measured to be 6th grade reading literacy. If a member is unable to understand their treatment plan, this increases chances of members missing medically necessary appointments and preventative exams such as annual physicals, colonoscopy and receiving their important vaccines. This can create issues with treatment management, leading to preventable emergency room visits.

1B Factor 4: Identifies and describes established relationships with partners in the community to provide needed resources

Recognizing the critical need of such a need can at times be relative to social services, Imperial helps members and their family/responsible party obtain access to information regarding community support,

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including clinical, behavioral/mental health, social, environmental/housing, financial and other personal health, and service resources such as:

- Personal care attendant
- Adult day care
- Assisted living centers
- Nursing homes
- Hospice
- Home modifications
- Home delivered meals
- Transportation
- Caregiver support groups
- Cell Phone Programs –Free or discounted cellular service for income eligible consumers
- Mobile Crisis Service Center –Services for people experiencing risks or a psychological crisis who requires mental health intervention, information and referrals, linkage to appropriate treatment
- Adult Protective Services /Elder Abuse to obtain specific Local Department of Social Services APS
- Texas Department of Mental Health
- Homeless shelters
- Soup kitchens and food banks
- Texas Health and Human Services Agency
- Caregiver Relief Services
- Department of Aging

Finally, Imperial is implementing processes aimed at improving integration of Medicare and Medicaid.¹⁸ These efforts aim at increasing the sharing of data across programs and including community-based social services. Additionally, Imperial coordinates with other plans and entities to encourage housing, food, and income security, availability of transportation and health-related quality of life.

Imperial has established relationships with community-based providers and agencies. These collaborations allow Imperial to work with these providers and agencies to coordinate care which is effective for our members unique circumstances. Imperial facilitates member and caregiver access based on member preferences through its large community-based network consisting of medical and ancillary providers. These providers have special expertise to care for the unique needs of our beneficiaries. These providers include primary care physicians, specialists in internal medicine other specialties including but not limited to orthopedics, neurology, physical medicine and rehabilitation,

¹⁸ Sorbero et al, 2018

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pulmonary critical care, nephrology, rheumatology, surgery, psychiatry, physical therapy, Podiatry and home health agencies.

2. Care Coordination

Imperial's Care Coordination program helps ensure that SNP beneficiaries' health care needs, preferences for health care services and information sharing is met over time. Member is informed of and consents to Case Management. This process may involve family meetings as well to ensure that patient and the caregivers are aware of the program and resources available. Each member participates in development of their Care Plan. Member agrees to the goals and interventions of their Care Plan. The member is informed of the Interdisciplinary Care Team (ICT) members and meetings. The member participates in the ICT meeting or provides input through the Case Manager and is informed of the outcomes. Member satisfaction with the SNP Program is measured annually. In accordance with regulations at 42 CFR §422.101(f)(ii) -(v) and 42 CFR §422.152(g)(2)(vii)-(x), Imperial coordinates the delivery of care and measures the effectiveness of the MOC delivery of care coordination.

2A SNP Staff Structure

Imperial Health Plan has defined staff role and responsibilities across all health care functions that are necessary to support and manage many Model of Care population members. Additionally, documentation includes job description and education or training/skills necessary to complete assigned tasks. All staff that function in administrative, clinical and oversight role are employed by Imperial Health Plan.

2A Factor 1: Administrative Staff Roles and Responsibilities across the health plan functions

Enrollment /Disenrollment/Coordination of Benefits (COB) Specialist: This staff is responsible for the thorough, accurate, timely processing of all enrollment/disenrollment requests or inquiries according to regulations and guidelines set forth by CMS. This role performs eligibility verification and monitoring, and responsible for all Member Services and verification and reporting. The Specialist is responsible for verifying Enrollment, Disenrollment, Residence Address Change, Cancellation of Enrollment, and Cancellation of Disenrollment transactions that may have been submitted to MARx by the daily batch process. The specialist is responsible for verifying eligibility procedures, documentation of findings, communications, workflow using the systems and the established policies and procedures.

Eligibility/Benefits Specialist: The Specialist works with the Enrollment /Disenrollment/Coordination of Benefits (COB) Specialist and the Enrollment and Eligibility Manager to assist in administering the

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COB program by updating the database with correct Medicare and non-Medicare coverage data (such as Medicaid, Commercial, Third Party Liability coverage) utilizing information provided by internal and external sources in a timely manner. The specialist confirms the various coverage information with each coverage referral source. The Specialist works collaboratively with the other departments to ensure that benefits available to the beneficiary through the various coverage sources are coordinated. The Specialist also conducts research and reviews cases of members with other coverage to identify cost recovery, potential high-cost cases and confirm that coordinated coverage is being delivered seamlessly.

Claims Processing: This role is responsible for the thorough review and accurate, timely adjudication of all physical and behavioral health medical claims. The Claims Manager oversees the staff including but not limited to Claims Examiners, Recovery Specialists, and Claims Auditors to ensure proper CPT, ICD-10, & HCPCS coding are used on all submitted claims. The team also performs tasks to identify claims for third party recovery.

Member Services Team: This team is responsible for providing high quality, customer focused service. They are responsible for answering all calls, answering inquiries regarding eligibility, plan coverage, coordination of benefits and claims payment. The member services representative serves as a point of contact for questions, problem-solving and access to care for members. In addition, he/she provides accurate, prompt, and courteous service in response to written and telephonic

inquiries from members. The representative also acts as point of contact for inquiries from the public/prospective members about Imperial, its benefits, services, and other information. If an issue requires escalation or further review, the Member Services Team member such as a Specialist, Supervisor, or Manager may escalate the matter to the appropriate department until the problem is resolved. The department is also held accountable for its services levels through Key Performance Indicators.

Complaint Specialist: This role is embedded in the Compliance Department and is responsible for logging and investigating all complaints. The department collects, reviews, and categorizes oral and written member complaints of dissatisfaction from internal and external sources. The process is set up to inform members of their complaint rights and freedom from retaliation. The Specialist consults with appropriate staff for resolution of complaint issues. The Specialist prepares and submits correspondence

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to members regarding complaints in accordance with current health plan specific requirements.

Clinical Services Manager: The Manager is responsible for documentation and coordination of information necessary for review by appropriate medical personnel in preparation for appeal or hearing. The department is responsible for the preparation and submission of correspondence regarding denials, appeals and hearings to members, providers, and health plan in accordance with current health plan specific language, citing accurate rules and criteria within timelines.

Oversight for administrative functions are performed by the following:

Claims Director: The Claims Director oversees the Claims Department and is responsible for timely and accurate claims payment as defined by established department standards in compliance with CMS regulations and State regulations. The Director is accountable for ensuring staff receive up-to-date communication and training on health plan products. The Director is responsible for meeting or exceeding established department standards for claims accuracy and claims turnaround time. The Director oversees claims examiners, auditors, recovery specialists, Coordination of Benefits specialists and works with other departments such as the Clinical Department, Provider Network Operations, Data Management, Member Services, and the Call Center.

Customer Service Manager: This individual is responsible for team focus on delivery of timely, courteous, and accurate customer service to members, providers, and others. The department manages the Call Center as well and is measured by Key Performance Indicators (KPI) that are aligned with CMS metrics related to Call Center metrics.

Enrollment and Eligibility Manager: The manager for enrollment and disenrollment oversees the functions performed by the coordinators and collaborates with the member services department and the call center. This supervisory role includes but is not limited to verifying eligibility procedures, documentation of findings, communications, workflow using the systems and policies and procedures established and maintains up-to-date knowledge of Medicare and Medicaid eligibility requirements to incorporate into operations and ensure compliance. The Manager ensures compliance with CMS requirements related to enrollment, disenrollment, adherence to situations such as Special Election Periods, Annual Enrollment Period and Open Enrollment Period.

Senior Director, Provider Network Operations: The Senior Director oversees the Provider Network Operations (PNO) department, which is responsible for network development, education of network,

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training of network, and ensuring network adequacy. The department also oversees provider data management and coordinates with the IT and Credentialing departments. The PNO team is responsible for training the network about the MOC and obtaining attestations to this training. The Senior Director oversees the PNO team that is involved in network and contract development in compliance with CMS requirements. It aims to achieve provider and member satisfaction to ensure access to care while ensuring timely communication with providers regarding modifications to any policies and procedures.

Senior Manager, Information Technology: The leadership of the IT department and staff include data management, website management, software development and technology support. The department develops and maintains the Information Security plan, ensures operational readiness, data backup, disaster redundancy and provides timely updates to the Compliance Officer.

Quality Manager: The Quality Manager leads Quality initiatives including but not limited to HEDIS, CAHPS, Health Outcome and Health Risks Assessment. The Quality Manager collaborates with the Clinical Data Manager to develop ongoing monitoring Quality Improvement Program initiatives. The manager oversees reviews of NCQA, HEDIS, CMS and state performance measures, reporting submission to regulatory personnel. The Quality Manager develops Quality Program, Work Plan, Annual QI Annual Evaluation and QI Policies to align with regulatory requirements. Under guidance from the Chief Health Officer, Quality Program Structures are implemented for respective sub-committees not limited to: Behavioral Health Sub-Committee, Model of Care, Pharmacy, Therapeutic and Timely Access and availability. The manager also develops HEDIS Road Map, Provider Quality Outreach and Member Engagement Strategies.

Manager, HEDIS and Stars Team: The Manager oversees the department that works under the direction of the Chief Medical Officer

and the Vice President of Operations. The team oversees medical record review and retrieval, data extraction, strategies to optimize HEDIS and Stars measures to ensure quality of care is maintained. This team collaborates with the Compliance Officer to ensure data validation audits with CMS auditors are fully supported with required data, records, processes, policies, and procedures. Team consists of physicians, nurses, pharmacists, database managers, statisticians. The department produces monthly reports listing gaps in care that must be addressed to ensure delivery of quality care.

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Vice President, Operations: The VP of Operations oversees all operational aspects of the organization outside of clinical operations. In this role, the VP-Operations has oversight of activities that allow the SNP to ensure that care is being delivered to the beneficiaries in an effective and efficient manner. The VP is responsible for overseeing the call center, claims, mailroom, IT, Data Management, Sales and Marketing, Quality Improvement, and Provider Network Operations.

2A Factor 2: Clinical staff roles and responsibilities:

Medical Management Specialists: The Specialist is responsible for administration of HRAs, development of member centered care plans, education on and coordination of, assessed needs and services. The Specialist coordinates with the Clinical Department and assists with referrals for social programs, medical needs, and transitions of care.

Health Education, Cultural and Linguistics Specialist: The Health Education Cultural and Linguistics Specialist is responsible for implementing Health Education programs catered to our SNP members. The specialist will provide Health Education program resources and materials in threshold languages for members. The Health Education Specialist, under guidance from the Vice President of Clinical Services and Chief Medical Officer, will collaborate with healthcare vendors focusing on but not limited to Diabetes Management, Smoking Cessation and Nutrition. In addition, the specialist implements Cultural and Linguistics training sessions for staff and providers, notifying them about accessible interpreter services.

Transitions in Care Planner: This individual is responsible for community outreach for transitions. The nurse assists members with navigating the health care community, supports members with self-care education and connections to community resources, and advocates on behalf of the member. The role also supports the clinical staff responsible for coordinating a member's care by ensuring that the team is equipped with a holistic understanding of the patient's situation.

Quality Manager: The Manager is responsible for the management and development of Care Coordination for the Special Needs Programs. The primary focus is on aging in place and improvement to quality of life, while ensuring promotion of quality assurance and adherence to company and programmatic policies and procedures. The manager, under the Chief Medical Officer's

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leadership, develops programs based on nationally recognized clinical practice guidelines. This process involves multi-disciplinary input from pharmacy, medical specialties, nursing, social services, and Behavioral Health. Consensus statements from national organizations are used to develop the clinical practice guidelines. Sources used include but are not limited to the Agency for Healthcare Research and Quality (AHRQ), Institute of Medicine (IOM), National Comprehensive Cancer Network (NCCN), American Heart Association (AHA), American Diabetes Association (ADA), and Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD). Clinical Guidelines from commercial vendors such as Milliman Clinical Guidelines are also used in the daily operations of the organization. The Manager participates in the monthly review of quality measures and facility issues, and in quarterly review of all program systems using established benchmarks. The Manager provides oversight of contracted providers when applicable, against an established program by monitoring, in conjunction with the Quality Improvement (QI) team, reported quality measures, outcomes, and quality improvement projects.

Director, Pharmacy: The Director of Pharmacy Operations is responsible for working with the Vice President of Clinical Operations and the Chief Medical Director. The Director works with the Pharmacy Benefits Manager, Vice President of Operations, and the Compliance Officer to ensure the development of clinical guidelines related to pharmaceutical agents, and appropriateness of use criteria in consultation with the medical and nursing resources. The Director oversees the development of and adherence to medication protocols. The Directors is responsible for ongoing management of pharmacy services for all Imperial products. The Director supervises pharmacists, pharmacy technicians, and pharmacy benefit specialists. The Director also manages the delegated entities such as the Pharmacy Benefits Manager (PBM). The Directors acts as a resource regarding clinical criteria/questions and complex requests; working with medical directors to provide benefits within State and Federal guidelines. Some other functions include but are not limited to:

- Supporting medical management nursing staff in making Part B decisions.
- Reviewing prior authorization requests/coverage determinations.
- Assisting with clinical aspects of grievances and appeals.
- Acting as primary management liaison with Pharmacy Benefits Manager (PBM).

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- Oversight and monitoring of Part D functions as mandated by CMS.
- Contributes clinical expertise to and work with staff to prepare materials for the Pharmacy & Therapeutics Committee (P&T).
- Clinical Services Manager manages MOC SNP members.

Manager, Utilization Management: The Manager is responsible for program development and coordination in medical management for all utilization management activities, post service review, and complex case management. The Manager acts as a resource regarding clinical criteria/questions and complex requests while working with medical directors to provide benefits within State and Federal guidelines. The role supports medical management nursing staff in making Part C decisions.

Compliance Officer: This individual is responsible for compliance with regulatory and contractual requirements. The Compliance Officer manages development and oversight of processes and procedure in the areas of compliance, auditing, and complaints. The compliance officer reports to Chief Executive Officer. The Compliance Officer is for implementing the organization's Compliance Program to help ensure adherence to all Federal, State, and contractual requirements. The Compliance Officer supervises the Compliance Department and the roles and responsibility include but are not limited to: Oversee reporting to regulatory agencies

- Coordinate internal investigations and external investigations of delegated entities as need to ensure compliance with CMS requirements by Imperial.
- Conduct annual compliance training as well as of new employees
- Lead the Compliance Committee and report to the Board at least quarterly
- Ensure adherence to the sponsor's contractual commitment to work with the delegated entities so that they are abiding by CMS requirements as well.
- Inform senior leadership and management about compliance status and updates
- Create, administer, and coordinate training programs to ensure the organization is educated about the Compliance Program, Standards of Conduct, compliance policies and procedures and all statutory and regulatory guidelines.

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Medical Management Coordinators are responsible for review of prior authorizations, post service review, Inpatient review, monitoring and coordination of complex care needs, directing member care through transitions of care, advanced care planning and education for members. The coordinator is also responsible for training for Care Transition, Case Management and ICT team. Their licensure may be RN, LVN, SW, PT, OT, ST, QMHP¹⁹ when in a supervisory role. The coordinators are overseen by the Manger of Utilization Management who in turn is led by the Vice President of Clinical Services.

Case Manager: The Case Manager leads the ICT and engages the member, member's family/caregiver to facilitate the development of a care plan in collaboration with the interdisciplinary care team. The case manager manages care plans which outline the activities and services that will be provided to the member to support established health goals and outcomes. Additionally, the ICT works with the members' primary care providers (PCPs) to ensure that care is coordinated. The case manager also coordinates with the team including the clinicians and social workers to ensure patient is being provided direct beneficiary care and education on self-management.

Pharmacist: The Clinical Pharmacist is responsible for pharmacy utilization management, pharmacotherapy, medication therapy management, pharmacy consultation, and drug trend analysis. This individual also monitors adherence to the clinical guidelines. Licensure: RPH, PharmD.

Chief Medical Officer: The Chief Medical Officer oversees the medical care delivered to beneficiaries for products and services and oversees the health care needs of the membership. The Chief Medical Officer is the senior most professional in the organization responsible for clinical oversight. The Medical Officer is accountable for and provides professional consultation related to the utilization/cost management and clinical quality management functions. The Chief Medical Officer works with the Compliance Department to ensure compliance by delegated entities. This role oversees the other medical directors and specialty panel as well. The Chief Medical Officer works collaboratively with other plan functions that interface with the medical management department. This physician leads the Clinical Practice Committee, Pharmacy Department, Health Information Management, Credentialing Department. The Chief Medical Officer providers clinical expertise related to the Interdisciplinary

¹⁹ RN-Registered Nurse; LVN-Licensed Vocational Nurse; SW-Social Worker; PT-Physical Therapist; OT-Occupational Therapist; ST-Speech Therapist; QMHP: Qualified Mental Health Professional

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Care Team, development of policies and procedures, and technological adoption to enhance value in care delivery. Licensure: Board Certified Medical Doctor.

Contracted Clinical Staff Roles and Responsibilities

Medical Director: These contracted physicians are responsible for oversight of practitioners providing midlevel practitioner (MLP) services in the long-term care setting and in their offices. They review the MLP against American Medical Director's Association (AMDA) clinical practice guidelines as well as monitoring of accuracy of program administration by MLP. They are contracted to render clinical services to the beneficiaries in accordance with professional standards. Licensure: Board Certified Medical Doctor (MD or DO)

Contracted Mid-Level Practitioner: This professional is responsible for provision of primary medical care in contracted facilities, with a focus to maintain or improve upon health and quality of life by identifying barriers and improving access and quality of primary and preventive care. When applicable they also provide care in the office setting under the supervision of a physician in accordance with professional standards and state regulations. They provide routine assessment and care planning of members. They collaborate and communicate with member's PCP in the community-based care setting. They are contacted to meet contractual requirements such as to promptly respond via personal visit, email, or telephone communication to all changes in condition. They attend care plan meetings, visit members who are hospitalized and provide transition information to the facility, staff, and family. The MLP acts as a liaison through the health care system for the member, to ensure that care needs are identified promptly, and key stakeholders adjust care appropriately. Licensing: Board Certified Nurse practitioner, Clinical Nurse Specialist, or Physician Assistant with experience in family practice, internal medicine, or geriatrics.

Contracted Clinical Nurse: This professional is responsible for assisting the Contracted MLP with management of members residing in community-based care facilities. Attends care conferences, works closely with member and caregiver on issues with care provision or access. Licensing: Registered Nurse, Licensed Practical Nurse with experience in LTCF, home health, hospice, medical practitioner office. Licensure: Registered Nurse, Licensed Practical Nurse

Behavioral Health Director: The Director of Behavioral Health Services is responsible for ensuring

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the interdisciplinary teams are ensuring assessment of emotional, behavioral, and cognitive problems, behavioral health case management; assist members to access timely and appropriate services. The Director analyzes data for oversight provider network, monitoring and coordination of complex behavioral care needs and transitions. The Director works with the Chief Medical Officer to develop Behavioral Health policies and procedures that are consistent with guidelines and regulations while optimizing value in care delivery. Licensing: Board Certified Psychiatrist

2A Factor 3: Coordination of Responsibilities and job titles

Imperial Health Plan employee responsibilities include but are not limited to their scope. In the event of an employee's title and/or position change, an appropriately trained employee will oversee and accommodate the position changes. In some situations, an individual may hold two job titles. Please see Appendix A for Imperial's Organized Staff Structure.

Refer to Organizational Chart Appendix A

2A. Factor 4: Contingency Plans Used to Address Ongoing Continuity of Critical Staff Functions.

Contingency Plan is used to address ongoing continuity of critical staff function. Imperial Health Plan has policy and procedure in place in case of natural disaster or weather-related issues. This has been further developed and strengthened to adapt to Public Health Emergencies (PHE) such as a pandemic. Communication is key element of Model of Care. To maintain continuity, Imperial has back up for its information system. The server backs up every night to an off-site server out of state but in the US. The server also backs up daily to the hard drive to ensure communication and information is maintained.

Staff are cross trained to ensure redundancy so that critical operations can continue in the setting of a disaster or situation due to which all staff personnel are not available. Personnel are also provided cell phones and laptop computers issued by the organization which can provide internet access as well as access to the company servers through a Virtual Provider Network (VPN). The phone exchange is programmable to transfer calls from the office-phones to mobile-phones as well. This contingency plan allows for critical operation to ensure ongoing continuity of staff functions by allowing the staff to work remotely. The organization currently does have staff on its payroll who work remotely, allowing it to scale up its remote operations during a contingency. Virtual meetings are currently held and will expand during contingency via conference calls and videoconferencing technology currently employed

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by Imperial. The organization has adapted to videoconferencing to ensure a hybrid workplace to accommodate individuals unable to attend physically. Video conferencing is being leveraged to engage with patients as well. Telehealth services through vendor agreements have allowed outreach to beneficiaries during PHE such as the pandemic.

As needed, Imperial Health Plan has contracts in place with human resources placement firms to provide temporary, *per diem*, and permanent staff to supplement the workforce requirements as needed in a contingency situation. The Vice President of Clinical Operations oversees the contingency plan and assigns roles and responsibilities as needed to ensure continuity. The contingency plan is reviewed at least annually. Ongoing communications are maintained with release of information via the website, fax transmissions and electronic mail communication.

2A Factor 5: How the organization conducts initial and annual MOC training for its employed and contracted staff.

The Human Resources Department in collaboration with the Clinical Services Department oversees the annual and initial MOC Training. The goal of the SNP Model of Care Training is to promote an understanding of the MOC requirements, the infrastructure in place to administer the MOC, help deliver value based coordinated care to beneficiaries, ensure compliance with CMS requirements for the MOC and elevate the care of vulnerable beneficiaries.

The Human Resources conducts the initial and annual MOC Training for departments that have administrative and clinical involvement and oversight in the MOC. The involved departments include but not limited to:

1. Appeals and Grievances
2. Behavioral Health
3. Claims
4. Clinical Services (Case Management, PHM, Utilization Management)
5. Compliance
6. Credentialing
7. Data Management
8. Health Education/Cultural & Linguistics
9. Human Resources

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10. Information Technology
11. Medicare Enrollment and Eligibility
12. Medicare Marketing
13. Member Services
14. Pharmacy
15. Quality Improvement
16. Provider Relations/Network Operations

Imperial's Human Resources (HR) Department plays a critical oversight role for the initial and annually required MOC training for employees and contracted staff. New employees are required to complete several mandatory training modules and annually thereafter.

Initial MOC Training

As part of the onboarding process for new hires and contracted staff, they receive the required MOC Training. Upon completion of the initial training, a signed attestation statement is signed by employee, then forwarded to Human Resources, and maintained in employee personnel file. Human Resources department ensures training is completed within 90 days of hire.

Annual MOC Training

Annually, the HR Department will conduct the annual MOC Staff Training in second quarter (e.g., May).

Additionally, HR sends an email to all staff including the MOC Training Deck that details:

1. The purpose of MOC training
2. Annual training completion deadline
3. A signed attestation (by employee and manager), providing evidence of training completion
4. Completed MOC Training Attestation should be submitted to HR within 90-days of the original communication.

Initial and annual MOC training is mandatory for all employed and contracted staff that work with Imperial Health Plan with the focus specifically for staff who provide or manage care coordination services, and administrative staff involved with enrollment, member care services, claims, pharmacy, and marketing. sales. All new hires receive training on the MOC during their orientation. The training

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is also provided in the form of PowerPoint slides on our website <https://www.imperialhealthplan.com/>.

The training covers the following elements:

- History of SNP plans
- Overview of the DSNP
- Specific population demographic, needs
- Eligibility for SNP
- Most vulnerable members
- Care Coordination in DNSP
- Staff Structure
- Health Risk Assessment
- Individualized Care Plan
- Face to Face
- Interdisciplinary Care Team
- Care Transition
- Provider Network
- CPGs and Care Transition Protocols
- MOC Training
- MOC Quality Measurement and Performance Improvement
- MOC Quality Performance Improvement Plan
- Goals and Health Outcomes for the MOC
- Patient Experience of Care
- Performance Improvement Evaluation of the MOC
- Communication of SNP Quality Performance Related to the MOC

Any changes to the MOC Training are communicated by the Vice President of Clinical Services in consultation with the Chief Medical Officer and HR to ensure the updated MOC is being provided to the intended recipients.

Training Oversight and Strategies

HR monitors for the updated MOC training attestations as it pertains the Initial and Annual MOC Staff trainings.

The training strategy is to leverage technology and personnel. The initial and annual MOC training is computer based via PowerPoint slides and discussion. A sign-in sheet logs attendance and follow up

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on the education delivered. Strategies include web-based training modules such as business overview, and Compliance, Fraud and Abuse, Cultural Competency, HIPPA and Confidentiality. Orientation guides and departments standard operating policies and mentoring over a 4-week period ensures knowledge transference and acquisition. The knowledge content includes the Model of Care, Health Risk Assessment Tool, Policies and Procedures of the Care Coordination, Disease Management, Case Management and Care Transitions team. The Chief Medical Officer will also offer didactic sessions related to population health. The VP of Clinical Services of Clinical Services and the Nurse Managers are responsible for ensuring adequate training of clinical and non-clinical staff with all aspects of the Model of Care, Health Risk Assessments, and the Annual Wellness Visits. The training records are maintained in the department's records as well as documented in the HR file of the relevant staff. All staff are expected to attend the mandatory training meetings.

The slides serving as examples of the training are provided in **Appendix D**

Imperial Health Plan recognizes that not all staff are able to participate when the annual MOC training is scheduled. Additional training opportunities are available in all the following formats to meet the needs of staff who cannot attend the annual MOC training include but not limited to:

- Meetings (team and/or department); Town Halls
- Web-based (PowerPoint training)
- Face to face (used when employee cannot participate in the other options).
- MS Teams/Videoconferencing

2A Factor 6: How Organization Documents and Maintains Training Records

All participation and completion of training is documented, tracked, and maintained through the HR Department which provides reporting and notification to managers for follow up for any staff who are delinquent in their training. The MOC training is mandatory for all staff and contracted employees. The training records are maintained in the HR department. Employees attend the webinar, and then asked to sign dated attendee list, and signed training attestations are placed in employee's HR file evidencing that training has been completed.

2A Factor 7: Actions if training is not completed

Upon notification from HR, the manager will work with the employees identified as not completing

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the mandatory initial and annual MOC training by developing a corrective action plan to complete the training. Failure to complete the training within the designated timeframe may lead to corrective actions. These will include but not limited to: reminder e-mails about trainings, phone calls to the employee, outreach, counseling, and written warning.

The training for the Model of Care is mandatory and provided at least annually. If staff, whether employed or contracted, are unable to complete the required initial and annual MOC training, the supervising manager responsible for oversight and follow-up with those specific employees not attending. Leadership works with HR to initiate disciplinary actions in accordance with HR policies and procedures and may include verbal and written warnings.

2B Health Risk Assessment Tool (HRAT)

In compliance with 42 CFR §422.101(f)(i); 42CFR §422.152(g)(2)(iv), SNP conducts a Health Risk Assessment for everyone enrolled in the SNP.

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

The quality and content of the HRAT will identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP beneficiary. The HRAT is appended in Appendix B.

Imperial uses a comprehensive HRA tool that quickly assesses risks and needs in the following areas:

- Medical- Diagnosis history, medications, pain, dental, immunizations, health screening
- Functional- Weight, physical activity, ADLs, IADLs
- Cognitive- memory, attention, language, thinking
- Psychosocial- Family/friend involvement, spiritual, stress, wellbeing, abuse, social concerns
- Behavioral-substance use/abuse, Readiness for Change

Refer to Imperial's HRAT Appendix B

The assessment has predetermined triggers that alert staff to follow up further with a more specific assessment. The HRAT allows for a standardized, comprehensive approach to collecting, analyzing and communicating information. The member's prior authorization, claims data, and HRA are used to screen the needs/risks of the member for development of a person-centered care plan. Areas identified for care planning include needs that require interventions by:

- Member services or enrollment

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- Care Coordination
- Access to Care
- Health literacy
- Transitions
 - End of life
 - Complex Case Management
- Primary Care
 - Preventive medicine
- Community Social Agencies
- Behavioral health
- Depression
- Disease Management

The main objectives of the HRA are to assess health status, estimate the level of health risk, as well as to provide feedback to members, their representatives, and interdisciplinary care team members. Information provided includes details about Medicare benefits, community resources, and their relationship with their PCP. Personal preferences and barriers are gathered.

The HRA is a combination of several assessments that focus on the medical, psychosocial, cognitive, and functional needs and disabilities of members of our target population and identifies current and future health risks. The initial HRA is completed by the Care Management staff within 90 days of the member's enrollment into the plan and is conducted in the member's home, via telephone or mail. Information obtained for the HRA is a combination of the member completing the form including but not limited to: Imperial Health member services may reach out to the member to remind them about their upcoming initial or annual HRA. An assigned case manager or department may call the member to complete Section 1 of the HRA and ask them questions to complete the remaining unanswered questions. Care Management staff use HRA information and work with the member, caregiver, and ICT to develop and implement Individualized Care Plan (ICP). The ICP is developed based on HRA data regarding their primary health concern, member's preferences, priorities, and risk level. The assessment includes a full medication review (prescribed, over-the-counter medications, vitamins, and herbal supplements; discussions with the member's PCP occur; review of the HRA for prioritization of problems and interventions and need for community resources, identification of comorbidities associated with common conditions found in this dual eligible population such as: chronic obstructive pulmonary disease, cardiovascular disease, cerebral vascular disease, and diabetes. The

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evaluation also includes but is not limited to an assessment of home safety, safety with mobility and equipment in the home, falls risk, functional limitations and decreased activities of daily living and the process for inclusion into the member's individual care plan (ICP) This information is then reviewed and collated by the interdisciplinary team (IDT) to strategize on developing an individualized care plan for each SNP beneficiary. Clinicians including the medical officer, providers for the patient, nurses, coordinators, social workers, pharmacist, and other staff collaborate to develop the ICP which is then elaborated in collaboration with the beneficiary and caregivers to guide the treatment for the duration of the member's enrollment. Imperial considers a Health Risk Assessment completed if they fill in Section 2, Health Questions, of the form and the remaining sections are empty.

For members who are unreachable through a telephone call, and are not residing in a care facility, Health Risk Assessments will be attempted through efforts such as mailed assessments, appointments at a provider's office, home visit by a home health agency contracted clinician, home visit by a licensed employee, as well as outreach to caregiver to coordinate a three-way appointment. In addition, to improve members response rates to HRAs, members will receive a letter notifying them about the attempts in contacting them, an explanation about the HRA and case management services that are free of charge.

HealthView X (HVX) is a software population health solution which Imperial is deploying in order to improve its population health and chronic disease management. The foundation of the interface with the SNP member is the Interdisciplinary Care Plan (ICP), which in turn is driven by the Health Risk Assessment. Answers to questions on the HRA in turn trigger algorithms to generate a generic care plan. For example, a positive answer to hypertension on the past medical history will generate a care plan involving limiting sodium, getting exercise, taking medication, etc. in the future, society clinical practice guidelines (such as American College of Cardiology, American Diabetes Association, etc.) will also be incorporated to make treatment recommendations. Patients who are unable to be reached after three attempts will have an attributed HRA and ICP constructed based on medical records and claims data. The interdisciplinary care team will then modify the pre-formatted care plans based on patient characteristics. After HRA answers are submitted in the HealthView X portal, the case manager will log onto the portal daily, review new HRA information to develop and update ICP. The case manager will

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subsequently present the care plan to the patient, for review and modification based on preferences and circumstances

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

Risk assessments are offered to all members within 90 days of initial enrollment, and then repeated either annually prior to anniversary of enrollment or at the time of any significant “change of condition” event that indicates a potential change in member health status. Imperial staff maintains a schedule of HRAs due by month. Staff receive a list of HRAs to be conducted the month prior to the members’ anniversary date. The assessment can be completed via telephone interview, face-to-face at the member’s place of residence, or by member and/or caregiver completing a paper version. On occasion a barrier to completing the HRA is encountered. In most situations, it is related to the member’s cognitive impairment and not having involved family or responsible party. In this case, the information is gleaned from the chart and from caregivers in addition to a face-to-face visit by a clinician. In the event of unstable conditions or based upon high-risk assessed scores, members may receive frequent or additional monthly home visits throughout the year based upon the professional judgments of the Care Managers and the ICT. For instances where the initial visit is not scheduled within the first thirty (30) days or if the member declines an in-home visit, a telephonic health risk assessment is conducted. Update of the HRAs completed is provided to senior leadership and the QI department to ensure completion rates can reach benchmarks.

2B Factor 3: How organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information.

Information collected from the HRA determines the risk level using Imperial’s risk stratifying methodology for each member and is used to develop the ICP. The system stratifies members into 3 categories (high, medium, or low) based on member conditions, utilizations, and level of care needs. HRA results are reviewed with members and incorporated the needs into member’s ICP and are shared with all ICT members, including the member, via telephone, fax, mail, or in the case of providers, through the secure web portal. The ICP is the main tool used to document changes and communications between members of the ICT. Information in the ICP is maintained in member health records Care Management system. Each ICT member or ancillary provider has access as applicable.

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The communications of the HRA findings are shared with the interdisciplinary care team. A copy of the HRA is provided for the member's chart for care planning consideration of identified issues. The Nurse Case Managers communicate directly with all ICP participants reviewing care plans, and telephone meetings to ensure all ICP participants have needed information. The ICP is reviewed with member and member's caregivers via telephone. The ICP is documented and maintained in the Care Management system.

PCPs receive a copy of the ICP updates from Imperial's Care Management team. The intervention provided by the contracted MLP is based on the PCP Communication Preference Form. Most PCPs opt to have the contracted MLP take the call for the member and provide the interventions within their scope of practice. The contracted MLP will follow up with a call and notation to the primary care provider, after the visit and assessment. When the contracted MLP completes any notes or assessments, they are faxed out to the primary care provider and care facility. Members/caregivers are offered a paper copy of the documents upon request.

The ICT will reach out to members three times to conduct their HRA. This is done either through mail or three phone calls. After the third attempt, if a member is unreachable or declines to complete their HRA, the case manager will reach out to the member's provider, requesting the medical records to complete the HRA. Once it is complete, the HRA will be sent to the member's provider for review and scheduling a follow-up appointment. Members will be provided with a hard copy of their HRA after their appointment.

HRA reassessment can be required soon if there is a change in the member's health status, worsening health, hospital readmission, change in medication or requested by the member's ICT.

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

Declines in function and health that may trigger a change of condition assessment are:

- Decline in decision making from last assessment
- Decline in mood pattern (sad or anxious)
- Behavioral symptoms
- Decline in an ADL area

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- Incontinence patterns change from last assessment
- Placement of indwelling catheter
- Emergence of condition or disease in which resident is unstable
- Emergence of unplanned weight loss (5% in 30 days or 10% in 180 day)
- Emergence of new pressure ulcer stage 2 or higher, when no previous stage 2 or higher was present
- Initiation of use of trunk restraint or chair prevents rising
- Hospital admits or emergency department visit.
- Change in cognitive status

Improvement in function and health that trigger a change of condition assessment are:

- Improvement in decision making from last assessment
- Improvement in an ADL area
- Decrease in the prevalence of sad or anxious mood pattern
- Decrease in the number of behavior symptoms
- Improvement in incontinence pattern.

The risk assessment self-scores are based on the risk areas. The scoring of the HRA is one component of the risk stratification determination. Another is based on the clinical assessment of the risk of clinical deterioration by a member found within Imperial's internal predictive modeling software. Based on authorization and claims data, a risk profile updated with each data in load. The scoring monitors the age, gender, high risk medications, mental health/substance abuse conditions, number of diagnosis, active medications, and previous hospitalizations in the past 6 months. The determination of involvement cadence is based on the needs of the member which include the calculation from the HRA, the calculated risk software and member preference. Members scoring high risk are offered weekly visits. Medium risk is offered bi-monthly. Low risk is offered monthly.

Through HealthView X platform, further, responses to the HRA will be combined with demographic, utilization, and non-clinical data (Census, etc.). through a modified Minnesota risk algorithm to produce a risk score for each member.^[1] The Clinical team will perform an analysis on the scores to determine groupings based on terciles: high, medium and low risk. The team will use these scores and terciles to assign members to programs, such as chronic disease management, and other interventions to maintain and/or improve health ²⁰.

²⁰ Haas LR, Takahashi PY, Shah ND, Stroebel RJ, Bernard ME, Finnie DM, Naessens JM. Risk-stratification methods for identifying patients for care coordination. Am J Manag Care. 2013 Sep;19(9):725-32. PMID: 24304255

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If a member has a utilization, whether inpatient or outpatient, data generated from these encounters will be used to modify the ICP. Similarly, encounters between the Imperial Health Plan care team and the patient, caregiver and family will also be used to modify the ICP to make the care plan a living plan that is responsive to the needs of the patient.

2. C. Face to Face Encounter

Imperial Health Plan assists members with scheduling face-to-face encounters through different modalities, based on member's health risk and needs.

2C Factor 1: Face-to-Face Essentials

Imperial Health Plan performs the Health Risk Assessment annually, with the first HRA beginning the first twelve months of enrollment. To ensure members schedule appointments with their Primary Care Physician (PCP), case managers in the member's ICT will offer to assist members in the process of setting up appointments. If the member accepts, the Case Manager will help schedule appointments, either in-person or a virtual encounter such as Teladoc.

The case managers will attempt to reach members three times, offering assistance in scheduling face-to-face encounters. If they are unreachable after three attempts, the Case Manager will mail a letter to the member regarding Imperial's attempt in contacting them.

2C Factor 2: Identifying Appropriate Personnel

Imperial Health Plan includes multiple appropriate personnel who can deliver care for our members including but not limited to licensed:

- Physicians
- Specialists
- Contracted Providers/Physicians
- Pharmacist
- Behavioral Health Consultant
- Nurse Practitioners

All appropriate personnel provide services for members based on their unique health needs, through different modalities. This includes in-person, Teladoc and Home Health Care. During home health care visits, licensed physicians, specialists or nurse practitioners will visit members to provide the care needed. Home Health services include completing health assessments, preventative exams, continuous

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monitoring of their health and assisting in reducing unnecessary emergency room visits. These services are offered to members who have limited access or resources to visit a physician in person or limited resources to utilize virtual visits and Teladoc. Clinical Pharmacists are available to assist members with questions and creating a plan for medication management. The coordination of services will be based on the care plan created by the Case Manager and the member's ICT.

2C Factor 3: Verification of qualifying encounter

After a member's appointment, contracted providers will submit a claim to Imperial Health Plan verifying the member's visit, documenting qualifying face-to-face encounters: in-person, Home Health Care and Teladoc. Case managers can also access appointment history from the documents submitted on EZCare detailing the visits.

2C Factor 4: Types of Clinical Functions

During face-to-face visits, various clinical functions are conducted including but not limited to:

- Health Risk Assessments (HRA)
- Coordinating face-to-face appointments
- Home Health Care Enrollment
- Annual Wellness Visits and Preventative Exams
- Member Care Plan Review
- Health Education Referrals
- Medication Management
- Behavioral Health Assessment

These clinical functions are used to ensure members are receiving continuous care and are aware of the various health care services offered in the health plan. Based on a member's overall health and an updated ICP, new specialists may be referred. Out-patient services or self-management programs referrals may be incorporated into face-to-face encounters. Further preventative exams may be conducted if a member addresses new health concerns. Examples of self-management programs can include diabetes, nutrition, weight maintenance and smoking cessation. Additional preventative exams may be conducted to prevent emergency room visits. If a patient is prescribed new medication, the pharmacist will provide guidance in medication administration and instructions for members to follow accordingly. If a member was newly discharged from the hospital, a new health assessment will be

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conducted to reevaluate their health status and new health risks that should be addressed. This can include post-discharge visits with their primary care provider, new diet changes, medication management and additional services that can assist during their recovery period.

2C Factor 5: Addressing Identified Health Concerns

The Imperial case manager is responsible for addressing how health concerns identified during encounters and educating members or their caregivers about issues that might develop. These concerns may include:

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

The case manager then works with the member, caregiver, healthcare providers and other members of the IDT to develop interventions to address these concerns and support the achievement of health goals. The case manager will set the frequency of reviews of the care plan, after determination of the member's risk level and utilization pattern, and then document the proposed intervention, communicate it to the member, and then set any necessary follow-ups. These interventions will be in addition to the at least annual review of the ICP, any time that the condition of the member changes, or upon the completion

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of an ICP goal or need for revision.²¹

Completion of the HRA will trigger standard care plans based on health status and established clinical practice guidelines and best practices. The care manager can, in consultation with the IDT and member, modify these care plans in drafting the ICP²².

Some of these interventions include:

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

Finally, the IDT will use Global IDT guidelines in streamlining the IDT and review processes. The guidelines in turn will identify members, based on severity and unmet needs, who will most benefit from intensive case management. Members with less severity and need can be reviewed less frequently, with a minimum of an annual review.

2C Factor 6: Care Coordination Activities

The ICT will help coordinate follow-up appointments for members based on their care plan and

²¹ Anthem Health Plans. H2593 Texas/Arizona. 2020 C-SNP MOC Cardiovascular. Available at: [2020 C-SNP MOC \(vanlangipa.com\)](https://www.vanlangipa.com). Accessed February 7, 2022.

²² NCQA. 2023 CY2023 NSP Model of Care Training FAQs. January 26, 2022. Available at: [CY2023 SNP Model of Care Training FAQs \(ncqa.org\)](https://www.ncqa.org). Accessed February 7, 2022.

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documentations provided after their annual visits. Case managers will discuss their health needs and what type of services can help address their health needs. Follow-up appointments are also advised and created for members to continue receiving adequate care from their providers. Member's ICT will review referral requests for specialists, following up on authorizations and referring members to preventative health education programs.

2. D. Individualized Care Plan (ICP)

In compliance with regulations at **42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv)** Imperial maintains an ICP for everyone enrolled in the SNP.

2D Factor 1: Essential Components of the model of care is ICP.

Depending upon findings of the triggered areas on the assessment completed by the facility or the completed HRA, the care plan includes the following:

- a. Functional status
- b. Sensory and physical impairments
- c. Nutritional status and requirements
- d. Treatments and procedures
- e. Psychosocial status
- f. Dental condition
- g. Rehabilitation and restorative potential
- h. Cognitive status
- i. Drug therapy
- j. Dietary preferences

The essential components of the ICP include the results of the HRA which helps risk stratify the member and allows for planning of resources needed to effectively serve that member. The ICP allows the Care Manager to focus on setting goals and interventions for the member based on that member's needs such as chronic conditions, psychosocial issues, personal goals. According to the needs identified in the HRA, special services and benefits are included in the members care plan. Outcomes of goals are measured and documented in the care plan. The care plan is developed in collaboration with the member and personal goals are a large factor for consideration. If caregivers are involved, they are ICP will detail their responsibility to help member's reach their personal goals. Caregivers can include paid caregivers or family members and friends. It is the members ICT to review goals and

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treatment plans with the member's caregiver. This can include medication management, providing transportation services to routine follow-ups and assistance with their ADLs.

Member preference for providers and care location, personal health goals and how the care is delivered are honored to the extent possible. The member's care preference is also accommodated such as the need for specific providers and location where care is delivered, personal health goals and achievements, milestones, self-management goals and objectives, the beneficiary's personal healthcare preferences (likes and dislikes), services specifically tailored to the beneficiary's needs, and the identification of whether these goals are met or not met.

Beneficiaries' personal health care preferences are also acknowledged and addressed. This may involve working with diet preferences due to cultural influences whereby a certain food may be unhealthy. The ICP will work within cultural context to help develop a diet plan that works for the beneficiary while attaining the hoped-for result.

If the beneficiary's goals are not met, a reassessment process of the goals will occur to identify a meaningful and achievable goal. Special services and benefits are included in the member's plan of care according to the needs identified on the Health Risk Assessment. The outcomes of goals are measured and documented in the care plan. The ICP also addresses add-on benefits and services for vulnerable beneficiaries such as those with dementia, persons with substance use disorders, frequent falls, member's utilizing 9 or more medications, unmanaged chronic disease, end-of life matters or no relationship with a PCP.

2D Factor 2: The process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change.

Based upon the above information, input from the member and Interdisciplinary Care Team (ICT), the team will develop a plan of care to include interventions, referrals, education opportunities, preventive care, medication, and safety based on member's preferences and needs. The ICP is developed in compliance with Regulations at 42 CFR §422.101(f)(ii); 42CFR §422.152(g)(2)(iv) that stipulate that all SNPs must develop and implement an ICP for everyone enrolled in the SNP.

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All members of the interdisciplinary care team (ICT) and the member work together to develop the care plan. To the extent possible, the member is a key part of the planning team and is involved in the development and review of the plan. The plan of care can be updated at any time. It is a living document and comes in two types, based on time resolution factors. For problems and issues that are short in time to resolve, they are placed on a temporary care plan as they are considered not to be a long or permanent change in care. Temporary care plans have short time frames and are discontinued when completed. They are tracked for trends. For long term issues, the care plan is reviewed and revised quarterly, annually and as a change in condition is identified. The care plan is maintained at the facility in the member's chart.

Modifications are made to the care plan as changes occur. Communication of the care plan and updates are provided through Imperial's Case Management System. A hard copy of care plan will be sent to the external providers via fax or email.

Member care plans are reviewed and revised by the member's care manager, in coordination with the member's primary care practitioner. All members of the ICT are involved in the development and review of the ICP. The member, whenever feasible is a vital component of the ICT and is involved in the development and review of his/her plan of care. In addition, specialists involved in the care of the member are involved in the development and review of the plan of care. Revisions are based upon the changing health needs of the member, as identified in the HRA and feedback from providers.

Care plans are reviewed and revised according to the following frequency:

- Every six months, following completion of the Health Risk Assessment.
- When there has been a change in the member's condition (i.e., hospitalization, new onset of chronic condition and change in psychosocial function). The ICP revision includes an evaluation of the identified goals and whether they have been met.

Depending on the clinical milieu, number of chronic conditions, extent of medication list, prior ER visits, prior hospitalizations, and review of HRAs and ICP, beneficiaries are stratified into low, medium, and high risk.

2D: Factor 3: The personnel responsible for development of the ICP, including how

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beneficiaries and/or caregivers are involved.

The case manager leads the ICT and engage the member, member's family/caregiver to facilitate the development of a care plan in collaboration with the interdisciplinary care team. The care plan outlines the activities and services that will be provided to the member to support established health goals and outcomes and will be managed by the case manager. Additionally, the ICT works with members' primary care providers (PCPs) to ensure that care is coordinated. The member and family representatives are also involved in the development of the plan as well to assist member in treatment plan management. All stakeholders work with the member's PCP and other providers to identify and prioritize issues, implement solutions, and deliver the services. The Care Managers who help develop the care plans are Registered Nurses. The model is member-centric and depends on member engagement, activation, and empowerment. The care plan identifies the member's services and benefit to be provided that have measurable outcomes and goals. The care manager discusses the plan with the member to reach feasible goals. The team meets at least quarterly and if the beneficiary is stratified into a medium of high-risk category, the meetings occur every 4-8 weeks.

The beneficiary and the caregiver are also involved to the extent possible. Their participation is encouraged during the team meetings and preferences and guidance factored into the care plan. This involvement is important to promote self-management. When engaged, the patient becomes the primary decision maker with the team engaging to identify patient needs, preferences, and strengths. Any changes are incorporated into the plan and shared with the beneficiary and caregiver.

ICP changes are made when a patient's clinical experience changes, such as diagnosis, admission, or change of support or functional status.

2D Factor 4: How the ICP is documented, updated and where it is maintained.

The ICP is created, maintained, revised, documented, and stored in HealthViewX. The member is mailed a hard copy of ICP. The external ICT receive the ICP via web portal mail or fax. Imperial maintains a policy and procedure relating to HIPAA and information system back-up and disaster recovery procedures. This also includes the ICP as well which is part of the patient's medical record. The ICP document is uploaded into the clinical health IT platform used by Imperial Health Plan and

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is accessible by authorized personnel. As the beneficiary conditions change or the ICP is modified, the updated document is also uploaded into the EZcare system.

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

The Case Manager is responsible for communicating to the members, ICT, plan staff and network providers of any revision to the ICP. ICP is changed with a consult with member and communicated via mail, face to face interaction, or telephone. Case Manager communicates the significant event that occurred to trigger the revision in ICP to all ICT by updating the management system. The PCP is faxed a copy of the updated ICP and is asked to verify their collaboration. Management team will be communicated via face-to-face interaction, fax, email, web portal, or telephone and ICP will be updated in the system.

2.E. Interdisciplinary Care Team (ICT)

In compliance with regulations at 42 CFR §422.101(f)(iii); 42CFR §422.152(g)(2)(iv) that require all SNPs to use an ICT in the management of care for everyone enrolled in the SNP, Imperial has assembled an ICT that caters to the needs of each SNP beneficiary.

2E. Factor 1: How the organization determines the composition of ICT membership.

The Model of Care relies on a patient-centric team of clinicians and other professionals who are contracted by Imperial Health Plan to care for frail, chronically ill members.²³ This interdisciplinary team is assembled to attain the goal of delivering patient-centric, whole-person, culturally relevant, value driven care to the beneficiary. A beneficiary's language and method of communication as well as preferences for representatives are respected. Imperial's, Case Manager coordinates the ICT which communicates regularly to manage the member's medical, cognitive, psychosocial, and functional needs. The Member and caregiver are included on the ICT whenever possible. The preferences of the beneficiary and the caregivers are incorporated into the ICP initially. Patient engagement and activation

²³ Philip AM, Saper MH. Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States. Center for Health Care Strategies, 2016. Available at: <https://www.chcs.org/media/INSIDE ICTs for Medicare-Medicaid Enrollees-012216.pdf>. Accessed April 30, 2021.

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require a concerted and sincere effort to engage the beneficiary in the conversation around the ICP. Structured interviews to identify beneficiary beliefs, expectations, perceptions, needs and perceived as well as actual barriers to access are very important in facilitating the participation of beneficiaries and their caregivers as members of the ICT.

In addition to the member and family/caregivers, the ICT is comprised of various disciplines whose primary purpose is to coordinate the delivery of services and benefits that address the member's specific needs. Members of the ICT are determined by analysis of the member's initial health risk assessment and/or subsequent follow-up assessments as well as the member's care plan. After a member is enrolled in the plan, he/she is assigned to a care manager. The care managers are Registered nurses and Licensed Vocational Nurses who have case management experience in long-term care continuum, including homecare. If a patient has a particular need, such as care for Diabetes Management or Hypertension, resources may be added to the ICT to address health risks. Specialists can include Dietician, Endocrinologist or Cardiologist who may be requested to join the ICT.

Imperial makes every effort to match our members with care managers who have similar cultural and lingual attributes to ensure communication between the two is effective. Depending on the unique needs of the members, the care manager determines the other appropriate members of the members care team. The primary care physician is at the core of the team with specialists and other professionals added as needed. At a minimum, the ICT members include the member, care manager, primary care physician/practitioner, specialists, home and community-based services providers, caregivers and/or family and a medical director. In addition, Imperial has access to a wide variety of internal team members including but not limited to Certified Inpatient, Outpatient Case Managers, Post-Discharge Case Managers, Health Educators, Health Coaches, Nutritionists. The ICT also includes: Licensed Physicians, Registered Pharmacists, Registered Nurses, Licensed Vocational Nurses, Nurse Practitioners, Social Workers, and Behavioral Health Specialists. These ICT team members work closely with community-based resources that may be added to the ICT as needed. These resources can contribute to social determinant needs of the member, such as food, housing, income, and transportation.

Member participation is facilitated through home health visits, if requested, face-to-face visits, telephone calls, video-conferencing, as well as through mail. The ICT is comprised of these

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professionals given to meet the need to ensure coordinated care across the entire clinical spectrum. The coordination of care requires an interdisciplinary approach that is holistic and comprehensive. This approach sees the member as an individual with specific strengths and vulnerabilities, as a member of a family and community, and thus addresses several social determinants of health so that beneficiaries are treated within the context of their demographic, social, cultural, and economic situations. Chronic care delivery includes addressing not only physical but mental and emotional health, so that mental health issues become routinized as chronic diseases, working to reduce stigma and improve access. These considerations require the expertise of all the members for the ICT.

The ICT uses health care outcomes and quality of life to evaluate the effectiveness of processes that have been established to manage changes or adjustments to the beneficiary's health care needs on a continuous basis. Some outcomes evaluated include but are not limited to process, administrative and clinical elements related to the HEDIS data. These include elements such as readmissions, blood pressure control, glucose control, adherence to medications, and other personal health goals relevant to each beneficiary. If the goals are being achieved, more stringent milestones are incorporated. If goals are not being met, a root cause analysis is performed to identify barriers to success. The barriers are then addressed or goals adjusted to incorporate milestones that are meaningful and likely to be achieved. This quality improvement process occurs within time frames chosen by the ICT. Outcomes, utilization, patient satisfaction surveys and related tools are used to assess the effectiveness of the ICT for any patient.

Training of the providers is confirmed to ensure they are qualified to meet the needs of the beneficiary as set forth in the ICP. The Credentials Committee conducts the credentialing of practitioners to ensure they have the training and expertise necessary for serving the targeted beneficiaries.

2 E Factor 2: How the roles and responsibilities of the ICT members (including beneficiaries and/or caregivers) contribute to the development and implementation of an effective interdisciplinary care process.

Case Management is a collaborative process which assesses, plans, coordinates, monitors and evaluates options and services to meet an individual's health needs. This goal is achieved through communication and available resources to promote quality and cost-effective outcomes. Imperial's

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Case Management team helps coordinate the care and ensures a smooth transition of care across the clinical spectrum that the patient navigates. The ICT develops the ICP based upon assessments, discussions with the member, recommendations of the care management team, and input from the PCP. The member is at the center of this enterprise. The care manager provides the coordination amongst the various stakeholders. The ICT helps ensure a comprehensive work plan with measurable goals that are clear as well as outcomes. The figure below illustrates the interdependence between the clinical, and administrative stakeholders in ensuring that the beneficiary has a seamless experience. The Care Management Process incorporates all these elements in a pictorial form as shown in the figure.

The member's Interdisciplinary Care Team (ICT) is responsible for developing the individualized care plan based upon assessments, including the Health Risk Assessment discussions with the member, recommendations by care management, input from Primary Care Physician (PCP) and other providers treating the member. The member and his/her family is at the center of the care team along with his/her physician. The care manager is the facilitator to assist the physician and the member to achieve the goals outlined in the comprehensive care plan. The ICT also works to ensure that the comprehensive care plan includes measurable and clear goals and objectives, measurable outcomes, as well as all appropriate services for the member. The comprehensive care plan is developed by the ICT during the first month of the enrollee's membership.

After the member completes a comprehensive assessment, he/she is assigned to a care manager who identifies the other participants of the member's ICT based upon the assessments conducted and communicates with the member and their primary care physician. If a specialist is needed based on their HRA report, they will be added into their ICT. This can include but not limited to: an Endocrinologist, Nephrologist, Cardiologist. Health Education specialist will also be included in the member's ICT if disease management programs are requested. Imperial Health Plan makes every effort to include the member and/or his or her caretaker in the development of the ICP and ICT meetings. ICT meeting attendance is open to members, families, or caregivers when available and willing to participate in meaningful discussion concerning the member.

Based on the member's overall health outcomes, continuous care and treatment management will help

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track member's progress. If certain health risks need additional assistance, their ICP will be regularly monitored to meet the health goals of the member including new specialists, medication management, chronic disease management programs and health education program referrals. Additional collaboration and programs may be included based on primary provider and member's input.

The member and her caregiver, if present are the drivers of the ICP/ICT process. The member and/or caregiver's answers from the HRA are the initial drivers to the initial ICP. Subsequently, the conditions identified in the ICP form the guidelines to the responses from the ICT, where each specialty contributes its perspective to the individualization of the ICP. But it is the preferences and circumstances of the member that drive the ICP. After the contributions of the ICT to the ICP, it is presented, or represented to the member or caregiver for review by the case manager. In revising the ICP, the ICT members will use their expertise to suggest interventions that will maintain or improve the outcomes on the Health Outcome Survey. The ICT will work on a whole person basis, taking into account the impact of each existing or proposed intervention on the person's physical and mental health. In doing so, the team will also look as synergy, such as a possible improvement in glycemic management with improvements in mental health, or the effect of adding an additional pharmaceutical treatment on a member's health related quality of life. If there are no identified pathways between the member data and the HOS, then the ICT will suggest further investigation as to the disjunction between the HRA and HOS.

The member or caregiver can then provide her or his input into the care plan. In addition to addressing the member's physical and mental health, the care plan will also address the member's social risk, such as housing, income, transportation, literacy/education and neighborhood. For factors such as housing or food insecurity, the case manager will refer the member to community resources.

After any urgent care, Emergency Department, inpatient or SNF utilization, the case manager will review the ICP, and also contact the member for any necessary or desired revisions. Such as review will also be performed after any major change in status, such as a new chronic or serious acute diagnosis.

The Required Team Members are:

- a. Case Manager (RN)

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- b. Medical Expert/ Primary Care Physician as a key leader of the ICT, the PCP provides a comprehensive view of the patient's clinical care, referrals to specialists as needed, and preventive and primary care.
- c. Social Services Expert / Social Worker the social services expertise is very important in leveraging community services that may aid the patient and serve as an advocacy resource for the beneficiary.
- d. Mental/Behavioral Health Expert –when indicated
- e. Member/Member Family --the member and/or member family provide critical input into their care plan, needs, goals and expectations
- f. Additional Team Members could be:
 - Pharmacist - the pharmacist reviews the patient's medication profile and assess medication adherence, medication interactions and implement interventions as needed to address issues around the medication profile of the patient.
 - Nutritionist. Health Educator/Coach,
 - Nursing/Disease Management Restorative Therapist; Community Resources

2E Factor 3: How ICT members contribute to improving the health status of SNP beneficiaries.

ICT Members contribute to improving the health status of SNP members. Working as a comprehensive team, the ICT collectively works to address all aspects of a member's care and the interactions between these aspects. This can include case managers notes during phone calls with the members and listening to their health concerns. Members and their caregivers are also invited to join in the ICT planning as well but their case managers will be the main liaison between the member and their ICT. Thus, different members of the team work together and with the member to ensure that the health status of the member is managed properly or improved while addressing diverse needs such as access to clinical care, medications, transportation, community resources, co-locating behavioral health needs, coordinating care, improving medication adherence. The team also works with data management professionals to ensure the MOC elements are being measured to determine if the interventions are having the intended effect

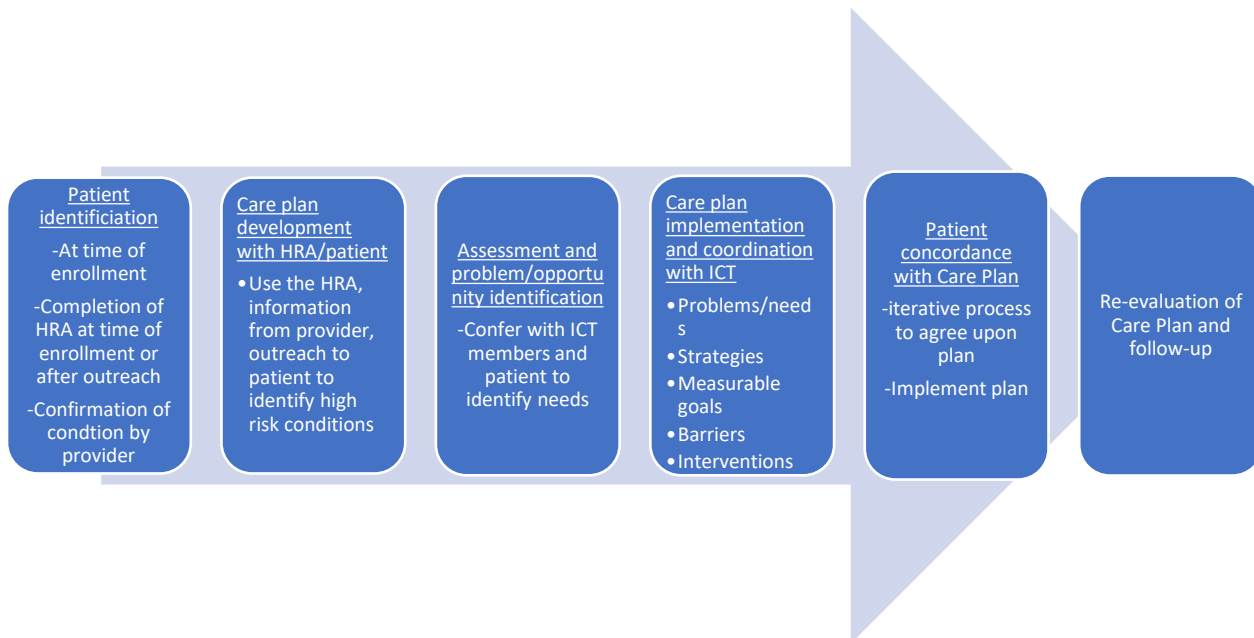
They make this contribution through the following methods:

- Analyzing and incorporating the results of HRA into ICP
- At least annually, if the condition changes, ongoing review, evaluation, and approval of the ICP

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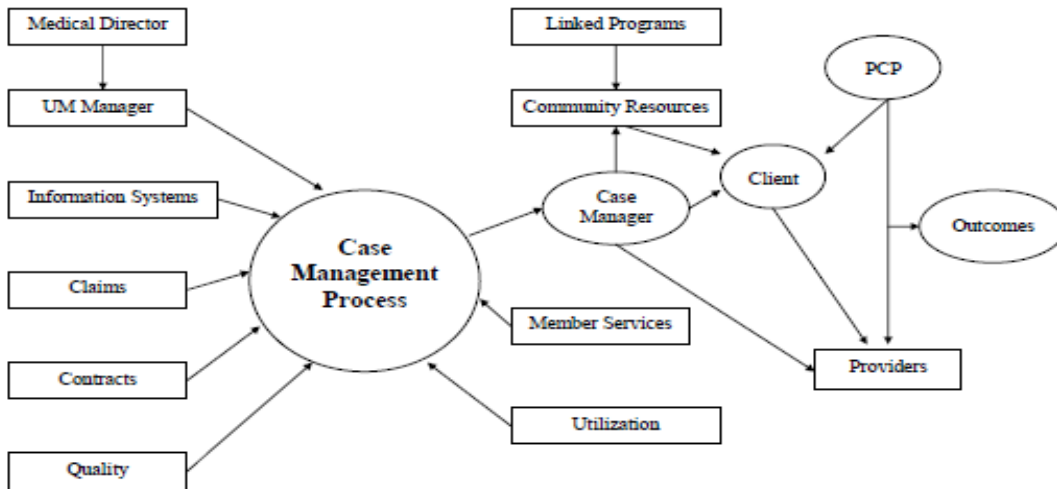
- Make recommendations based on reports from the UM, Claims, and QI and identifying opportunities to improve care/service, actions taken, and improvements resulting from monitoring and evaluation activities
- Assuring adequate resources and systems necessary to support the ICP are available
- Taking appropriate action on recommendations for changes in the ICP
- Ensuring that contracted practitioners and Plan Members actively participate in the meeting the goals of ICP
- Communicating and coordinating the ICP



Communication and coordination is the key element in the success of reaching goals of ICP. ICT member communicates via face-to-face meetings, web portal, telephone, written documents, reports, and secure emails. The care manager is the main point of contact and is responsible for collecting information for all team members and developing the ICP. The Case Manager responsible for exchanging information regularly within ICT during and after regular ICT meetings. The figure below demonstrates the interdependency of the various components of an effective ICT.

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2E Factor 4: How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.

Communication and collaboration among the members of the ICT, clinically directed by the PCP and supported and managed by the care manager, is the foundation of Imperial’s integrated approach to coordinated care. This approach adds considerable value to chronic SNP eligible beneficiaries and their providers from whom communication and coordination of services may be difficult. To promote effective and efficient communication, ICT members communicate via many ways including phone calls, secure email, secure web portal, web-conferencing, conference calls, written documents and reports and face-to-face meetings. The participation of the beneficiary is also facilitated via education and outreach to beneficiaries about the ICT. The care manager acts as the main point of contact and is responsible for collecting information from all providers and incorporating all into the central repository, the plan of care. Imperial directs staff to document in the record on a real-time basis through the care management system. All internal members of the ICT can access the latest information regarding the member. ICT members may document directly in the record or are able to scan and store related documents in the record as well. The care manager disseminates reports generated through the proceedings of the ICT to the primary care physician and the other ICT members within five business days of the meeting. ICT members may review the documented outcomes of the meeting real-time in care management system, EZCare, that is also the repository of clinical information including authorizations for clinical services and inpatient services Imperial Health Plan. IT system incorporates

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documentation related to authorizations, encounters, claims data, Health Risk Assessments, care management plans, and member contacts, member demographics, and available clinical records. All internal members of the ICT can access the latest information regarding the member. ICT members may document directly in the record or are able to scan and store related documents in the record as well. The care manager disseminates reports generated through the proceedings of the ICT to the primary care physician and the other ICT members within ten business days of the meeting. ICT members may review the documented outcomes of the meeting real-time in care management system. Record of communication between ICT members can be obtained in the IT platform EZCap and EZcare that is used by the team. The patient's clinical team can access the system via the provider portal. Imperial is currently in the process of implementing Fast Healthcare Interoperability Resources (FHIR) functionality that will support a patient portal where the beneficiaries can access details as well directly and independently.

The ICT also meets quarterly and monthly. It meets more frequently as needs warrant. The reports and discussions of these meetings are saved on a secure server that is available to authorized ICT members. Other forms of communication with the patient and providers include faxes, letters, and secure email related to medications, and recommendations.

The member is mailed a written version of the comprehensive care plan as well as updates. Regular quarterly meetings may be more frequent if the beneficiary's condition warrants the meeting.

Communication plans are created for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers. Imperial leverages its resources for translators to communicate with beneficiaries in their preferred. Behavioral specialists, speech therapists, psychologists are also incorporated in the ICT to ensure that barriers related to cognitive deficiencies are addressed. The use of TDD technology facilitates mitigating barriers related to hearing impairments.

The communication with the member starts upon:

1. Enrollment into the SNP
2. Procurement of the HRA

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3. Identification of SNP conditions and verification through various sources including communication with PCP and / or specialists
4. Communication with the patient and family/advocates
5. Categorize by estimated intensity of involvement needed.
6. Identify potential barriers to care for the patient
7. ICT meetings to discuss issues and set meeting with patient/representative
8. Obtain patient input into needs, and share considerations from ICT
9. Prepare a ICP and obtain sign off upon finalization
10. Conduct regular ICT and monitor progress and outcomes
11. Update ICP as needed, and change frequency more than quarterly as needed
12. Continue ongoing monitoring and communication between ICT members and patient as needed
13. Measure outcomes and share details with all stakeholders

2F. Care Transitions Protocols

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

Imperial Health Plan complies with regulations at 42 CFR §422.101(f)(2)(iii-v); 42CFR §422.152(g)(2)(vii-x) that require all SNPs to coordinate the delivery of care. Imperial coordinates transitions for SNP members from one care setting to another. Imperial's care coordination team uses evidence-based transitions protocols based on Eric Coleman's Care Transition Model and incorporates the Four (4) Pillars for consistency and continuity of care across all settings.

The Four Pillars are:

1. Medication reconciliation
2. Primary care / specialty care follow-up as well as access to community-based services
3. Personal Health Record/Self-Management
4. Signs of red flags that indicate a worsening in condition and how to respond

The transition of care for a member from PCP to specialist starts with the member visit to the PCP. The PCP is responsible for the assessment, selection of the specialist, and referral of the member to the specialist. The PCP uses a certified EMR to prepare the consultation request to the specialist, including

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all relevant clinical data, including laboratory results and imaging, if applicable. The provider transmits the consult request to the specialist. The specialist receives the request and reviews the data submitted. If the member is established with the specialist, the specialist reviews the medication, medication allergy, and problem lists provided, and updates the member's record if required. If the patient is new, the specialist incorporates the data submitted into the EMR for a new patient record²⁴.

Care transition planning starts sending updated clinical documents and communication to the receiving care setting. Nurse Case Manager works closely with the ICT and providers to develop and implement a plan of care. Imperial Health Plan identifies planned and unplanned transitions through the following mechanisms:

- Prior authorizations
- Concurrent review
- Inpatient hospital census report
- Emergency Department report
- Telephonic notification
- Face to face notification

Imperial's standardized practices and systems ensure timely and thorough communications. This also helps avoid complications due to transitions in care. Imperial closely monitors and intervenes in hospitalizations and readmissions to support improved health care of covered beneficiaries.

Care Transition process identifies member needs and preferences across the different care settings. During transitions in care, Imperial ensures that the care management team, ICT, providers, member, and family follow safe and effective protocols to facilitate a smooth transition from hospital, skilled nursing facility, sub-acute, behavioral health facility, and emergency room. Imperial works toward timely and early identification of the participant's need for such care setting transition, a standardized and well documented process for communication among settings and related Care Management/ICT determinations and actions. The participants remain a vital part of the care transition process.

Additionally, when new members are enrolled, during the intake, it is determined if beneficiary is

²⁴ Office of the National Coordinator for Health Information Technology. PCP referral to a specialist. Available at: https://www.healthit.gov/public-course/interoperability-transitions-of-care/HITRC_lsn1080/010301----.htm#. Accessed February 14, 2022.

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undergoing ongoing care. In that case, the SNP works to ensure that continuity of care with non-contracted providers is maintained to ensure there is no disruption in care. When continuity of care needs are identified because of a variety of changes, the Clinical Services Department is informed so that they may coordinate to ensure continuity of care.

The specialist contacts the member to schedule an appointment and sees the patient at that appointment. The specialist orders and further required laboratory tests or imaging, and/or makes further recommendations to the PCP. Alternatively, the specialist assumes care of the member for the problem that is the subject of the referral. The specialist then transmits the consult report back to the PCP using a certified EMR.

If patient is transitioning across level of care, the Care Transitions team coordinates to ensure the transition is completed in a patient centric manner, to facilitate medication self-management and adherence, continuity of care, timely provider follow up and ways to flag clinical deterioration.

2F Factor 2: The personnel responsible for coordinating the care transition process.

Once a transition notification is received, it is entered into a shared care plan in Care Management System which allows for notifications to be sent to the assigned team. The care coordination team is responsible for transition coordination efforts. An assigned care coordinator reaches out to the member scheduled for a transition or who is already in the process of a transition. This assigned care coordinator will remain the point of contact for the member throughout the transition.

Care coordinator can be an inpatient review nurse, SNF case manager, prior authorization nurse, social worker, and/or clerical support staff who work together to assist with transition of care. Member's status is reviewed and assistance with coordination of transition is offered. The member has a right to decline this service. For members who are recognized to be in the initial stages of preparation of a planned transition. A Care Coordinator assists with preparatory work with the member to focus on discharge needs to return to their usual setting or another as appropriate. The Care Coordinator will notify member's PCP of the transition within 2 business days of notification that a planned condition occurred. The updated clinical records with approved authorization are faxed to the receiving setting within 1 business day. If the transition is unplanned, notifications are received from contracted

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facilities within 24 hours of transition to obtain an authorization. Clinical reports are received from contracted facilities within 24 hours of admission.

The transition to a skilled nursing facility are prior authorized by the SNF Case Manager and it is considered planned transitions. The SNF Case Manager forwards the member's clinical records within 1 business day of the transition and communicates with the receiving facility and conducts SNF reviews within 2 business days of the transition. The SNF Case Manager will contact the member during their transition and assist with planning for the discharge in collaboration with those involved with discharging at one site and those involved with admitting at the admitting site.

If the member was enrolled in case management, the Nurse Case Manager who was working with the member prior to transition will continue to work with member to identify any needs. The Nurse Case Manager contacts the member or caregiver to determine the care transition needs and revising the ICP. The Nurse Case Manager works with the PCP and specialists to ensure follow up care, services and appointments are scheduled.

2F Factor 3: How the organization transfers elements of the beneficiary's ICP between health care settings when the beneficiary experiences an applicable transition in care.

The care coordination team contacts all those who are involved in the various care settings to ensure that important information related to provision of ongoing care is appropriately shared. Information transferred may include: Demographic information including involved ICT, current medication list, Advance directives/advance care orders, Care plan is provided. Information can be transferred in many ways to meet the need of the situation. This could include, but is not limited to; telephonic, email, fax, face to face. Members that are noted to have transitions that are determined to be avoidable are contacted. Care coordination staff offer education on options and tools for better management of their care needs. Community navigators may also provide a face-to-face visit to assist members that require more assistance with planning. It could be as simple as having a list of medication the member is taking.

Imperial has developed and implemented mechanisms for monitoring MA enrollees that are participating in the chronic care program. These mechanisms may include, but are not limited to:

1. Program participation (e.g., involvement in care planning)

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2. Receipt of recommended tests/ services (e.g., cholesterol testing)
3. Use of recommended pharmaceuticals
4. Compliance with prescribed pharmaceuticals
5. Emergency room visits and hospital (re) admissions
6. Clinical indicators of effectiveness (e.g., LDL-C levels, smoking cessation, weight loss)

The organization transfers the SNP member's ICP between healthcare settings during the care transition process. Prior to a transition in care, the plan identifies a planned transition is going to occur by requiring pre-certification for the following services: elective inpatient admissions, skilled nursing facility admissions, long term acute care, acute inpatient rehabilitation, and home health services.

During planned and unplanned transitions, the plan sends the member's ICP when a member transitions from each of the following settings. This includes communicating changes in health care status or beneficiary Plan of Care. - Hospital to nursing home – inpatient case manager identifies admission level of care and participating nursing home facilities and directs the hospital discharge planner to in-network nursing facility. The inpatient case manager will issue an authorization for the facility within 1 business day.

Nursing home to hospital – receives notification from the nursing home about the transfer. The coordinator will enter the authorization for hospital admission and notify the inpatient case manager. The inpatient case manager will monitor the inpatient admission and coordinates discharge planning with the hospital and nursing facility staff. Also, work with the nursing facility for bed hold if member is long term care resident at the facility.

Hospital to Home – inpatient case manager coordinates post discharge care plan with hospital discharge case manager and ICT. Initiates care transition event by authorizing needed services within 2 business day receipt of discharge order. Once member is discharged home, the nurse case manager conducts transition assessment with member within 5 calendar days of discharge. Additionally, the nurse case manager schedules assessments, updates ICP and coordinates with ICT when change status has occurred. PCP will receive updates on hospital stay via discharge summary.

Home to Hospital - Notifications from member, care giver, home care nurse, or PCP of impending

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transfer to hospital. The care coordinator will forward clinical records to admitting facility and enters authorization for the admission. The inpatient case manager will be notified of the admission and contact the facility to perform medical necessity review and monitors progress of inpatient stay. The inpatient case manager will coordinate discharge plan with hospital case manager.

The plan runs a daily SNP inpatient census that displays newly captured admissions. A case management coordinator uses this list to send SNP Member ICPs to the receiving facility within one business day of the notification of the unplanned transition and/or within one business day of the planned admission.

Inpatient to Skilled Nursing Facility (SNF): The responsibility of sending information for this transition is given to the inpatient facility and monitored by Imperial. The inpatient facility completes the discharge instructions, which the SNF facility uses as the admission care plan information. It is supplemented by attached admission orders.

Planned Outpatient, Ambulatory Care, and Surgery Center Transitions: Select outpatient, ambulatory care and surgery center procedures require health plan authorization; however, all are planned and scheduled by the rendering providers. Therefore, the plan entrusts member communication and support of these transition types to the authorized provider.

2F Factor 4: How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings or specialists.

Members are provided a hard copy of their ICP. A copy of the ICP is also sent to member's PCP. Members who have an ICP are educated to share their care plan with others in the healthcare setting. The care plans are written at a 6th grade reading level to ensure that the members can use and understand the plan. The member is provided the contact information (phone and email) of the Care Management team. Members are encouraged to complete their own Personal Health Goal survey as well. This survey also contains a medication list, allergies, questions for providers, member conditions and issues that providers should know about.

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The care management staff can access member's information 24/7 via care management system and through secure fax server, email, and telephone to facility inbound and outbound communication.

The member's ICT is developed and updated in collaboration with the member and ICT. The ICP includes short/long term goals, time frames to meet medical, behavioral, and functional goals and are shared with member. Member and/or caregiver can access the member's personal health information upon request via mail, fax, verbally, or any other HIPAA compliant method.

Members who complete the HRA tool are mailed care plans and they are encouraged to share them with their providers to facilitate communication during the transition process. These care plans are written at or below a 6th grade reading level to ensure that members can use and understand them. In these letters, members are provided with the telephone number and contact information for the Care Management department. Care managers can work with the member or caregiver to update the care plan, mail updated care plans to the member or share care plan information with the member's PCP or treating physician in any care setting. Members are also encouraged to complete and maintain their Personal Health Record (PHR) which contains member goals, a medication list, allergies, questions for providers, member conditions and "red flags" and should be shared at all visits to the member's doctor or to the treating facility. Imperial works with members to complete the PHRs and ensure that they understand how to use them.

2F Factor 5: How beneficiaries and/or caregivers will be educated about the beneficiary's health status to foster appropriate self-management activities

Once the member is discharged, the assigned case manager will perform a new health assessment. During regular communication with member and PCP to monitor any changes in member's health, members or designated family member are encouraged to contact the case manager via telephone through the transition process. During care transition, when a patient is discharged home, a clinician visits the patient at home to evaluate the patient, and home safety, as well as to arrange for any durable medical equipment that the patient may require. Working with the PCP, care managers will help educate the member and caregivers regarding the patient's clinical condition, signs to monitor, signs of clinical deterioration and how to communicate these to the clinical team. Weekly and monthly contacts will be documented in the clinical system for clear understanding of their treatment plan.

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Member with chronic conditions may be enrolled in disease management programs and receive educational materials to assist them how to manage their chronic conditions. The nurse case manager provides outreach and educational materials to members who have cardiac, diabetes, HTN, and CHF diagnoses via telephone calls and brochures to help member's self-management of chronic conditions.

Post discharge follow-up, medication reviews and care supports are the important elements to have successful transitions and overall self-management. The nurse case manager will review the medication with member and/or caregiver to ensure understanding and remind member to bring all prescription, including over the counter medications with them to physician appointments. Also, clinical pharmacist can be consulted for any medication issues and contacting the treating physician to address the potential risk. Based on the discharge instructions, the nurse case managers assist the member to schedule follow up appointments and removing barriers for office visits such as lack of transportation. The nurse case manager identifies the needs for durable medical equipment, home health services and refer to community-based programs that can help keep member safe at home.

2.F. Factor 6: How the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

Beneficiaries and caregivers are provided the phone number of the Care Coordination department and the care manager so that they contact Imperial. Web access for queries is also provided. When a member experiences a transition in care, they are assigned to the transition team who contacts the family and the new setting such as the hospital or the post-acute care facility. This is done to identify the plan of care and the potential discharge date. A social worker works with the facility's discharge planning team to maintain optimal contact and planning. Frequent updates via phone calls to the family by the care management team is achieved as well.

During transition, the nurse case manager reaches out to member and care giver to coordinate transition of care activities and interventions. The nurse case manager will be the main point of contact during the transition period, but other care management staff may be involved in the process as needed, i.e., member's ICT, UM team, Clinical Pharmacist, social worker, as well as Medical Officer.

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3. SNP Provider Network

In compliance with regulations at 42 CFR§422.152(g)(2)(vi), Imperial has established a provider network of healthcare professionals who have specialized expertise in the care and are contracted to provide health care services to SNP beneficiaries.

3A. Specialized Expertise

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

The Credentialing Department follows the following procedure.

Credentialing: The scope of credentialing includes, but not limited to: MD, DO, DDS, DPM and DC. The credentialing and recredentialing of Allied Health Professionals (AHP) is also included. Upon receipt of the State's standardized application (registration with CAQH) an Imperial Profile Document, authorization to release information and a W-9, the CR Department date stamps all incoming applications. Applications are reviewed for completeness and the applicant is notified of missing documentation with (5) business days. Imperial accesses routine reports monthly of licensing board sanctions to detect restrictions. These are used to trigger the Credentialing and Privileging Committee review, as described above.

Licensing: All Providers must possess a valid, unencumbered license in the state which he/she wishes to practice. The highest level of education will be verified for Practitioners. Online primary source verification of Board Certification is obtained from the appropriate certifying Board. The CR Department utilizes Primary Source Verification for all licenses, DEA certificates and malpractice insurance. Online Primary Source Verifications are used for the following: Opt-Out, SAM, OIG, Medical Suspension, CLIA, HIV/AIDS specialist, SSDMF. Online Primary Source Verification of malpractice history of past or pending suits is obtained from the National Practitioner Data Bank (NPDB).

Note: Medicare requires the IPA/Medical Group to ensure that no payments are made with respect to any item or service (other than an emergency item or service) furnished by an individual or entity when such individual or entity is excluded from participation in Medicare/Medicaid programs (including

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Medicare Advantage plans).

Provider Directory: The online provider directory is the primary source for Imperial with member's also being able to access their medical records through their personal web portal. The physician directory allows members to compare physicians on criteria, including language, gender, education, and specialty certifications.

Imperial provides access to physical and behavioral health preventive and primary care, dental care, acute and post-acute rehabilitation through a specialized provider network with understanding of the needs of this population and the coordinated care model, aimed at increasing access to physical and mental health resources. Imperial network of providers is comprehensive and structured to meet the needs of our entire population, especially members who are frail, disabled, or require end of life care. The provider and facility network delivers services that includes, but is not limited to the following provider types: Acute care facility, hospital, medical center, Urgent care, Laboratory, Long Term Care Facility/skilled nursing facility, Pharmacy, Radiography facility, Rehabilitative facility

The provider core of the ICT is the primary care provider (PCP). To meet the needs of coordination and oversight, Imperial maintains a network of Board-certified Family Medicine, Internal Medicine, and Geriatric physicians and nurse practitioners. Additionally, specialists in the specific areas of care (SCP) are included in the network. These providers include medical specialists in Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Endocrinology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology, and General Surgery. Behavioral health specialists include Psychiatry, Clinical Psychology, Masters or above level licensed social workers, and certified substance abuse specialists. Allied Health professionals include Pharmacists, and Registered Physical, Occupation, and Speech Therapists, as well as Registered and Licensed Vocational Nurses.

The network includes contracted providers with specialized clinical expertise that is pertinent to the targeted SNP membership. Imperial's specialty network includes geriatricians, internists, endocrinologists, and nutritionists to manage diabetes. Specialists including cardiologists, nephrologists, orthopedic surgeons, vascular surgeons, cardiac surgeons, ophthalmologists help

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manage diabetic complications and comorbidities. Other specialists determined by member diagnosis are also part of the network and mentioned above. Nurses, behavioral health specialists, social workers, and benefits coordinators work with Imperial to deliver a coordinated care delivery plan to members.

Similarly, for Imperial's Chronic Heart Failure and Cardiovascular Disorders, the provider network includes those mentioned above as well as experts in the management of heart failure, rhythm disorders, peripheral vascular disease, hypertension, and syncope. Cardiac rehabilitation centers, wound centers, radiology facilities and other ancillary facilities are also part of the network.

The network is not limited to the providers and includes other specialists as determined by member diagnosis including nurses, behavioral health specialists, social workers for care coordination, benefit, and housing needs, social or medical equipment and resources as applicable. Available facilities for our chronic diabetes and cardiovascular SNP includes acute care hospitals and tertiary medical centers, dialysis centers, acute care rehabilitation facilities, laboratory providers, skilled nursing facilities (SNF), pharmacies, radiology facilities, outpatient diabetes management and cardiac rehabilitation centers and wound care centers. The goal is to ensure that we provide a network of providers who will meet the needs of the beneficiary and include all facilities where members may receive care. As needed, ad hoc providers will also be enlisted for services.

Moreover, Imperial requires its providers to function as members of the interdisciplinary team, and in an integrated fashion, so that traditional barriers, such as between physical and mental health, are lowered and more efficacious, evidence-based, and affordable care is available to its SNP members. For example, a diabetes treatment team starts with the member and her family, and moves on to include the primary care provider, a clinical pharmacist, nutritionist, mental health therapist, and health coach. For members with mobility or other physical challenges, a physical therapist may join.

3A Factor 2: How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.

Imperial has a close relationship with our practitioners in the community, and contracts with practitioners or groups of practitioners who are licensed, certified, or registered by the state. Medical

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Management communicates closely with our contracting department to make sure that Imperial has the most updated information on all our contracted practitioners and facilities. The plan has policies and procedures for credentialing, monitoring, and re-credentialing the network. Imperial's Provider Relations Representatives perform site reviews for the contracted provider types.

The health plan maintains credentialing, monitoring and re-credentialing procedures that include standard verifications e.g., licensure, sanctions, and professional liability claims history. These procedures are compliant with all relevant state, Federal and NCQA requirements. Prior to review, the Credentialing department collects and verifies the following information:

- Credentialing application
- Active licensure
- State license sanctions
- Education and training (residency and fellowships)
- DEA or other prescriptive authority
- Board certification
- Work history
- Professional or facility liability insurance
- Malpractice history, including adverse clinical privilege actions, Federal and state licensure and certification actions, and state and Federal program exclusions (National Data Bank)
- Medicare opt-out status
- Medicare/Medicaid sanctions
- Appropriate facility accreditation (Joint Commission, state or CMS deemed accreditations)

There is a monthly process to monitor all credentialed and non-credentialed providers that have an active provider number. Providers are also required to notify the plan of any material change in the information including privileges, licensure, and ability to perform professional duties or change in OIG Sanction or GSA debarment status. All practitioners and facilities are re-credentialed within 36 months of the previous credentialing decision to identify any changes in a practitioner's licensure, sanctions, certification, clinical privileges, competence, or health status that may affect the practitioner's ability to serve our members. The process also includes an assessment of the provider's performance as part

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of our network through the Quality Improvement department that meets at least quarterly. Quality based metrics are assessed and acted upon. The organization has access to the National Practitioner Data Bank, credentialing services, specialty boards, state licensing departments to confirm training, certification, licensure statuses. The Credentialing and Privileging Committee may review any provider's practice at any time, including between recredentialing cycles, to consider additional information relevant to that practice. The committee may decide at any time to act regarding a provider's credentialing. Such action or decision may include, but is not limited to, the suspension, termination, limitation, or revocation of credentialing. Written notification of such decision of action will be made to the provider.

Evidence of Specialized Provider expertise and training

Refer to Imperial's Appendix C for Medical Committee Services Contact Sheet

3A. Factor 3. How the SNP documents, updates and maintains accurate provider credentialing information.

On an ongoing basis, credentialing staff query their credentialing database on individual providers and incorporate these scores into the credentialing and re-credentialing process. Results from the reviews are aggregated and submitted to the Credentials Committee quarterly for review. Reports by provider, medical group or survey item may be produced as needed. All reporting is coordinated through the Quality Improvement team to review and suggest actions. The QI Committee evaluates reports, monitors for trends, and recommends actions. QM staff may be involved in any follow-up action. If an opportunity for improvement is identified for a provider, a practice site or provider group, the involved parties will work together to develop a corrective action plan (CAP).

Imperial's Credentialing Department verifies the active licenses of all practitioners and facilities contracted with Imperial to care for the SNP population. Imperial also confirms the applicable board certification of specialized practitioners. The plan checks all practitioners every three years when contract renewal occurs.

Imperial also uses the list of excluded providers and entities to ensure that our practitioner and facility panels are not sanctioned by Medicare. Imperial checks this Medicare excluded list monthly.

Imperial maintains current practitioner facility information in our software program called Streamline Verify[®]. Provider directory printed in addition to online directory is available. The directory contains

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basic information that member can use to compare physicians based on their needs.

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

The Primary Care Physician (PCP) determines the service needs of the member. The PCP and Case Manager work together in managing the care of the member. The Case manager enables the PCP in authorizing and facilitating access to specialty care. Planning and utilization needs are reviewed by other ICT providers. Case Manager maintains and updates all information from PCP, specialists, and other providers into the ICP. The ICP is communicated to the PCP via web portal, fax, letter, or telephone. The program is member-centric, and the PCP is the ICT member who determines which services the member needs. The care manager coordinates all aspects of the care and ensures that the ICT is involved and the ICP is being followed.

The primary care physician (PCP) is the ICT member who determines ultimately which services the member will receive. The member is at the center of the ICT and the PCP is the clinical driver of all the care the member receives. The PCP works collaboratively with the Care Manager, who is the single point of contact for all ICT members involved in the care of a member. The member's Care Manager acts as the coordinator of services and is the person who executes/authorizes services for the member with ongoing input from the other ICT members. The Care Manager helps to ensure member access to specialists and other needed services. The other ICT members contribute to care planning and utilization as the members care needs change over time.

The Care Manager documents all communication regarding clinical needs of the member in the system. Reports on services delivered are incorporated into the care management record to maintain a complete and up-to-date member record and disseminated to applicable ICT members. Information obtained from the PCP, specialists, hospitals, and other providers is incorporated into the individual plan of care, which is sent to the PCP electronically, via fax or written correspondence. The information including the ICP is shared with the beneficiary, PCP and any other providers as needed.

The ICT ensures that specialized services are delivered timely and efficiently to its SNP members by ensuring that services needing prior authorization are sent to Imperial as soon as the need is identified and within CMS timelines. Imperial abides by CMS timeliness requirements and processes these

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authorization requests accordingly. Care is directed to appropriately credentialed and specialized providers as is appropriate. Imperial monitors access to care reports and grievance reports to ensure care is timely, quality, adequate and effective.

3B Use of Clinical Practice Guidelines and Care Transitions Protocols

The SNP adheres to the Regulations at 42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix) that require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols.

3B Factor 1: Explain the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols.

The protocols that are developed for the Special Needs Plans utilize the latest evidence base that has been endorsed by the professional clinical societies and the case management societies. Thus, for Chronic Heart Failure and Cardiac Disorders SNPs, Imperial utilizes the Clinical Practice Guidelines that have been endorsed by the American College of Cardiology, American Heart Association, and the Heart Failure Society of America. For management of beneficiaries with Diabetes, the Guidelines endorsed by the American Diabetes Association. Furthermore, input from the National Quality Forum and NCQA endorsed literature is also utilized.

Imperial Medicare CPGS include:

- Obesity
- Heart failure
- Coronary artery disease
- Chronic kidney disease
- Asthma
- Chronic obstructive pulmonary diseases
- Diabetes
- Depression
- Anxiety
- Opioid management
- Substance use treatment

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The health plan also provides coverage for diagnostic and other preventive procedures based on the recommendations published by the US Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. These guidelines include such measures as screening for breast and colon cancer, CT scans of the chest for smokers, and vaccinations.

The Plan maintains a Chronic Care Improvement Program (CCIP) consistent with CMS requirements. CCIP will target at-risk Members to reduce the incidence of heart attacks and strokes as outlined in the Million Hearts initiative.

The Plan establishes participation criteria and an effective mechanism for systematic monitoring of the progress of Members enrolled in the CCIP program(s). Eligible members are identified based on presence of one or more of the chronic conditions as identified through medical and pharmacy claims data, as well as other means of risk stratification. Members may also be referred by any participant in the member's interdisciplinary care team, including providers, the member and/ or member's family/ caregiver. The program design addresses Member health literacy and cultural needs, and care plans are customized based on these needs and Members' readiness to make changes.

The protocols and guidelines are annually reviewed by the Chief Medical Officer and the Quality Improvement team to ensure that the protocols are consistent with the guidelines, culturally sensitive and relevant to the needs of the Imperial membership. Member education material, benefit plans and coverage parameters are reviewed against these guidelines annually to ensure consistency. Random sampling of provider records are reviewed for compliance with these clinical practice guidelines. Guidelines and any changes are disseminated annually to the providers. The changes are also communicated as they occur via the provider manual, newsletters, town hall meetings, and the website.

Oversight includes monitoring the provision of services to ensure providers adhere to nationally recognized clinical practice guidelines in clinical care; clinical services are appropriate and timely; follow-up on provision of services and benefits; seamless transition of care across settings and providers; and targeted medication and medical record reviews. Results of monitoring are housed in our data warehouse. Additions and deletions to protocols are updated in the database and on our website upon approval. Clinical Practice Guidelines are obtained through the National Guideline Clearinghouse, National Institute of Health (NIH), American Diabetes Association (ADA), and

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various Physician Associations. CCGs are approved by the Quality and Performance Improvement Committees (QPI) for provider network review. The guidelines are reviewed, revised, and approved on an annual basis, using nationally recognized evidenced based literature. The guidelines are developed with input from community physicians via the Quality Assurance and Performance Improvement Committee and approved by the QPI.

Member education material, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. A random sample of provider records is reviewed for compliance with one or more clinical practice guidelines. For example, with oncology practices, Imperial's Pharmacy and Therapeutics Committee works with the Oncologists to encourage use of guidelines as developed by the National Comprehensive Cancer Network (NCCN). It reviews the medication administration records and prior authorization records. When care is not clearly adhering to NCCN guidelines, the Oncology Medical Director will conduct a peer-to-peer discussion with the treating oncologist. Similarly, Imperial staff including the medical directors, and the Quality Improvement team will review other clinical notes to identify adherence to national guidelines. When access to the provider's electronic medical record (EMR) is available, then the team avails of this resource as well to determine if clinical guidelines are embedded.

Imperial also reviews the HEDIS reports to determine adherence to guidelines as apparent with metrics such as adherence to medications rates for applicable patients with hyperlipidemia, hypertension, diabetes, and other chronic conditions. The Pharmacy Director reviews the opioid overuse reports and works with the PBM and providers to ensure safe and intended utilization. Utilization reports also guide determination of adherence to guidelines and protocols through bed days/1000, readmissions, length of stay by DRG, pharmacy utilization.

3B Factor 2: Identifying and documenting instances where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries

Ongoing review of claims data, pharmacy data and clinical records allows for identification of gaps in care. This review facilitates production of clinically recommended services that are derived from evidence based clinical practice guidelines. Scorecards provide biannual updates to providers regarding their adherence to guidelines. The QI committee annually reviews provider compliance with

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guidelines. The data is also used to identify opportunities for provider education and program changes to improve performance. The guidelines from the national societies fit Imperial's SNP membership well. If the guidelines do not fit the needs of the membership with complex needs, the medical director in collaboration with the Chief Medical Officer and other providers will confer to agree on an appropriate deviation for the beneficiary.

Imperial also accesses regional tertiary care academic centers for guidance as needed as well as commercially available solutions and groups that review data and produce specific guidelines. Imperial maintains an agreement with Advanced Medical Reviews (AMR) giving the Chief Medical Officer access to nationally recognized specialists and subspecialists for consultation in applicable areas. Imperial Health Plan has similar agreements with Independent Review Organizations to ensure unbiased, high quality care is available to its beneficiaries. Furthermore, Imperial utilizes Centers of Excellence when contractually and logistically feasible.

To assist providers to use appropriate clinical practice guidelines, Imperial Health Plan conducts ongoing data mining of pharmacy and medical/behavioral health claim data and medical record information to identify gaps in care. Peer to peer meetings between providers and Medical Directors at Imperial to facilitate a dialogue to promote evidence-based care. Such engagement also allows for customization of care when given members vulnerable status, a nationally recognized protocol may need to be modified. On an annual basis, the QM team collects data and reports on provider compliance with clinical practice guidelines.

The data collected is used to identify opportunities for provider education or program changes to improve performance. Should a challenge arise where clinical practice guidelines or nationally recognized protocols do not fit the needs of beneficiaries with complex healthcare needs, the medical director, in conjunction with the Chief Medical Officer will confer with the beneficiary's treating physicians and other IDT members, as needed, to agree on an appropriate deviation for the beneficiary. The ICT is helpful in identifying situations where such deviations are needed. For example, a patient with risk of falls may not be safe for tighter glucose control. A patient with a reaction to statins may not be able to tolerate guideline driven statin use for hyperlipidemia. A patient with a history of anaphylaxis to ACE-inhibitors and intolerance to other similar agents may not be able to be optimized

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on guidelines driven treatment for CHF. In such situations, the Chief Medical Officer works with the clinical team and the providers to identify appropriate exceptions. This is recorded in the ICP and made part of the treatment plan. Subsequently, outcomes are still followed to ensure the patient is receiving the appropriate alternative treatment.

3B Factor 3: Providing details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT.

Imperial Health Plan has developed process and outcome measures to assess the adherence to best practice clinical guidelines and Member-specific health goals. Imperial Health Plan expects its providers to utilize guidelines, the complexity of the membership may make it difficult to do so due to the unique circumstances of a member. Thus, providers have flexibility in using professional judgement to incorporate patient specific clinical and other data to modify or not follow a particular guideline. When this occurs, providers are asked to supply additional clinical documentation and/or professional citations to justify the guideline deviation for authorization of a service. The medical director reviews this information to determine the appropriateness of the deviation. The ICT and providers discuss the benefit of the deviation, update the ICP and address the goals and interventions now agreed to. The case manager facilitates this process who is responsible for ensuring that the ICP includes an explanation regarding the deviation. Providers, members, and caregivers are given these updated ICPs reflecting the changes.

For example, for a member who may have income and housing instability that may create barriers to implementation of medication elements of care plans, the practitioners may adjust the CPG goals, such as an HbA1c of 7 or less for people with diabetes, to the circumstances of the member. For a patient with end stage CHF who chooses her definition of quality of life versus CPGs on CHF, dietary restrictions may be adjusted, given the wishes and circumstances of the member. In this way, Imperial adheres to harm reduction, that is recognizing the unique circumstances of each individual and meeting them with individualized care that reduces harm and aims to improve health to the greatest extent possible. Please also see 3B Factor 2 for further description of details on process of modifying guidelines for clinically complex members. The changes are documented in the ICP. The IDT is made

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aware during meetings as well as through portal, email or phone communication as changes are contemporaneously made.

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

SNP providers maintain continuity of care using the care transition protocols. Imperial manages care transitions and identifies problems that may result in unplanned transitions. Its care transitions team works with the member and providers to prevent unplanned transitions when possible. It educates members on ways to avoid having an unplanned transition such as a readmission or an avoidable admission. Imperial makes a special effort to coordinate care as members' transition from one level of care to a higher or lower acuity.

To achieve this goal, the following procedures are followed:

- The Utilization team works closely with providers to authorize planned procedures and admissions in a way that discharge planning starts before the procedure or admission. In this way, upon discharge, the member has services ready to ensure care at the least level of acuity. The UM team works with the provider's office to ensure authorizations are in place. Providers are trained to use the portal to have access to time sensitive data. The Care Transitions nurse works with case managers in hospital and nursing homes to ensure that discharge planning is robust and ancillary services such as DME, home health, PT, OT, transportation, post discharge provider visit are already scheduled. For high-risk patients, the IDT and the Care Transitions nurse collaborate to ensure that risk of readmission is lowered. For example, if a patient with heart failure (DRG 293) was admitted, then a home health visit may be arranged for counseling on a low salt diet, weight measurement and 5–7-day post discharge visit for medication reconciliation, and medical optimization.
- The authorization coordinator enters the pre-service inpatient authorization in the EZ CAP Citra Health Solutions (EZ CAP) system and provides notification to the Care/Case Management Associate for initiation and coordination of care plan with appropriate individuals within 72hours or next business day when urgent, and within 5-14 days for non-urgent, standard issues.

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- The Care/Case manager reviews daily elective approved authorizations and weekly open authorization referral report to identify that a planned transition is about to happen. Planned transitions include:
 - Elective hospital admissions
 - Elective skilled nursing facility admissions
 - Elective acute rehabilitation admissions
 - Elective Long Term Care Admission
 - Identifying Planned Transitions
 - Unplanned transitions are unanticipated changes in the member's level of care or care setting.
 - The Concurrent Review Coordinators enter the inpatient admission or Long- Term Care admission in EZ CAP system and provides notification to the Care/Case Management Associate for initiation of the coordination of a plan of care with appropriate individuals with hospital and or post-acute facility.
- Imperial identifies transitions by reviewing the following for facilities in its network: 1) Reports of hospital admissions within one business day of admission; 2) Reports of admissions to long-term care facilities within one business day of admission by reviewing the daily inpatient census.
- Care/Case Management associate may be notified of unplanned transitions of care through the following:
 - Non-contracted facility notification
 - Daily inpatient census
 - Home Health contracted vendors
 - Pre-service, concurrent, and retrospective review process
 - Health Plans internal associates also notify assigned Care/Case Management associate of new authorization requests as applicable.
- Management of Care
- The Provider Network inpatient management review occurs within one business day of notification of admission.

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- The Care Plan is tailored to each individual and takes the member's health status into consideration.
- The Care/Case Manager develops and/or updates the care plan.

Upon completion of an inpatient authorization and/or notification of concurrent admission process, an assessment for discharge planning procedures begins. The Case Manager contacts the interdisciplinary care team to assist with the completion of the assessment for appropriate discharge planning and care plan development. ICT members are added to team as needed.

Thus, providers are involved in the ICT and are encouraged to use the ICP to maintain consistency. Communication through the case manager and the web portal allows coordination.

The plan oversees care transitions by adhering to the Transition of Care policy and procedure and the Transition of Care program description outlined in MOC2 element E. All members admitted to a facility must meet the clinical guidelines for admission. Imperial providers are made aware of these requirements in the provider manual which is distributed upon orientation and electronically. It is also available for download on the website. Planned transitions from the member's usual setting of care to another setting, require prior authorization. When approved, providers and members receive written confirmation. Imperial maintains paper and electronic files on all authorization requests to facilitate the transfer of this information from one care setting to another.

For transitions such as to an acute care hospital, Imperial receives notification of the admission from the facility. It also receives an initial clinical review from the facility. Imperial notifies the primary care provider of the admission within 24 hours of receipt of this notice so that the PCP can be involved in continuity of care. Imperial's Chief Medical Officer provides oversight of the Transition of Care program. This involves establishing and maintaining active relationships with physicians, facilities, hospitalists, and conducting physician-to-physician discussions. The concurrent review nurse confers with the Medical Officer for case review. The Case Manager also assists members with establishing follow-up PCP and sub-specialist appointments and helps with coordination of services such as DME, home health and follow up appointments.

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Physicians and providers involved in the ICP are directed to use the plan of care as a tool to maintain alignment and consistency with treatment goals. They are also directed to communicate updated information related to the plan of care directly to the beneficiary's care manager or by entering information through the provider web portal as a care plan note. The Imperial provider network management policies and procedures document the process for linking members to services including care transitions. The plan oversees care transitions by adhering to the Transition of Care policy and procedure and the Transition of Care program description outlined in MOC 2 Element E. All members admitted to an acute hospital or sub-acute facility (i.e., SNF, Rehabilitation facility), must meet the clinical guidelines for admission.

Additionally, Imperial will be conducting a trial of an in-person Post Utilization Clinic, where a mid-level provider, social worker and pharmacist will review the admission with the patient, conduct a clinical assessment including physical exam, necessary labs, and imaging, and ensure that patients have necessary appointments and/or referrals in order to successfully transition out of the utilization to her former, or new routine.

Imperial network providers are made aware of the requirements for transitions of care in the Provider Manual, received during provider orientation and available electronically on the website. Planned transitions from the members' usual setting of care to another setting, such as elective inpatient admissions, require prior authorization by the plan. As noted in the Provider Manual, providers must submit an authorization request. After the authorization request being approved, providers and members receive written confirmation of service prior authorization, and the plan maintains paper and electronic files on all authorization requests to facilitate the transfer of this information from one care setting to another. When an unplanned transition from the members' usual setting of care to another setting, such as an inpatient acute facility setting, the plan receives notification of the admission from the facility and obtains an initial clinical review from the facility.

After receiving the notification Imperial notifies the primary care provider of the admission within 2 calendar days of the receipt of transition notification to support continuity of care upon discharge. The

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Imperial Chief Medical Officer provides oversight of the Transition of Care program, which includes establishing and maintaining active relationships with array of community providers (physicians, facilities, hospitalists, etc.), and conducting physician-to-physician discussions regarding the plan of care for members in unplanned transition and planned transitions when appropriate. As a part of the Transition of Care program, the concurrent review nurse confers with the Medical Director for case review in preparation for physician-to-physician calls. To maintain continuity of care during transitions, the case manager will also communicate to the accepting/transiting provider to facilitate the member's change of level of care.

3.C. MOC Training for the Provider Network

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

Imperial will be compliant with regulations at 42 CFR§422.101(f)(2)(ii) that require that SNPs conduct MOC training for their network of providers

Model of Care (MOC) Training Initial and annual MOC training is mandatory for all Providers contracted as well as out of network providers who see our SNP members. A Model of Care training is conducted initially at the time of contracting the provider via provider onboarding. Annual training is done via conference calls, WebEx, and PowerPoint slides. A fax and letter are sent out to the providers notifying them to access the website for their annual SNP training. The training, attestation and survey are provided in the form of PowerPoint slides on our website <https://www.imperialhealthplan.com>

Training content includes but is not limited to policies and procedures, including focused campaigns on Model of Care, Care Gaps, clinical guideline adherence, transitions of care and functionality available through the Provider Web Portal. To ensure consistency in the training content, standard presentation materials and handouts, accompanied by speaking points, are used. Participants are also given printed materials to reinforce key points of the training. The slides are attached to Appendix D. The training covers the following elements:

- History of SNP plans

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- Overview of the DSNP
 - Specific population demographic, needs
 - Eligibility for SNP
 - Most vulnerable members
- Care Coordination in DNSP
 - Staff Structure
 - Health Risk Assessment
 - Individualized Care Plan
 - Face to Face Encounters
 - Interdisciplinary Care Team
 - Care Transition
- Provider Network
 - CPGs and Care Transition Protocols
 - MOC Training
 - MOC Quality Measurement and Performance Improvement
- MOC Quality Performance Improvement Plan
 - Goals and Health Outcomes for the MOC
 - Patient Experience of Care
 - Performance Improvement Evaluation of the MOC
 - Communication of SNP Quality Performance Related to the MOC

3C Factor 2: How the Organization documents evidence that network providers receive MOC Training.

Network Physicians are provided training through, PowerPoint Slides, available on our website and announced through new provider onboarding training, fax blasts and conference calls. The MOC training is always accessible on the website for providers to complete as needed and directed to the website when the training must be completed. Upon each provider completing the MOC training and signing the attestation, each provider who signs attestation will fax or email to Provider Network Management. The verification of training is maintained internally in each provider/vendors record. Proof of training is maintained by a completed signed attestation form by the providers. Provider Relations Director works with providers and out of network providers to meet the annual training requirements and administer a correction action plan when they are not met. Imperial requires annual MOC training and the contracts with providers list this as a condition of participation. A sign in sheet is also provided to providers after training is complete.

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3C Factor 3: Explain challenges associated with the completion of MOC training for network providers.

Arranging training for all providers across a large area of operation to attend sessions can be a challenge. Capturing modifications to the physician roster by health systems and provider groups can make it difficult to keep track of providers needing training. Since providers may participate with several plans, the administrative burden may be high. Providers may miss training due to scheduling conflicts, increase in member needs, time limitation and staffing resource challenges. In the past year of the pandemic, ensuring providers complete the training has been a particular challenge. As the pandemic recedes, this barrier is reducing. Furthermore, with the adoption of videoconferencing technologies, a new opportunity for training has arisen.

3C Factor 4: Taking action when the required MOC training is deficient or has not been completed.

A post SNP MOC Evaluation is given to all providers to measure the effectiveness of the training with a scale 1, very dissatisfied to 4, very satisfied. The questions may include but are not limited to the following:

- Was the online SNP MOC Training PowerPoint easy to use?
- Was the training content easy to understand?
- Did you find the PowerPoint training helpful in understanding the MOC processes?
- Did the presentation provide the appropriate guidance to understand your role and responsibilities within the MOC?

The information gathered from the evaluation is used to make changes to the annual training each year. If exhaustive attempts to make training available to providers do not lead to compliance with training, then corrective action plans may need to be issued. If these are not completed, then further action may be needed such as withholding a portion of the contracted amount due to a provider until the training is completed. The Chief Medical Officer confers with the provider to determine barriers to the training and explore alternative ways to deliver the training. The provider is counseled about the Plan's

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obligations to CMS to ensure adherence to the MOC. If quality of services issues arise in the practice indicating the provider is not performing to contractual obligations and to professional standards, then referral to the QI team can be made. The Credentialing Committee may also be involved in off cycle reviews. Actions may include but are not limited to informal discussion, peer to peer discussions, referral to the QI/Credentialing committee. Termination from the network or temporary suspension from participation may be necessary in extreme cases.

4. MOC Quality Measurement and Performance Improvement

Imperial will be compliant with regulations at 42 CFR §422.152(g) that require that all SNPs conduct a quality improvement program that measures the effectiveness of its MOC.

4A. MOC Quality Performance Improvement Plan

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

Imperial has a comprehensive Quality Improvement (QI) Program to measure performance. This program is in place to determine if systems and clinical processes are effectively supporting the SNP beneficiaries' unique needs, including any modifications made as greater experience with the program develops.

Imperial's QI Program is designed to monitor key components, compare results against goals or benchmarks, identify opportunities for improvement, make decisions to prioritize identified areas of focus and allocate resources. Additionally, the QI Program evaluates the quality, appropriateness and outcomes of care and services that are being delivered to our SNP members. Feature of the program include on-going monitoring of quality activities throughout the year. This also includes quarterly evaluation of key performance initiatives. The QI Program evaluates how well the medical and behavioral health and services are coordinated and delivered to our members with their eligible benefits.

The QI Program has mechanisms to continuously pursue opportunities for improvement. The Model

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of Care/Quality Improvement Committee (MOC/QI) is a committee with accountability that provides oversight to ensure that the performance of the MOC Program meets its established goals. The Committee establishes direction, recommends changes and evaluates results of the on-going SNP clinical and service improvement activities documented in the work plan. The MOC/QI committee will meet on at least a quarterly basis, and may meet more frequently, if needed to ensure it meets the established goals.

Imperial's goal is to deliver high quality health care services and benefits to our SNP beneficiaries. Imperial defines its MOC by the delivery of high-quality medical care by its contracted providers, as well as care coordination, including care transitions services to our diverse CSNP target population. Our model of care is focused on meeting the clinical, social, and behavioral health needs of our patients.

The key components of the Imperial MOC are:

- To perform annual population assessment for each service area that identifies the specific needs of the SNP population. The annual assessment identifies the most vulnerable members including an evaluation of any special or unique needs. These may include age, race and ethnicity, language, disease categories, risk status aimed as well as other factors. The MOC also evaluates if these needs are being met.
- Hire and train qualified administrative clinical staff supporting the delivery of care and medical management services for the SNP beneficiaries.
- Ensure all administrative and clinical staff/teams are trained on MOC requirements, upon onboarding and on an annual basis.
 - Ensure that our Health Risk Assessment (HRA) Tool identifies key indicators. These include a patient's medical, functional status, cognitive, psychosocial, and behavioral health status. This assessment is performed upon enrollment (within 90 days), and annually for all SNP members.
 - Ensure Practitioners are utilizing nationally recognized Clinical Practice Guidelines for managing SNP members. The Chief Medical Officer, in collaboration with the Medical Directors, evaluate the delivery of quality of care by the provider network. Some criteria

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used for ensuring that Clinical Practice Guidelines are being followed is to assess the adherence to the Appropriate Use Criteria as promulgated by the American Board of Internal Medicine and other professional organizations, consensus statements on clinical practice set forth by the various medical and surgical specialties, and clinical protocols.

- Individualized Care Plan (ICP) is developed for all SNP members.
- Develop an Interdisciplinary Care Team (ICT) which has access to clinical information including HRAs, ICPs, care transition protocols. The ICT is comprised of the Chief Medical Officer, UM and Care Management Teams, Primary Care Practitioners (PCPs) and any Providers involved in delivering coordinated care that involves the member and/or caregiver.
- Develop and maintain a specialized provider network, including specialists and facilities.
- Ensure Providers including Out of Network Providers receive MOC Training, initially and annually, and understand the requirements
- Disseminating the Quality Improvement activities results to our internal, external stakeholders, SNP Beneficiaries and Providers.
- Implementation of MOC Quality Improvement Work Plan and completion of the annual MOC Quality Program Evaluation assessing overall effectiveness and outcomes for SNP beneficiaries.

4A Factor 2: Describes process how plan collects specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance.

Imperial's Quality and Performance Improvement ensures appropriate services are being delivered to SNP Beneficiaries. The improvement plan detects whether the MOC Structure effectively accommodates beneficiary's health care needs. The Model of Care is evaluated based on processes and measures detailed below.

Specific data sources used to assess and administer the MOC include but are not limited to the following:

- Healthcare Effectiveness Data Information Sets (HEDIS). These utilize encounters claims, and medical records as data sources. A measurement and reporting tool developed and maintained

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by the National Quality Committee for Quality Assurance (NCQA); Imperial uses HEDIS clinical measures to evaluate the MOC annually. These measures are a component of the Star program as well and are used by the Stars program at Imperial.

- CAHPS Survey (Member Satisfaction): This survey is conducted annually. These patient surveys rate the healthcare experience and are utilized by CMS to measure member satisfaction in five key areas:
 - a. Getting Care Quickly
 - b. How Well Doctor Communicate
 - c. Health Plan Customer Service
 - d. Enrollee Ratings.
 - Rating of healthcare
 - Rating of Personal doctor
 - Rating of specialist
 - Rating of Health Plan
- Grievance and Appeals Data: This data allows Imperial to identify challenges with access to care or reasons for delays in care. The A& G performance reports are evaluated for trends and will be presented to MOC Committee. Imperial can identify grievance and appeals but limited to the following methods:
 - Member call to Member Services Department
 - Written letters from members
 - Grievance can also be submitted from a Practitioner/Provider office, on behalf the member.
 - These data sources are reviewed and annualized by month
- Health Risk Assessments: HRA Data is documented in HealthViewX and is reviewed weekly to evaluate HRA completion rates. Additionally, the HRA metrics are evaluated by clinical team and reviewed at Quality Management Team meetings and at least quarterly at the MOC Committee.
- Eligibility and Provider Network Data: These data sets are used to evaluate provider access and availability.
- **Appointment Availability:** The Network Adequacy Team oversee and measures the SNP Member access to care that includes but not limited to: regular and routine care appointments,

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urgent care appointments, and after hours. The appointment availability is monitored at least quarterly and an annual qualitative and quantitative evaluation is reviewed and presented at the Model of Care Committee.

- **Network Adequacy Geographical Access to Provider**

The Network Adequacy/Contracting team oversee and monitor the SNP Member geographical access to provider within the required travel time and distance requirements, ensuring SNP members have access to care. The Provider Geographical Network adequacy is monitored at least quarterly. An annual qualitative and quantitative evaluation is reviewed and presented at the Model of Care Committee

- Encounter Claims and clinical information is used to stratify patients by their imputed risk for medical issues and need for care/support. Member data is used to perform the annual population assessment and risk stratification. The Population Assessment will be utilized to stratify members by disease state for targeted intervention.
- Health Outcomes Survey (HOS): The Quality Team oversees the HOS Survey Project which is conducted annually by a certified vendor. Each year a baseline cohort will be drawn and a statistically significant sample size for eligible members per reporting unit will be surveyed. The survey is designed to achieve a 75 percent response rate. Each year a cohort drawn two years previously will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well-being of each respondent. The HOS project is a performance improvement initiative that is part of the MOC Work Plan and annual results are reported at the MOC Committee.
- Each of the Quality Measures described above are documented in MOC Work Plan and reviewed quarterly at the MOC Committee. All annual summary reports, findings and recommendations are reviewed at the MOC Committee. For any MOC metrics that does not meet goal, will be reevaluated by committee, and goal will be adjusted (e.g., by 5%) and proposed interventions to implement for the following year.

Imperial is committed to continuously improving the quality of care and services provided to our enrollees and promoting effective and efficient utilization of health care resources. These commitments are achieved through an organization-wide Quality Improvement Program (QI Program.) The QI Program is designed to improve the health of enrollees, deliver the best possible

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health care value, promote objective and systematic program measurements, monitor, and evaluate services, and implement quality improvement activities based on these findings. The QI Program facilitates safe, appropriate, and efficient quality care by using evidence-based standards of medical care that meet regulatory requirements. Imperial's MOC is based on evidence-based guidelines and data and is continuously reviewed and updated. Its model of predictive analytics, population health, care coordination, prevention, wellness, and continuity of care allows it to deliver care that is accessible, high quality and with good outcomes. Imperial is data driven and collects information that can then be shared with all stakeholders. Imperial's evaluation methodology allows for tracking and trending to improve services. The ability to assess trends and establishing corrective action plans that can be implemented assure that Imperial is solving an identified issue.

These reports and outcomes are reviewed as made available by CMS, contracted vendors, and HPMS. This is typically at least annually. Other reports are available quarterly and some monthly, Imperial also leverages its internal reports which are tracking the mandated reports with internally available data on a real time basis.

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

The Senior Manager of the Quality Improvement department, under the direction of the CMO, works with the plan's operational departments to collect, analyze, report on data for evaluation of the MOC. Different reports are generated based on the specific needs at the time. The QI department in consultation with the Chief Medical Officer and staff performs required qualitative and quantitative analysis of all MOC Metrics and will be formalized in the annual SNP MOC Evaluation Report. These summary analyses are reviewed and discussed at the MOC Committee on a quarterly basis. These meeting may be more frequent, as necessary. Any MOC performance metric that does not meet goal, will be added to the following year's MOC Work Plan. The Quality Improvement department along with Directors/Leaders in Credentialing, Case Management, Utilization Management, Disease Management, Complex Case Management, and other departments work with the Information Technology Department to ensure all data is captured. Information from the Medicare Quality Improvement Organizations (QIO) may also be obtained.

Additionally, data from the pharmacy benefits manager administering the Part D benefit is incorporated

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along with Claim's data. The data is shared and joint decision making to resolve issues is made. Data from medical record reviews, annual wellness exams, and record surveys to report on HEDIS measures are performed.

The performance improvement process is highly valued as part of the quality structure at Imperial, and requires involvement from senior leadership, the Chief Medical Officer and CEO and is demonstrated through quarterly Model of Care Committee.. The MOC Committee reports up to the Quality Management Committee which reports to the Board.

Contracted vendors are retained to perform annual data validation audits as well. Care managers, supervisors, and other staff review, generate and analyze reports related to the MOC. Recommendations for actions to appropriate committees are made. The QI department also follows up with the data to ensure that the recommendations are implemented as approved and appropriate.

Additionally, other resources that are involve include but not limited to:

- The Medicare Quality Improvement Organization (QIO) that provides reports on Medicare Part D and aids with state requirements
- Contracted vendor that conducts surveys and provides analysis on the CAHPS and member satisfaction surveys.
- Contracted vendor that conducts patient record surveys to report on HEDIS measures and conducts the annual data validation audit.
- Pharmacy Benefit Management (PBM) - Part D resource supporting collection and analyses of pharmacy utilization management and medication therapy management program data as well as patient safety reports.
- Care manager and/or care manager supervisors, reviews, generates, and analyzes all reports related to the evaluation of the Model of Care. Care managers and/or supervisors makes recommendations for action to appropriate committees and provides the follow-up in the quality work plan to ensure the recommendations are implemented as approved and appropriate.

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As a result, departmental and organizational leadership are also involved in the Model of Care performance improvement plan to ensure that there is an organization wide commitment to the process. While leadership has decision making authority, to maintain a high reliability organization, Imperial strives to ensure that all stakeholders are empowered to affect the outcome and ensure that their views/concerns are addressed.

4A Factor 4: Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B).

Imperial's Quality and Performance Improvement ensures appropriate services are being delivered to SNP Beneficiaries. The improvement plan detects whether the MOC Structure effectively accommodates beneficiary's health care needs. The Model of Care is evaluated based on and not limited the following measures:

- Process Measures
- Grievances related to access of care
- Timeliness of Assessment Processes
- Physician Relationships (% populations with PCP or Medical Home Relationship)
- Care Meetings- Case/Care Management Performance Care Measures
- Utilization Patterns
- Prescribing Patterns
- Drug Interactions
- Readmissions Quality Measures
- HEDIS
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Outcome Measures
 - HEDIS Outcome Measures
 - Health Outcome Surveys
 - Effectiveness of Quality Improvement Initiatives

These data sources and measures are reflected on the MOC Work Plan and communicated to all stakeholders. Through joint operating conferences, tracking, trending, and identification of causes of issues are made, these can then be resolved. The prior quarter's data is also discussed at the MOC

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committee. At this time, the Chief Medical Officer will provide additional feedback to departments and providers as needed.

To carry out processes for continuous collections, analyses, evaluation and reporting on quality performance, the Quality Improvement (QI) Department has designed an MOC Evaluation Work Plan.

Specific data sources used to analyze, evaluate and report MOC quality performance include inter-departmental reports (such as utilization reports), MOC Work Plan and the data collected for completion of the MOC annual evaluation, and CMS MOC audit results. Measurements relevant to identifying MOC performance measures include the outlined MOC goals and their identified benchmarks.

Every quarter, the QI department uses the MOC Work Plan described above, to ensure that processes relevant to the MOC are implemented according to timeframes. Each process owner will report on their respective item and share an update. The QI department uses the MOC Work Plan as a guide and tool to measure its performance improvement. The work plan goals are made a part of the key performance indicators for the involved departments and its leadership. Benchmarks are used to measure progress towards goals set forth in the MOC. Departments will be advised, individually, regarding results of MOC audit and given recommendations by the QI department. The quarter following the internal audit, reports/results of quality performance as discovered during audit will be presented during the MOC Committee. At this time, the Chief Medical Officer will provide additional feedback to departments, as necessary. The QI department provides feedback and support, as needed.

The data sources are incorporated into the MOC Work Plan and are assessed qualitatively and quantitatively, as part of the annual MOC evaluation, to identify trends, opportunities for improvement. While results are presented and discussed quarterly, the SNP performs continuous evaluation to create a process of constant improvement to enhance outcomes, efficiency, and member satisfaction.

MOC goals reset annually to encourage Imperial practitioners to provide preventive services, acute care services, and chronic disease management at the highest standards of current healthcare quality.

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Benchmarks are developed based on the most up-to-date data available for industry-wide performance (example: HEDIS Medicare Advantage HMO percentiles) and prior performance within Imperial (example: year-to-year comparison of hospital readmissions). Progress toward goals the organization has established for healthcare quality measures from HEDIS, CAHPS and HOS results, and Part D medication adherence is reported on a quarterly basis. Internal reports on elements such as hospital and SNF utilization, disease management program effectiveness, member complaints and grievances, and credentialing reviews are analyzed on a quarterly basis to ensure overall performance is maintained.

Performance improvement is a continuous and iterative process. When evaluating MOC performance, the Plan, Do, Study, Act (PDSA) methodology is used to address below expected results. This includes planning the improvement, performing the intervention, studying the results, and acting to stabilize and continue improvement. Based on such processes, stakeholders implement changes identified, along with allocating needed resources. The plan outlining goals, strategies, expected results and timeline is created and shared. The MOC Committee is an ongoing oversight process to evaluate results and review progress toward goals and discuss proposed interventions in a formalize committee. Every quarter, the results and recommended actions/impact are reported to the MOC Committee by the managers and projects updates are provided.

Imperial uses the data from the HOS, CAHPS, HEDIS, patient surveys, encounter data, internal Star measures to determine if goals are being met. The internal surveys are performed quarterly. The encounter data is evaluated monthly. The HOS, CAHPS and HEDIS data is evaluated. The goal for the HOS, CAHPS and HEDIS data is to achieve 5 Stars level achievement. Scorecards with internal data are used as a surrogate marker for the official results annually provided by CMS. These scorecards are produced monthly and presented in a dashboard that is shared with all stakeholders. Providers are given visibility to this data as well with the assistance of the Provider Network Operations department. An annual MOC workplan is created with goals determined and measured against publicly available industry benchmarks. The workplan is evaluated quarterly and if not meeting the stated benchmark, then the QI team determines the likelihood of achieving the goal and resources needed to achieve the goal. Senior leadership may be involved to prioritize the goal and deploy the needed resources and support necessary. Once an intervention is made, internal metrics continue to be

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monitored on a monthly and quarterly basis.

See table 1 below detailing if HEDIS, CAHPS and HOS goals were met and the intervention plan if goals were not:

Metric	Old Target Goal	Goals Met	Intervention if Goals Not Met	New Target Goal	Data Source
Healthcare Effectiveness Data and Information Set (HEDIS)					
Comprehensive Diabetes Care- Eye Exam	To reach 4 stars at 73% performance	No Diabetic eye exam rate was 39.48%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 73% performance	HEDIS
Comprehensive Diabetes Care- HbA1C Control < 8%	To reach 4 stars at 73% performance	Yes HbA1C Control rate was 88.80%		To reach 4 stars with 73% performance	HEDIS
Comprehensive Diabetes Care- Nephropathy	To reach 5 stars at 95% performance	No Nephropathy rate was 93.60%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 73% performance	HEDIS
Kidney Health Evaluation for Patients with Diabetes- KED	To reach 4 stars at 95% performance	No KED rate was 46.50%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 Stars with 95% performance	HEDIS
Breast Cancer Screening (BCS)	To reach 4 stars at 76% performance	No BCS rate was 58.57%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 76% performance	HEDIS
Colorectal Cancer Screening (COL)	To reach 4 stars with 73% performance	No COL rate was 24.28%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 73% performance	HEDIS
Controlling Blood Pressure (CBP)	To reach 4 stars with 75% performance	No CBP rate was 37.27%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 75% performance	HEDIS
Care for Older Adults	To reach 4 stars with:	No	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To achieve 4 stars with 95% performance	HEDIS
	Advance Care Planning: 85%	Advance Care Planning: 28.21%			
	Functional Status: 85%	Functional Status: 45.05%			
	Pain Screening: 85%	Pain Screening: 21.42%			
	Medication Review: 87%	Medication Review: 18.68%			
Medication Adherence					
Diabetes Medication	To reach 5 stars with 83% performance	No Diabetes medication rate was 82.62%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 5 stars with 83% performance	HEDIS
Statin Use in Persons with Diabetes	To reach 5 stars with 83% performance	Yes Statin use in Persons with		To reach 5 stars with 83% performance	HEDIS

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		Diabetes was 85.28%			
Cholesterol	To reach 5 stars with 87%	No Cholesterol Medication rate was at 79.18%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 5 stars with reaching 87% performance	HEDIS
Blood Pressure Medications	To reach 5 stars with 88%	No, BP Medication rate was at 83.99%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 5 stars with 88% performance	HEDIS
Transition of Care					
Patient Engagement	To reach 4 stars at 73% performance	No, TRC rate was 70.31%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 71% performance	HEDIS
Medication Reconciliation Post-Discharge MRP	To reach 4 stars with 73% performance	No MRP rate was at 9.03%	Track Trends and improvement to give evidence that proactive efforts are improving our rates to meet performance	To reach 4 stars with 71% performance	HEDIS
Consumer Assessment of Healthcare Providers & Systems (CAHPS)					
C03: Annual Flu Vaccine	To reach 4 star level Based on SPH Star Cut Points: 76%	No Rate: 65.3%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
C23: Getting Appointments and Care Quickly	To reach 4 star level Based on SPH Star Cut Points: 80%	No 65.3%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
C24: Customer Service	To reach 4 star level Based on SPH Star Cut Points: 92%	No Rate: 85.5%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
C25: Rating of Health Care Quality	To reach 4 star level Based on SPH Star Cut Points: 88%	No Rate: 80.3%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
C26: Rating of Health Plan	To reach 4 star level Based on SPH Star Cut Points: 88%	No Rate: 80.3%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
C27: Care Coordinator	To reach 4 star level Based on SPH Star Cut Points: 87%	No Rate: 77.3%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
D07: Rating of Drug Plan	To reach 4 star level Based on SPH Star Cut Points: 87%	No Rate: 85.5%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
D08: Getting Needed Prescription Drugs	To reach 4 star level Based on SPH Star Cut Points: 92%	No Rate: 83.8%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on SPH Star Cut Points	CAHPS
Health Outcome Surveys (HOS)					

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Discussing Urinary Incontinence	Goals based on CMS Region 9 Goal: 75%	No Rate: 61.20%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Receiving Urinary Incontinence Treatment	Goals based on CMS Region 9 Goal: 56%	No Rate: 46.74%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Impact of Urinary Incontinence	Goals based on CMS Region 9 Goal: 31%	No Rate: 17.85%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Discussing Physical Activity	Goals based on CMS Region 9 Goal: 74%	No, Rate: 54.02%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Advising Physical Activity Rate	Goals based on CMS Region 9 Goal: 63%	No Rate: 52.22%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Discussing Fall Risk Rate	Goals based on CMS Region 9 Goal: 37%	No Rate: 27.69%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Managing Fall Risk Rate	Goals based on CMS Region 9 Goal: 78%	No Rate: 59.30%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS
Osteoporosis Testing in Older Women	Goals based on CMS Region 9 Goal: 89%	No Rate: 73.55%	We will track trends and improvement to give evidence the proactive efforts are improving our rates to meet performance.	To reach 4 stars with reaching benchmarks based on CMS Region 9	HOS

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4B. Measurable Goals and Health Outcomes for the MOC

4.B. Factor 1: Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.

The goal of the SNP is to improve upon access and affordability, continuity of care and appropriate delivery of services. It seeks to enhance care transitions across all settings, and to use appropriate services for preventive and chronic conditions. The SNP measurable goals described in the table detail additional process and member health outcome measures, including data sources and performance goals, used to evaluate the Model of Care. Each measure has a different measurement frequency in accordance with the data sources used to collect the measure, time needed to impact the measure, or regulatory requirements. The timeframe for meeting each goal is typically one measurement year. All measures not meeting the specified goal within the timeframe are added to the following year's MOC Work Plan with a revised goal and reviewed at the MOC Committee. Evaluated.

MOC data elements below are used to evaluate the overall SNP population on a quarterly to annual basis:

- Appeals and grievances (part C and Part D)
- Behavioral Health access (authorizations, claims)
- Care Plans (System or facility care plans)
- Care transitions across care settings (facility reporting, authorizations)
- Complaints and grievances (complaint data)
- Complex case management (CCM data)
- Drug utilization review (poly pharmacy, high narcotic use, duplicate therapy reports)
- Emergency Department utilization (claims data)
- Hospital admissions, readmissions (authorizations, concurrent review, claims)
- HRA (HRA data)
- Monitoring of SNP members risk stratification (risk stratification software and reporting)
- Monitoring of HEDIS outcomes measures specific to the SNP members against NCQA HEDIS benchmarks (HEDIS reporting)
- SNP Members participating in medication therapy management program (pharmacy data)
- Top medication and medication classes report (pharmacy data)
- Network Adequacy evaluated monthly
- Monitoring of Star measures for the current measurement year.

These measures include data sources and performance goals and are used to evaluate the MOC and

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included in the MOC Work Plan. The measures are reported on a frequency determined by internal policy and regulatory requirement.

The SNP conducts ongoing reviews of the results on a monthly, and on a quarterly basis using internal ad hoc reports. These are then measured against public and regulatory benchmarks as applicable to measure the accuracy of the SNP’s internal metrics. Goal for Star measures is to achieve at least 4-star level of achievement on metrics. A monthly dashboard with achievement of scores is tracked and distributed to all stakeholders. Please see the table below: Tracking of HEDIS Goals.

Similarly, a HEDIS dashboard is tracked internally as below:

H2793	HEDIS Measure	Compliant	Total Pop	2021 Rate	Hits to 2 Star	Hits to 3 Star	Hits to 4 Star	Hits to 5 Star	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
BCS	Admin	41	70	58.57%	NA	5	12	17	< 50%	≥ 50% to < 66%	≥ 66% to < 76%	≥ 76% to < 83%	≥ 83%
CBP	Hybrid	161	432	37.27%	59	107	163	193	< 51%	≥ 51% to < 62%	≥ 62% to < 75%	≥ 75% to < 82%	≥ 82%
CDC <8	Hybrid	222	250	88.80%	NA	NA	NA	NA	< 37%	≥ 37% to < 61%	≥ 61% to < 72%	≥ 72% to < 85%	≥ 85%
CDC Eye	Hybrid	102	250	40.80%	56	71	81	93	< 63%	≥ 63% to < 69%	≥ 69% to < 73%	≥ 73% to < 78%	≥ 78%
CDC Hba1c Test	Hybrid	222	250	88.80%	NA	NA	NA	NA	< 37%	≥ 37% to < 61%	≥ 61% to < 72%	≥ 72% to < 85%	≥ 85%
CDC Neph	Hybrid	234	250	93.60%	NA	NA	4	9	NA	NA	≥ 80% to < 95%	≥ 95% to < 97%	≥ 97%
COA ADVCare	Hybrid- Retired Measure	167	985	16.95%	NA	NA	NA	NA					
COA FSA	Hybrid- Display Measure	411	985	41.73%	131	288	426	505	< 55%	≥ 55% to < 71%	≥ 71% to < 85%	≥ 85% to < 93%	≥ 93%
COA MedRev	Hybrid	184	985	18.68%	437	574	673	752	< 63%	≥ 63% to < 77%	≥ 77% to < 87%	≥ 87% to < 95%	≥ 95%
COA Pain	Hybrid	211	985	21.42%	370	587	636	715	< 59%	≥ 59% to < 81%	≥ 81% to < 86%	≥ 86% to < 94%	≥ 94%
COL	Hybrid	67	276	24.28%	52	104	134	154	< 43%	≥ 43% to < 62%	≥ 62% to < 73%	≥ 73% to < 80%	≥ 80%
KED	Admin	133	286	46.50%	NA	96	139	144	NA	NA	≥ 80% to < 95%	≥ 95% to < 97%	≥ 97%
TRC MRP	Hybrid	29	321	9.03%	125	170	199	241	< 48%	≥ 48% to < 62%	≥ 62% to < 71%	≥ 71% to < 84%	≥ 84%
TRC Patient Engage	Hybrid	226	321	70.40%	NA	-27	2	44	< 48%	≥ 48% to < 62%	≥ 62% to < 71%	≥ 71% to < 84%	≥ 84%

When the benchmarks and internally determined goals are not met, these are used as a rationale for root cause analysis, quality improvement projects, PDSA and opportunity to re-determine priorities and strategies.

4B Factor 2: Identify specific beneficiary health outcomes measures used to measure overall SNP population health outcomes.

Utilizing measurable metrics as identified below, Imperial focuses on measurable goals, benchmarks, and the frequency of each goal. Additional clinical outcomes measures are also described below.

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Please see table 2 below, detailing old and new target goals plus the intervention plan:

Metric	Old Target Goal	Goals Met	Intervention if Goals Not Met	New Target Goal	Goal Source	Data Source	Measurement Frequency
Improving Access to essential services such as medical, mental health and social services							
Provider Network Access and Availability	Access to Providers: 100%	No	<p>1) Continuous Provider education regarding appointment access so physicians can provide coverage for urgent and emergent appointments.</p> <p>2) Increase the scope/size of the assessment.</p> <p>3) Prioritize the providers with the highest number of member interactions</p>	Access to Providers: 90%	Internal	Internal Survey	Annually
	After Hours: 95%			After Hours: 90%			
	Urgent Care within 24 hours: 95%			Urgent Care within 24 hours: 90%			
	Non-Urgent Care within 48 hours: 95%			Non-Urgent Care within 48 Hours: 90%			
	Routine Primary Care within 10 days: 95%			Routine Primary Care within 10 days: 90%			
Provider Network Adequacy	Time and Distance Requirements	No	<p>1) Continue recruiting Primary Care Physicians, Specialists, Hospitals, Ancillary Providers into network either through direct contracts with Providers or through PPG/IPAs. The recruitment will also consist of high Impact and High-volume providers.</p>	Time and Distance Requirements:	CMS	Quest Analytics Report	Annually
	Micro: 100%			Micro: 90%			
	Metro: 100%			Metro: 90%			
	Large: 100%			Large: 90%			
	Rural: 100%			Rural: 90%			
Member Complaints about Network Access	<4 complaints/1000	Yes/1.64		<4 complaints/1000	N/A	Report	Semi-Annually
Generic Drug Dispensing Rate	80%	Yes/85%		80%	Internal	Pharmacy Data	Quarterly
Improving Access to Affordable Care							
Member Service Appeals	Appeals/1000	Yes/10.52		Member Service Appeals/1000	Internal	Member Service Appeals Log	Quarterly
Out-of-Network Utilization	30%	Yes/ 0.54%		30%	Internal	Utilization Reports	Quarterly

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Improving Health Outcomes								
Health Risk Assessments	New Goal				Members Complete HRA: 100%	Internal	Utilization Reports	Quarterly
Individualized Care Plans	New Goal				Members with ICP: 100%	Internal	Utilization Reports	Quarterly
Individualized Care Team	New Goal				Members with ICT: 100%	Internal	Utilization Reports	Quarterly

As the table above demonstrates, outcomes measures related to access and affordability, continuity of care, and care transitions are being measured and evaluated quarterly to annually. Clinical measures are detailed below.

Increase the medication adherence by members who fail to fill their medications regularly because of cost. Even with low-income subsidies, many of our members go without needed medications because of the high-cost sharing. Many of these members have many drugs prescribed each month. The combined cost sharing adds up quickly when a member takes over 10 medications. Here is an opportunity to consolidate medication therapy and educate members about plan benefits that help with costs. In addition, Imperial has an opportunity to work with providers to reduce waste, improve adherence and educate on cost options. Imperial’s Director of Pharmacy collaborates with the Member Services department and the PBM to ensure calls are made to patients to remind them to renew and pick up their prescriptions. When feasible, conversion to 90-day supply is supported. Goal: Achieve >85% adherence to Statins, antihypertensive, and lipid lowering agents.

Improvements made in the coordination of care and appropriate delivery of services through direct alignment of the HRAT, ICP and ICT. The IDT meets monthly to review high risk patients. The interdisciplinary meetings review utilization, clinical metrics, adherence, outreach, admissions, readmissions, care transitions needs and community support for members. The goal is to maintain readmissions less than 7.5%. A quarterly UM committee meeting also reviews metrics related to utilization to ensure that high quality, cost effective care is being delivered. These improvements reduce the number of emergency room visits by the imminently terminal patients (disease prognosis is under six months). For example, a goal for reduction in ER visits is to reduce such visits by 10% over the course of the year. This goal is to be achieved by careful outpatient care planning, member outreach,

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facilitating appointments with providers, care planning and medication adherence. Data sources for measurement of these metrics is from medical claims data, hospital reports, prescription drug events (PDE), medication therapeutic management (MTM) reviews, Comprehensive Medication Reviews. The time frame for these measurements is monthly as reports are received through the CMS TPA and HPMS reports along with internal tracking. If goals are not met, the QI team confers with the clinical teams to perform a root cause analysis (RCA) to Identify the barriers or reasons that we did not meet this goal for members and practitioners. Resolution of the issue may involve working with primary care providers and patients to address the barriers. The IDT and QI teams develop a plan of action and implement changes to meet the goal.

Expected Health Outcome:

Remain independent at home and symptoms well controlled.

Given the prevalence of chronic conditions in its beneficiary population and frailty of its dual eligible membership, an important target is the management of chronic conditions. To manage such beneficiaries, the following steps are taken:

- All heart failure patients have a comprehensive assessment every 12 months
- Those who are determined to be high risk are contacted weekly for approximately six months
- Those developing symptoms of a heart failure exacerbation are referred to their primary providers

During phone calls or visits, case managers provide self-management support, educate individuals and caregivers about the disease process, promote medication adherence and help identify early signs of a heart failure exacerbation. The clinical team, in collaboration with the data management team tracks metrics as below to identify high risk patients who are then closely followed over the year by care transitions nurses.

The following are outcome measures:

- Heart Failure Hospitalization Rate
- Heart Failure Readmission Rate
- Heart Failure Emergency Department Utilization Rate
- Medication adherence to high blood pressure medication

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Please see table: Heart Failure Outcome Measures

Heart Failure Measure Outcomes				
Topic	Measurable Objective	2021 Outcome	Measurement Frequency	Data Source
Heart Failure Hospitalization Rates	Hospitalization Rate/1000	182.56 /1000	Quarterly	Utilization Report
Heart Failure Readmission Rate	Readmission Rate (%)	15%	Quarterly	Utilization Report
Heart Failure: ER Visit Rate	Er Visits/1000	697/1000	Quarterly	Utilization Report
Mean Heart Failure Enrollee Cost	Our goal is to not surpass the national average of \$24,383			

If goals are not met as detailed in the MOC Work Plan, the annual results are reviewed and discussed at the MOC Committee. Formalized interventions will be reviewed and agreed upon that will be documented in the next year's MOC Work Plan. Remeasurement will occur to evaluate the performance outcomes and achievement of goal.

In addition to educational opportunities, resources are provided such as peer to peer review, curbside review with a paneled specialist, newsletters to the beneficiaries. Other opportunities to educate are through the following options:

- Articles in provider newsletters
- Website updates
- Individual letters to enrollees reminding them of the appropriate use of the emergency departments
- Individual education to enrollees on the importance of follow a hospital discharge Continued education with Care Coordinators on transitions
- Reeducating nursing home on protocols for Intensive Service Day utilization

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Based on its 2021 experience, Imperial's UM workplan goals are as follows:

2023 Inpatient Goals-Imperial

Metric	2023
ALOS	Below 5
Bed Days/1000	1200
Admits/1000	170
Metric	2023
Clinical IRR	96%
Authorization	
Turnaround Time	95%
Denial Rate	Below 4%
Clinical IRR	90%
Clinical IRR	90%

2023 Outpatient Goals-Imperial

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

Goals are set based on Imperial's MOC and conditions targeted. Additionally, since the MOC Committee has oversight for the quality and SNP outcomes and meets on a quarterly basis, this is the forum that determine the if performance has met goals. The MOC Committee will review the performance outcomes for SNP reporting activities, and any metric falling below established goals/thresholds will require an action plan and/or remain on the next year's Work plan, until it meets specified goal

Imperial incorporates the membership characteristics, burden of disease, operational realities, network, utilization, and member satisfaction related metrics. Goals are also set based on the needs of the membership and the health outcomes believed to merit high priority. Goal setting also addresses the plan's ability to affect an outcome positively or negatively. Process improvement is used to identify root cause analysis of negative outcome measures and early identification and remediation of process breakdowns that can affect the membership. The MOC committee reviews these goals. Measures related to readmissions and utilization are measured continuously. Health outcomes are monitored using the monthly reports which provide member specific compliance data. Case management uses these data to identify members who need an intervention. By comparing the current data to the previous year,

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Imperial can determine improvements year over year. As referenced in Factor 1, When the benchmarks and internally determined goals are not met, these are used as a rationale for root cause analysis, quality improvement projects, PDSA and opportunity to re-determine priorities and strategies.

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

Performance indicator results are presented and reviewed quarterly by Model of Care Committee, process owners and clinical leadership. This leadership includes but not limited to: the Managers/Directors of case management, quality improvement, the VP Operations, Manager of Member Services, Vice President of Clinical Services and the Chief Medical Officer. These MOC Annual Summary results are then reported to Model of Care Committee and Quality Management Committee. Results are measured against benchmarks and thresholds against which Imperial may compare its performance. This allows for an objective and consistent identification of goals met as well as variances. For each measure, a quantitative analysis is performed by the appropriate department leader to assess the plan's performance against prior performance. This review also incorporates the plan goal and the benchmark for the measure. Process data and population characteristics specific to the SNP membership is collated to provide context and insight into each market's outcomes measures and performance. Identified remediation activities and interventions are multifaceted and include direct outreach to members to address preventive health measures. It also includes outreach to other stakeholders.

To determine if a goal is met, internal surveys are done with calls by the call center to determine if the providers are accessible within 24-48 hours. Network adequacy is measured utilizing the Quest Analytics software which has been licensed by Imperial. The Appeals and Grievances department tracks member complaints and monitors and acts upon the CMS CTM module. Using the HEDIS roadmap, Imperial measures the readmission rates for conditions such as CHF, MI. Using the Pharmacy Benefits Manager (PBM) Part D data, Imperial calculates compliance rates for medications.

Available benchmark data is obtained form:

- Medicare Health Outcomes Survey (HOS)
- Chronic Care Improvement Program Reports

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- HEDIS® Effectiveness of Care Measures

Consumer Assessment of Healthcare Providers and System (CAHPS)

The HOS data is used to gain insight into the Care for Older Adults measure. CAHPS is used to evaluate the SNPs customer service through the patient satisfaction metric. HEDIS measures are used to assess clinical and process measures. As mentioned in Factor 1, When the benchmarks and internally determined goals are not met, these are used as a rationale for root cause analysis, quality improvement projects, PDSA and opportunity to re-determine priorities and strategies.

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

When goals are not met, the MOC/QI Work Plan incorporates the results which are then shared with all stakeholders. Performance improvement measures such as root cause analysis, failure modes effect analysis, plan do study act, process mapping, outlier identification are all utilized

Stakeholders are notified about the results. If necessary, senior leadership is involved as well. Performance improvement plans are implemented, and monthly updates provided until the under-performance is resolved.

Other actions taken when goals are not realized include:

- i. Quality Improvement investigates and follows-through with report and recommended actions.
- ii. Care management staff and/or providers are notified about the deficiency and the corrective action plan is established.
- iii. Care management staff and/or providers are placed in plan for performance improvement activities for the identified deficiency.
- iv. Members are notified through mail and website about new quality initiatives and performance improvement projects.

Quantitative factors are very important to ensure that the goals of the MOC are being met. Qualitative factors are equally important to assess a beneficiaries life situation to meet them where they are to enhance their care. Frequent communication with the membership guides this knowledge. Analysts and medical professionals collaborate to review clinical data to identify causes and consequences of clinical conditions and opportunities for improvement. Imperial's internal QI and UM workplan allows it determine causes for when goals are not met. Some insights gained from these reviews now guide the process when goals are not met. Some of these steps are

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- Increase staffing in affected departments
- Deploy technology such as call center management software, and a SQL data warehouse to gain a holistic view of the beneficiary
- Develop, modify, and strengthen organizational policies and procedures
- Hold monthly managerial meetings where each manager's Key Performance Indicators (KPI) are shared and discussed to close gaps. This is discussed in a just culture environment so staff feels comfortable discussing opportunities for improvement
- Enhance communications through initiatives such as a quarterly provider and member newsletter
- Enhance telehealth features

4.C. Measuring Patient Experience of Care (SNP Member Satisfaction) (Dr. Liu/Bridget)

4C Factor 1: Describing the specific SNP survey used.

Imperial Health Plan recognizes the importance of member experience and satisfaction. A good experience can lead to better member engagement and a willingness to participate in a provider's care instructions. These two points alone can lead to improved patient outcomes. Imperial uses the patient experience surveys to identify barriers and carry out improvement activities to improve patient satisfaction.

To ensure that Imperial is receiving feedback from a broad sample of members, it performs quarterly outreach to patients and is not limiting itself only to members reaching out to the SNP. Member experience surveys are the key mechanism for this feedback. It also leverages the CAHPS surveys for more comprehensive feedbacks which are done annually. This survey was selected since its externally validated, valid, and reliable. The instrument is standardized and captures issues related to quality of care. The survey reaches beneficiaries enrolled for 6 months or more, who receive a survey through the mail. They receive a letter, booklet, and business reply envelope. A random sample of the population is drawn and de-duplicated.

Imperial measures member satisfaction in the following ways:

Grievance Process- Clinical grievances can be reported by members and their authorized representatives telephonically, in person, or in writing. This provides a means to report and seek resolution of concerns

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regarding any practitioner's ability to provide appropriate health care services, access to care, cultural and linguistic issues, or quality of care/service issues. All staff are trained to receive grievances. Issues that become apparent through resolving the grievance process allow Imperial to identify and mitigate patient dissatisfiers. Feedback from patients during disenrollment, when available, is an opportunity for improvement. Complaints available from the CTM module on HPMS is very helpful to track and trend issues.

CAHPS: Findings from the Consumer Assessment of Healthcare Providers and Systems® survey as relevant to Imperial are leveraged along with the Health Outcomes Survey (HOS) are used to identify issues affecting care for beneficiaries.

Member Satisfaction Surveys are conducted to monitor members' satisfaction with health care services, accessibility to care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunity to improve member satisfaction and the processes which impact satisfaction. Survey is conducted annually. Imperial evaluates the results of the survey annually and develops an improvement plan to address areas identified. All results are presented to the MOC/QI Committee for recommendations and interventions.

Disenrollment Reasons Survey- The reason for leaving a SNP plan is reviewed in a survey administered by CMS via both mail and phone follow up. Imperial reviews these results to identify areas for improvement and develop and improvement plan to address identified issues.

It consists of six questions:

1. How would you rate the overall service you receive from the special needs program?
2. Is the written information you receive from Imperial clear and understandable?
3. Is the information you receive from Imperial helpful in managing your condition?
4. How would you rate the knowledge and helpfulness of Imperial staff?
5. How would you rate the friendliness and courtesy of Imperial staff?
6. How would you rate the SNP treatment plan for managing your condition?

Imperial member satisfaction survey – Imperial offers a member satisfaction survey to all members enrolled in the SNP to determine satisfaction with services provided by the plan. The survey is available

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telephonically, after a member calls into member care services, or mailed paper copy. The survey is voluntary and considered anonymous.

The survey results are compiled and reviewed quarterly for trends below established benchmarks for the SNP MOC. Results are reported to QI for recommendations and interventions. QI reviews and determines status of proposed changes and interventions.

4C. Factor 2: Explain the rationale for the selection of the specific tool.

The topics in the survey are derived from the CMS findings from the CAHPS survey. These are important determinants of the healthcare experience. They have been validated through focus groups and studies. Interviews with patients identified these issues to be the types that are important to them. It affects their perception of quality and the experience. Imperial's satisfaction survey also addresses the unique needs of our SNP membership. The case management satisfaction tool evaluates the primary functions and services performed by case managers. The survey focuses on the quality of member interactions and member's perception of the case manager's assistance in improving his or her health status. The case management teams evaluate results annually to determine opportunities for improvement.

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

The SNP integrate the results of experience surveys into the overall MOC performance improvement work plan. Findings from member satisfaction surveys are reported at MOC Committee (MOC meeting and shared with relevant shared services departments as well as marketing staff. Survey results are evaluated against internal plan processes, operations, and observations to determine opportunities for improvement. In addition to the MOC Committee, the QI staff evaluate CM member satisfaction and CAHPS survey results and makes recommendations to the MOC Committee based upon completion of the qualitative and quantitative analyses. This allows Imperial to identify needed interventions and identifies opportunities for improvement, based upon the annual re-measurement survey. The annual satisfaction surveys are documented on the MOC work plan. Case management satisfaction survey results are analyzed at least annually, and the results are shared with the CM departments. The CM Team will perform an annual qualitative and quantitative analysis to determine trends, opportunities for

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improvement and recommend interventions to MOC Committee. This annual performance is included in the MOC work plan reviewed quarterly at the MOC Committee.

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

Survey results are shared with clinical staff, administrative staff, member services and the marketing team. Educational points from these results are discussed and incorporated into operations so that dissatisfaction factors are mitigated to improve the patient experience. Internal processes are reviewed for opportunities for improvement which are then implemented. Changes are tracked and measured to see if desired effect is achieved. Case management is responsible for monitoring these results and working with stakeholders to help achieve better results.

The QI department analyzes the results and works with stakeholders to determine when and what intervention is needed. A dashboard tracking the result, intervention and outcome is created and shared internally. The results are measured on a regular frequency and effect of interventions studied. Status updates are provided. These processes for patient satisfaction are like Imperial's other performance improvement initiatives. Results of the survey are shared organization wide for discussion and opportunities for improvement when applicable. Positive results are also evaluated to ensure that the processes are hardwired and replicable. Low score areas are processed through the QI process, and RCA, PDSA and pilot programs. The results are then used to change processes which are monitored as described in MOC4. The changes are re-assessed with the next cycle of measurements and surveys.

4.D. Ongoing Performance Improvement Evaluation of the MOC

4D Factor 1: How the organization uses the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

Imperial uses quality performance indicators and measure results to monitor and make supported changes to the MOC. The data is collected and analyzed to track clinical issues that are relevant to the specific SNP populations. When possible, measures are compared to National benchmarks. Measures that do not achieve benchmark goals are targeted for improvement. Inter-disciplinary teams collaborate to identify root causes for the outcome and determine ways to improve the outcome. Using the Plan-Do-Study-Act or PDSA methodology, Imperial teams plan on an intervention by launching a pilot, study

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the results, and if successful, act on the approach more globally.

Annually, Imperial has identified reports which analyze emergency department visits, inpatient admissions, readmissions, and transitions which have occurred, to identify areas for improvements by minimizing transitions and maintaining members in the least restrictive setting. These reports are reviewed by management and provided to QM to identify changes to the current process.

Evaluation of the MOC is recorded on the MOC workplan and measured against goals/benchmarks. These elements are part of the organization wide Key Performance Indicators which are discussed monthly organization wide and are also linked to leaderships metrics for evaluation. Such an approach has allowed the organization to remain focuses on enhancing quality and value for patients. The evaluation process involves the following steps:

- Identification of specific MOC goals
- Identification of measurement periods,
- Delineation of measurement goals
- Reporting monthly, quarterly, and annually
- Dashboard creation
- Categories measured:
 - Structure and Process measures,
 - HEDIS measurement and outcomes,
 - HOS measures and outcomes,
 - Health & Lifestyle Assessment analysis
- Tools used for measurement:
 - Member surveys,
 - Provider office evaluations,
 - Provider use of appropriate clinical practice guidelines,
 - Provider interaction with the Model of Care
 - Staff consistency and accuracy of decision making measured by KPI
 - Analysis of staff effectiveness in participation in the Model of Care per KPI
- Interventions: Measures specific to Imperial's SNP population are reported out as well and monitored.
 - Data are analyzed considering variations in contributing factors.
 - Results of clinical and satisfaction studies allow an opportunity to understand and address the health status of the members.

Findings are presented to the QI committee for changes in policies and procedures to align with

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these findings.

4D Factor 2: How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.

Imperial's performance and activity reports build towards measurement of the efficacy of Imperial's health management programs. The results of quality performance indicators are used to support ongoing improvement of the Model of Care and continually assess and evaluate quality. The Chief Medical Officer and the Manager of Quality Improvement (QI) have oversight responsibility for monitoring and evaluating the effectiveness of the MOC. The MOC committee is chaired by the Chief Medical Officer and meets on at least a quarterly basis. The Chief Medical Officer and the Manager of QI present and review performance data and analyses at the meetings of the MOC committee. At these meetings, participants discuss and plan for opportunities to improve the MOC. Discussions also include identifying priorities for the allocation of resources to improve the MOC, and setting any revised goals for quality, availability, and continuity of care for members. The Chief Medical Officer and the QI Manager are responsible for follow-up actions, implementation plans and/or additional analyses that are called for by the MOC committee.

Additional staff supporting efforts to improve the MOC include the following:

- Manager, Care Management
- Director, Marketing and Outreach
- Manager, Information Systems & Technology
- Senior Manager, Provider Relations and Contracting
- Manager, Intake and Enrollment
- Care Manager Supervisors and Care Managers

Imperial's reports are focused on specific SNP subpopulations, HEDIS measures, and those elements of importance to the quality assurance and utilization review functions. Data are analyzed considering variations in many factors including demographics of the population, the reasons for grievances and appeals, and the overall effectiveness of the program. All those components help us to identify possibilities for improvement of our MOC. Care managers and the ICT are provided with reports that

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assist them to understand and address the health status of the members. Additional measures are collected through encounter data to determine access/availability of care and appropriate use of services. HEDIS results, including national and local comparisons, are used to report and measure progress and opportunities for improvement. All findings and recommendation are presented to the MOC/QI committee for incorporation into the workplan so that the MOC can be continually improved and more effective toward the improvement of the model of care.

These steps are used by Imperial to incorporate the results of quality performance indicators and measures to continually assess and evaluate quality. The efforts now focus on global components, including those that are more specific to the SNP membership. The culture of continuous improvement, performance improvement, LEAN and Six Sigma processes, is being encouraged in the organization so that it achieves its goal of becoming a High Reliability Organization. This involves a commitment from all staff, including administrative and clinical staff. Middle management and senior leadership also takes a great interest and is involved in such performance improvement.

4D Factor 3: The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

Imperial's committee structure, open communication culture in the organization and channels of contact with providers and beneficiaries is an important component of its ability to timely improve mechanisms for interpreting and responding to the results of MOC evaluations. Data collection, analysis and remediation is done on a continual basis. Imperial's reporting system is user friendly, allowing for analysis by all stakeholders. This facilitates performance improvement by all staff.

Real time HEDIS measurement efforts allow for constant outreach to providers to ensure that quality care is being delivered and care gaps are being closed. Data is updated monthly. Even if a measure is reported by a public agency on an annual basis, Imperial created an internal dashboard as a surrogate resource to track process improvements. Real time analysis of authorization logs claims data and pharmacy data allows Imperial to intervene quicker and prevent avoidable clinical outcomes that may be harmful to a member. This approach has allowed Imperial to address patient care comprehensively, proactively, and better engage patients and providers.

Imperial is now able to receive and respond to real-time HEDIS data instead of having to wait for annual

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HEDIS data results. This real-time data access has allowed us to respond timely to member health outcomes results and intervene as appropriate. The measures are now monitored through a monthly data refresh and disseminated to all departments via a monthly set of reports.

These reports are available at the patient-level and physician-level and reflect members who are missing preventive screenings, medication refills, and missing PCP visits. This targeted approach improves our ability to ensure that members are receiving the attention necessary to enhance their self- management skills and improve overall care.

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

Imperial maintains its QI program activities in electronic form for 10 years. The Quality Department maintains the Model of Care annual evaluation including the measurable goals, performance through a qualitative and quantitative annual evaluation . In addition, the MOC performance Metrics will be documented in the annual MOC Work Plan. Any MOC performance metric not meeting goal is added to the next year's MOC Work Plan with re revised goal. The MOC Committee includes specific MOC reporting activities, programs, and studies that support the quality plan, organizational goals, and objectives. The quality improvement program includes the measurable improvement goals identified in the MOC. MOC reporting of these activities are carried over year to year. This is also the case with regulatory measurements and reporting requirements. The plan is the result of surveys, stakeholder input, regulatory requirements, and mission, vision, and values of Imperial. Beneficiary preference has a large role in this process. The MOC is also documented through the MOC minutes, work plans and actions of various committees involved in analyzing and improving the MOC. The committees involved include utilization review, quality and performance improvement, pharmacy and therapeutics, and peer review. These committees meet on a regular basis to analyze the trends. Each committee maintains minutes as part of documentation The MOC and other sub-committees' minutes are provided to Quality Management Committee, on a quarterly basis.

Results of the MOC improvements and initiatives are communicated at least annually to providers and beneficiary's executive summary mailer. This communication may be more frequent if needed. The communication is shared via conference calls, webinars, town halls, website distribution, and newsletters. This communication also includes the performance improvement evaluation and the lessons

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that were learned during the evaluation period. Such communication helps underscore the dynamic nature of the evaluation process and strengthens a culture of continual improvement.

4E. Dissemination of SNP Quality Performance related to the MOC

4E Factor 1: Describe how performance results and other pertinent information are shared with multiple stakeholders.

The stakeholders with whom Imperial shares the performance results on a regular basis are diverse and broad. They include but are not limited to:

- SNP leadership
- SNP management groups
- SNP boards of directors
- SNP personnel & staff
- SNP provider networks
- SNP beneficiaries and caregivers
- The public
- Regulatory agencies

There are many ways Imperial communicates with stakeholders. Effective and timely communication among all parties participating in the MOC is important to ensure positive health outcomes and improved health status for the member as well as ensuring the engagement of the whole organization.

Providers and community partners receive information on the current goals and objectives, performance results, improvements, updates, and ad hoc alerts on the MOC. Notifications involve quarterly newsletters, monthly to annual joint operating meetings with the provider network staff, website postings that are monthly to quarterly, and email/fax notifications that are as needed.

Members receive information on changes, performance results, improvements, updates, and ad hoc alerts on the MOC in the following formats and schedules during ICT meetings (as needed) and Written notification (as needed). Furthermore, patients, caregivers, and the public can access the SNP's public website for communications. They may also access the quality performance information on Medicare's website when the annual Star Ratings are reported.

All quality improvement activities are presented and reviewed by Model of Care Committee and Quality

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Management Committee. Once reviewed and approved the information is presented at the frequency and format listed above.

Regulatory agency such as CMS, State agencies and public health departments also receive Imperial's performance data through contractually and statutorily mandated reports. Some examples of such QI reports include: Star Rating; CAHPS survey results; HOS survey results; HEDIS performance measures; Chronic Care Improvement Plan updates.

4E Factor 2: Scheduled frequency of communications with stakeholders

Communication schedule shall be as follows

Stakeholder	Report	Frequency
Plan leadership	Process reports	Weekly
	Committee reports	Quarterly
	Board Reports	Quarterly
	SNP MOC Training	Annual
Beneficiaries & Caregivers	Member newsletter	At least Quarterly
	MOC Member Executive Summary	Annually
Regulatory Agencies	SNP applications/MOC	Annual or every 3 years
	Quality submissions	Per agency
	QI projects	Annually
Provider Networks	Provider newsletter	Quarterly
	Delegated JOC	Quarterly

4E Factor 3: Describe the methods for ad hoc communication with stakeholders.

Ad hoc communications to stakeholders are made through email, weekly reports, telephone, committee meetings, in-person meetings, website, email, staff meetings, townhalls, in person meetings, workgroups, US mail, interactive voice response calls, Medicare Health Plan Management system, fax blasts, provider portal, patient profile reports.

4E Factor 4: Identify the individuals responsible for communicating performance updates in a timely manner

The results of the annual MOC performance evaluation are shared internally at all the committee meetings as well manager's meeting and at the staff meetings. The Managers of the Case Management, Utilization Management, Disease Management, and Quality Improvement departments are responsible

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for sharing and discussing these results with their teams. These internal stakeholders also review and provide input to the annual MOC executive summary before it is shared publicly. The MOC Executive Summary is then reviewed and approved by the Chief Medical Officer. The CMO will share the MOC Executive Report with medical directors and to Senior Manager of Provider Relations to disseminate the findings in the provider newsletter. The Senior QI Manager is responsible for communicating the performance updates in a timely manner.

The Senior QI Manager and Quality Manager draft the contents for the MOC Executive Summary for Members and Providers and coordinate the dissemination plan. For the Provider dissemination, the Senior QI Manager and Quality Manager will coordinate with Sr. Provider Relations Manager. A quarterly newsletter to the provider network disseminates performance updates as well.

The MOC Executive summary is shared and not limited to: employee and provider trainings, provider newsletters, member newsletters and the Imperial website. Should a business department change a process that impacts the implementation of the Model of Care, it is the obligation of the department head or process owner to communicate this information to the Chief Medical Officer and Senior QI Manager who will then determine how to disseminate the information to additional stakeholders. Results may be shared with the MOC Committee and Quality Management committees chaired by the Chief Medical Officer who also may determine if additional internal or external communications are required to internal stakeholders such as the board of directors or external stakeholders such as providers. The MOC Committee strives to ensure that communications are deployed timely under the leadership of CMO and assistance from the Sr. QI Manager and Quality Manager.

Performance updates are also provided to CMS monthly through the regularly scheduled meetings that Imperial and its CMS Account Officer conduct monthly. The CEO and Compliance Officer from Imperial attend this meeting when CMS is updated about progress, successes, and opportunities for improvement.

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APPENDICES

Appendix A: Organizational Chart

Appendix B: Health Risk Assessment Survey

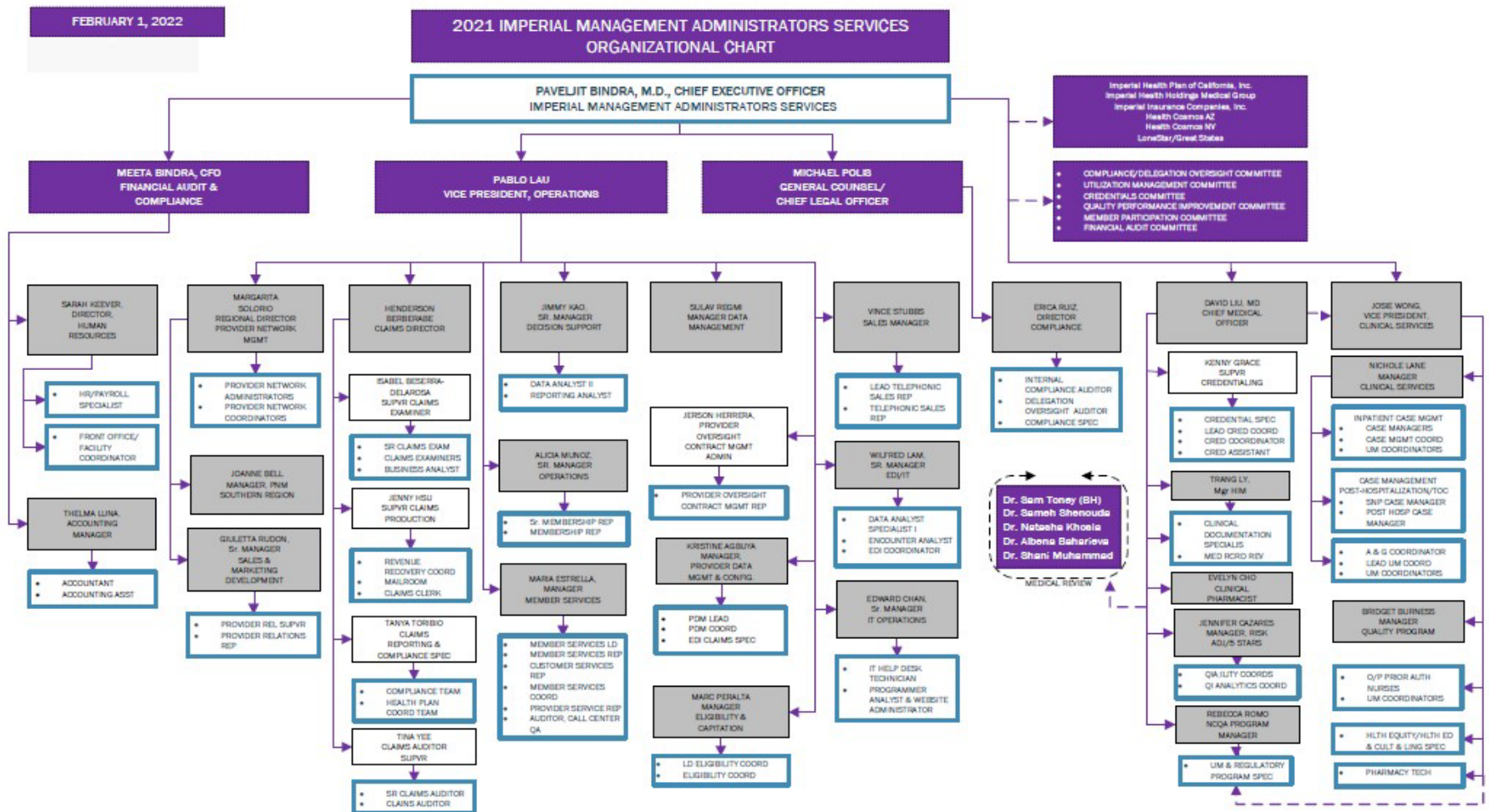
Appendix C: Medical Services Committee Contact Sheet

Appendix D: MOC Training Slides and Attestation Form

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APPENDIX A - ORGANIZATIONAL CHART



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**Appendix B
IMPERIAL HEALTH PLAN SURVEY**

Date:		Member ID:		Plan Effective Date:	
First Name:		Last Name:		Date of Birth:	
Gender:		Home phone:		Other:	
General Questions					
A	In general, how would you rate your health? <input type="radio"/> Excellent <input type="radio"/> Very good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	B	For Women Only) Are you currently pregnant? <input type="radio"/> Yes <input type="radio"/> No How is your eyesight? <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor		
C	Did you receive your flu vaccine this year? <input type="radio"/> Yes <input type="radio"/> N <input type="radio"/> Did you receive your pneumonia vaccine this year? <input type="radio"/> Yes <input type="radio"/> N <input type="radio"/>	D	What is your primary language? <input type="radio"/> English <input type="radio"/> Other: What is your current weight?		

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E	<p>Is there a friend, relative, or neighbor who would take care of you for a few days if necessary?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <p>Do you have access to transportation for medical appointments?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No 	F	<p>What is your living condition?</p> <ul style="list-style-type: none"> <input type="radio"/> Live alone <input type="radio"/> Live with spouse <input type="radio"/> Live with son or daughter <input type="radio"/> Live with other family <input type="radio"/> Other, please explain: <p>Do you live in</p> <ul style="list-style-type: none"> <input type="radio"/> An independent house, apartment, condo, or mobile home <input type="radio"/> As assisted living apartment of board and care home <input type="radio"/> A nursing homes <input type="radio"/> Other:
Health Questions			
A	<p>In the previous 12 months, have you stayed overnight as a patient in the hospital?</p> <ul style="list-style-type: none"> <input type="radio"/> Not at all <input type="radio"/> 1-2 times <input type="radio"/> 3-4 times <input type="radio"/> 6 or more <p>In the previous 12 months, how many times did you visit a physician or clinic?</p> <ul style="list-style-type: none"> <input type="radio"/> Not at all <input type="radio"/> 1 time <input type="radio"/> 2-3 times <input type="radio"/> 4-6 times <input type="radio"/> More than 6 physician visits 		
B	<p>Are you currently using any Durable Medical Equipment?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <p>If Yes, please specify which one of the following</p> <ul style="list-style-type: none"> <input type="radio"/> Wheelchair 		

<ul style="list-style-type: none"> o Walker o Cane o Oxygen o Other: 	
<p>What medical conditions do you have, or have you had in the past? (Please indicate all that apply.)</p> <ul style="list-style-type: none"> o Anxiety o Asthma o Bi-polar o Cancer o COPD/ Emphysema o Coronary Heart Disease o Dementia o Depression o Diabetes o Hearing problem o Heart Failure o Hypertension o Renal/Kidney failure o Stroke o Vision problems o None o Other: 	<p>Which of the following are you currently receiving treatment for? (Please indicate all that apply.)</p> <ul style="list-style-type: none"> o Anxiety o Asthma o Bi-polar o Cancer o COPD/ Emphysema o Coronary Heart Disease o Dementia o Depression o Diabetes o Hearing problem o Heart Failure o Hypertension o Renal/Kidney failure o Stroke o Vision problems o None o Other:
<p>How many different prescription medicines do you take?</p> <ul style="list-style-type: none"> o 1-2 Rx o 2-3 Rx o 4 or more 	<p>Are you on a special diet recommended by your doctor?</p> <ul style="list-style-type: none"> o Low fat o Low Sodium o Low Cholesterol

What conditions would you like help with managing within the next 30 days? Specify:

Assessment of Activities of Daily Living

Activity	Need Help	No Help	Need Some Help	Unable to Do at All
1. Using the Telephone				
2. Getting to Places Beyond Walking Distance				
3. Grocery Shopping				
4. Preparing Meals				
5. Doing Housework or Handyman Work				
6. Doing Laundry				
7. Taking Medications				
8. Managing Money				
9. Getting in or out of Bed or a Chair				
10. Using the Toilet				
11. Getting Around Inside Your Home				
12. Access to Transportation for Medical Appointments				
13. Reading or Writing				

Appendix C (3A Factor 2): Evidence of Specialized Providers for ICT

Printed Name	Specialty/ Title
Paveljit Bindra, MD	CEO
David Liu, MD	Chief Medical Officer/ UMC Chair
Gargi Upadhyaya, MD	Oncology
Natasha Khosla, MD	Pediatrics
Hareesh Khilnani, MD	Nephrology
Kamalakar Rambhatla, MD	Internal Medicine
Shani Muhammad, MD	Family Practice
Han Lee, MD	Psychiatry
Sam Toney, MD	Behavioral Health
Josie Wong, RN	Vice President, Clinical Services
Rebecca Romo	Project Manager
Evelyn Cho, RPh.	Clinical Pharmacist
Nichole Lane, RN, CCM	Manager, A&G
Sharon Ng	Clinical Services Coordinator
Elaine Woo	Health Education & Cultural & Linguistic Specialist

Appendix D: MOC Training Attestation and Slides

ANNUAL SNP MODEL OF CARE TRAINING 2023 ACKNOWLEDGEMENT

Provider:

(Please write in your Name on the above line)

I acknowledge that I have completed the 2023 annual SNP Model of Care Training. _

Signature:

Print Name:

License(s):

NPI/Tax ID:

County

Date:

Participating Health Plan's

- Blue Shield Promise
- Blue Cross
- Alignment
- Brand New Day
- Well Care (Easy Choice health Plan)
- Imperial Health Plan
- Scan

You may Fax or Email this signed form to:

Email: pnm@imperialhealthholdings.com

Fax: (866) 525-7136

2023 SNP
MODEL OF CARE (MOC)
TRAINING

IMPERIAL HEALTH PLAN



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SNP Overview

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Choice Plans specifically designed to provide targeted care to individuals with special needs.

“Special needs individuals” are

- 1) dual eligible; Members who qualify for both Medicaid and Medicare
- 2) institutionalized individuals; and/or
- 3) individuals with severe or disabling chronic conditions, as specified by CMS



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SNP POPULATION

- **Imperial Insurance Companies services SNP members in the following Counties**

Texas	Arizona
<ul style="list-style-type: none"> • Bexar • Collin • Comal • Dallas • Denton • El Paso • Fort Bend • Harris, Hays • Montgomery • Nueces • Tarrant • Travis • Williamson • Wise 	<ul style="list-style-type: none"> • Coconino • Maricopa • Pima • Pinal • Yavapai



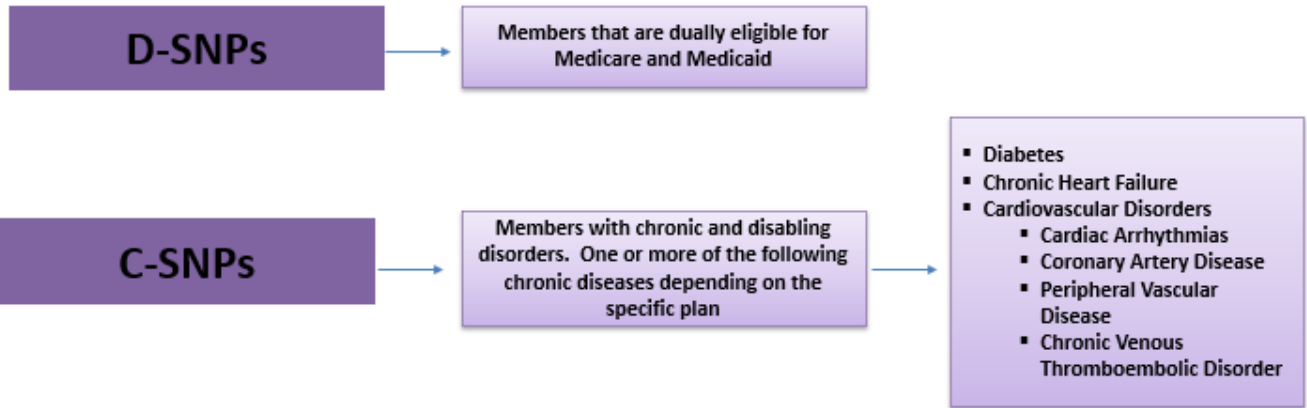
SNP Overview

- We perform a population assessment to build a Model of Care that will best serve the needs of the members.
- Some of the factors identified include but not limited to the following:

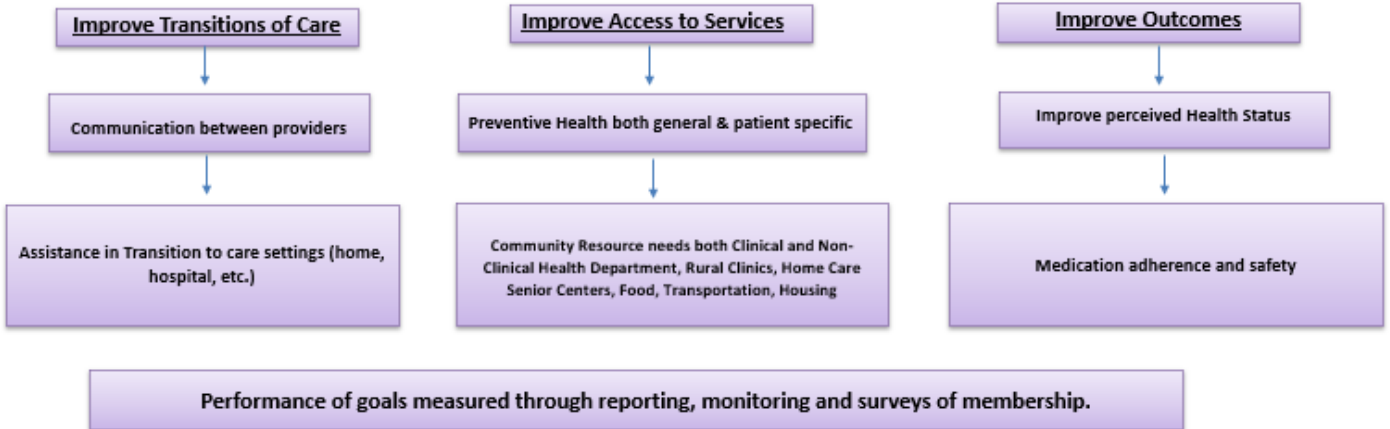
Age
Gender
Ethnicity
Incidence of major diseases and chronic conditions
Language barriers and health literacy
Identification based on multiple hospital admissions, high pharmacy utilization, high cost
Combination of medical, psychosocial, cognitive and functional challenges



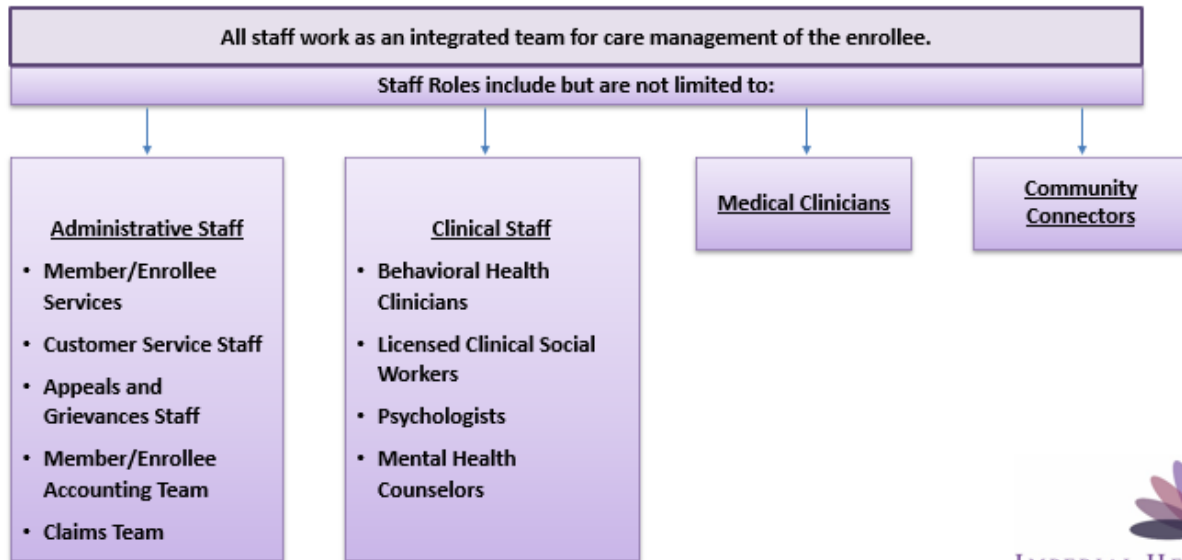
SNPs



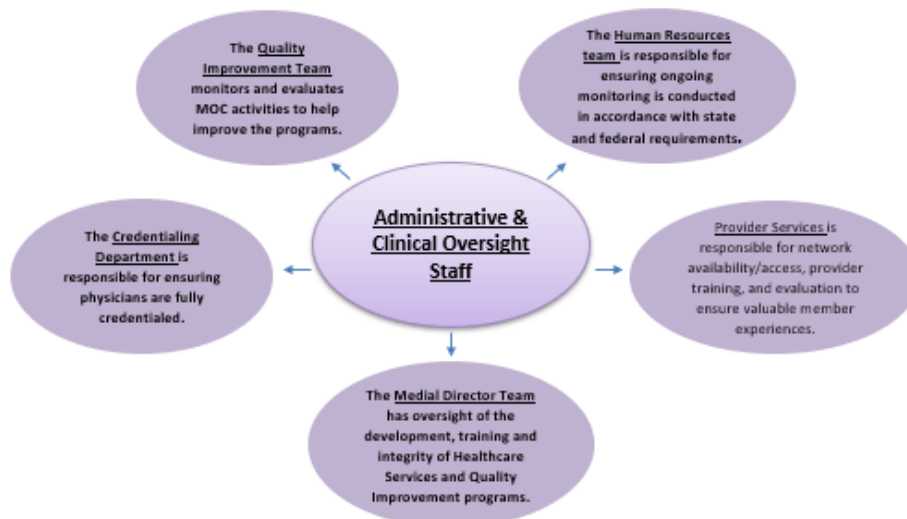
MOC Goals



Staff Structure



Staff Structure and Description



The team serves as a resource for Integrated Case Management Teams and providers regarding member/enrollee's health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.



Specialized Provider Network

Imperial Insurance Inc., has an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population

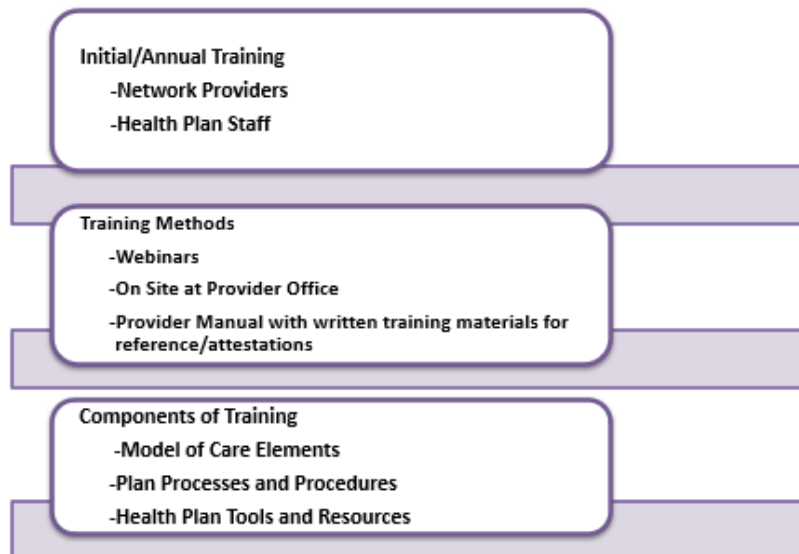


IIC provides the full SNP Model of Care with team based internal case management when it is not provided by the member's primary care provider and medical group.

Provider Network has Specialized Expertise, utilizes clinical practice guidelines and protocols

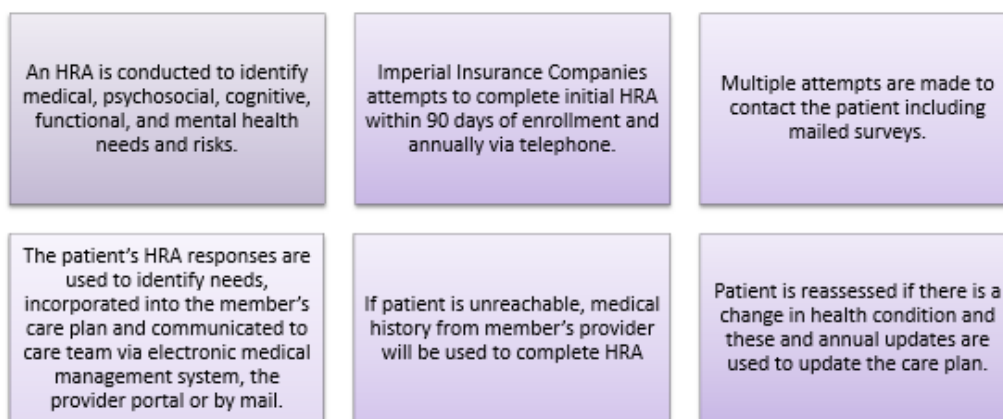


Model of Care Training



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Health Risk Assessment (HRA)



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Individual Care Plan

1) Individual Care Plan (ICP) is created for each patient by the Case Manager with input from the care team.

2) The member and caregivers are involved in development of and agrees with the care plan and goals.

3) ICP is based on the patient's assessment and identified problems.

4) Goals are prioritized considering patient's personal preferences and desired level of involvement in the process.

5) ICP is revised when change such as new diagnosis/hospitalization or at least annually and communicated to Interdisciplinary care team (ICT) and member.

6) Patient's self-management plans and goals are described.

7) Barriers and progress towards goals are listed.



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Care Management

Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes designated IHP's staff, the member and their family/caregiver, doctors, specialists and vendors, anyone involved in the member's care based on the member's preference of who they wish to attend.

Case Managers strive to do the right thing for members by encouraging self-management of their condition as well as communicating the member's progress toward these goals to the other members of the ICT

IIC is responsible to maintain a single, integrated care plan that requires reaching out to external ICT members to coordinate many separate plans of care into one that is made available to all providers based on member's preference.



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Interdisciplinary Care Team (ICT)/Integrated Communication Network

Imperial's staff works with all members of the ICT in coordinating the plan of care for the enrollee



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Face to Face Encounters

What are Face to Face encounters?

In-person doctor's visit

Teladoc

Appropriate Personnel for Face to Face

Physicians

Specialists

Contracted Providers/Physicians

Pharmacist

Behavioral Health

Clinical Functions of Face to Face

Completing HRA

Care Plan Review

Health Education
Referrals

Coordinating
Appointments

Home Health
Enrollment

Annual Wellness
Visits &
Preventative
Exams

Medication
Management

Behavioral Health
Assessment



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Performance and Health Outcomes Measurement



QUESTIONS/COMMENTS

Providers:

- Please contact our Provider Relations Department at (626) 838-5100 Prompt 5

Staff:

- Please contact our Health Education Department at (626) 838-510 ext 266



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