



2026
Special Needs Plan (SNP)
Model of Care

H5852 – Los Angeles, California

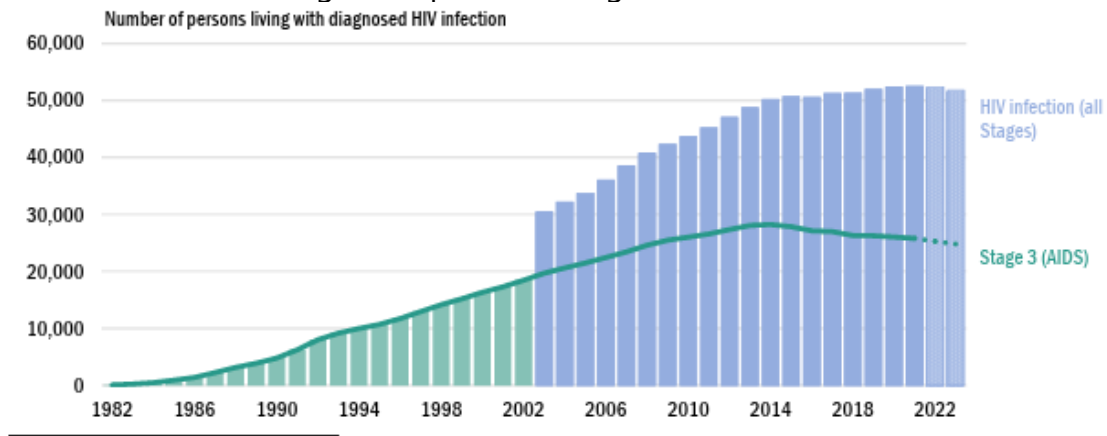
Effective Jan. 1, 2026, through Dec. 31, 2026

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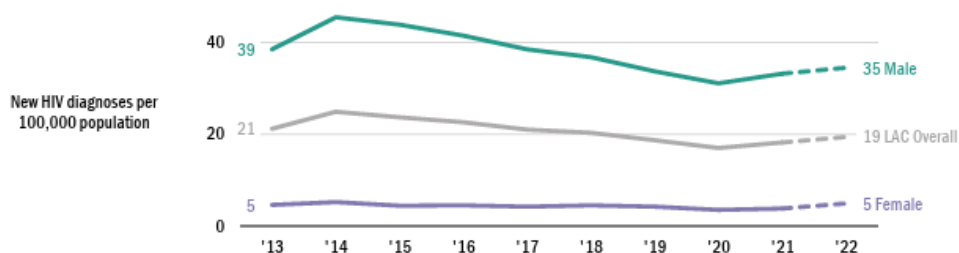
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MOC 1:Description of SNP Population (General Population)

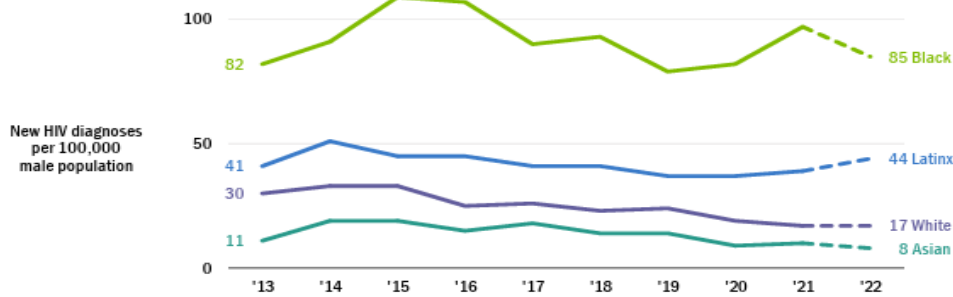
AIDS Healthcare Foundation (AHF) offers a Medicare Advantage special needs health plan in California called "PHP" that includes prescription drug coverage. The plan is an HMO and is for Medicare beneficiaries who have a prior HIV diagnosis and live in Los Angeles County, California. The "Los Angeles County Annual HIV Surveillance Report for 2023" reports 51,796 persons living with HIV infection (PLWH) as of December 31, 2023, compared to the 2022 LAC Annual HIV surveillance Report for 2022 and 59,400 for 2021. This does not include undiagnosed persons living with HIV. ¹



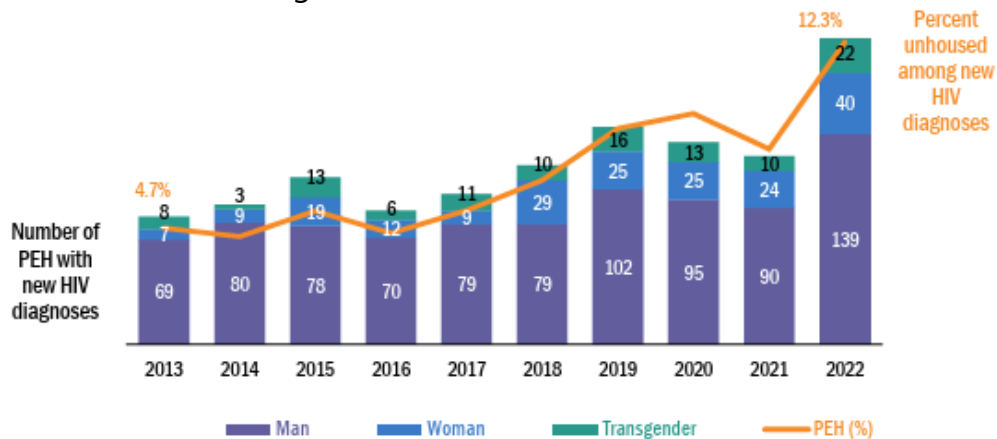
Disparities continue to be a factor in reported cases. Newly diagnosed HIV cases continue to show greater numbers in males versus females. ¹



Black African/Americans have a continued higher rate of infection as shown below. ¹.



Housing stability continues to impact persons with HIV. Persons experiencing homelessness (PEH) typically have suboptimal outcomes as well as the Transgender population. Among 201 PEK with a new HIV diagnosis, 69% were men, 20% were women and 11% were Transgender¹.



They are also more likely to not seek care and have greater difficulty achieving and maintaining viral suppression. Women and Black/African Americans, along with individuals classifying as other, had the lowest linkage to care rates¹.

1. Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, Published December 2, 2024. <http://publichealth.lacounty.gov/dhsp/Reports/HIV/2023AnnualHIVSurveillanceReport.pdf>.

MOC 1 Element A: Description of Overall SNP Population

A population with such a heavy disease burden requires a special, focused approach, which is what PHP practices with enrollees based upon their individual needs. PHP staff provides medical care coordination support, behavioral health support and the Plan Interdisciplinary Care Team (ICT) for enrollees experiencing fear, stigma, and discrimination around their HIV status, because if ignored, these issues can manifest in

denial of one's status, engagement in risky behaviors, and avoidance of treatment and care. AHF has found that the intersection of HIV infection with the diagnoses of co-morbid conditions (Hepatitis C co-infection, mental illness, and/or substance abuse) contribute to poor adherence to medications and inability to keep medical and other appointments, thereby contributing to suboptimal health outcomes if there is not a continual process to keep enrollees engaged in care.

The clinical care team of nurses, social workers and care coordinators maintain contact with enrollees based upon either their acuity rating as determined by their Health Risk Assessment (HRA) and Individual Care Plan (ICP) intervention schedule. The PHP Care Team reaches out to each enrollee to complete the HRA upon enrollment and annually thereafter. Nurses drive the assessment and care plan development to create an individualized treatment plan designed to meet the enrollee's unique needs. Since the HRA is heavily focused on the enrollee's perspective of his or her health condition, the care team also reviews encounter data (such as pharmacy claims) to ensure health conditions that require care plan development are included. The care team staff follow up with each enrollee based upon ICPs interventions and activities.

Factor 1: Determine, Verify and Track Eligibility

Based on the data and because of the high incidence of the barriers to care for persons with HIV/AIDS, the health disparities found in men-who-have-sex-with-men (MSM) and the Black and Hispanic population disparities, as well as the growing incidence of HIV among transgenders, PHP Ca targets this population for enrollment. Enrollment is possible online via the website, contacting Enrollee Services via phone or email or via AHF Enrollment Agents at special events. Due to the respect for the confidentiality of an enrollee's diagnosis, the Plan is careful to provide privacy in the enrollment process. New enrollee information is obtained through the appropriate health plan application. The new enrollee completes the application and submits it to either Enrollee Services or a Health Plan marketing representative. Applications are accepted in person, mail, fax, or email. Enrollee Services' Enrollment and Eligibility Analyst assigned to process applications confirms:

1. Completeness of application,
2. Low-income subsidy (LIS) information,
3. Assures the authorization for "Use and Disclosure of Health Information" is present and executed,
4. CMS Marx eligibility and the Passport (Medicaid) eligibility to confirm dual eligible status, and

5. HIV positive status by contacting the enrollee's current medical provider and obtaining documentation.

Potential enrollees are called and/or emailed for missing information.

Upon confirmation and verification of a complete application, the Enrollment and Eligibility Analyst enters the beneficiary into the PHP intake log and information system database (HEALTHsuite Advantage by RAM Technologies). The information system assigns a unique Enrollee ID for all enrollees.

After submission of the application for enrollment to CMS, Medicare Enrollment files are updated with additional information supplied by CMS.

For those enrollees who are not in care, the last known medical provider who made the diagnosis of HIV is contacted and HIV diagnosis documentation is obtained. For enrollees who do not reenroll or cannot provide previous provider information, the enrollee is scheduled an appointment with the assigned PCP and the HIV diagnosis is obtained from that first visit. The visit is scheduled within 90 days. To date, HIV disease is not curable and once an individual is HIV positive, they will remain positive with HIV disease for the rest of their natural life.

Every month the Enrollment and Eligibility Analyst performs a payment reconciliation and enrollment data verification that involves reviewing any enrollment data exceptions from CMS data and correcting them, if applicable, in the plan's and information system database (HEALTHsuite Advantage by RAM Technologies). The plan verifies the following enrollment data through this monthly process: Medicare eligibility; Medicaid eligibility, if applicable; and low-income subsidy assignment, if applicable. In addition, the plan receives daily transaction reply reports (DTRR) from CMS that include enrollment data. The plan updates its enrollee management system based on data from DTRRs.

Factor 2: Describe health status and health disparities of target population.

PHP is not a new plan and does not have enrollees, therefore the data and reports provides validated historical data for the service area and PHP.

There continues to be a profound stigma, fear, shame, and lack of access to knowledgeable HIV/AIDS medical care that people living with HIV/AIDS (PLWHA) face in the communities. The three most important factors for length and quality of life for PLWHA are access to HIV experienced Primary Care Physicians (PCP), adherence to antiretroviral medication therapy and a system of care to keep PLWHA engaged in their care. Without access to knowledgeable HIV medical care or a system to support engagement, or care that is not delivered in a culturally sensitive manner, PLWHA will

fall out of care and without adequate treatment experience not only significantly higher morbidity (e.g., opportunist infections such as Pneumocystis pneumonia, mycobacterial infections; opportunist cancers such as Kaposi’s sarcoma and lymphoma; HIV dementia; HIV wasting, cardiomyopathy and cardiac disease specifically related to HIV, increased complexities of managing other co-morbid medical conditions such as hypertension, diabetes, hyperlipidemia, pulmonary disease) but significantly higher mortality rates. In addition to higher mortality rates and the presence of multiple complex medical conditions, issues with behavioral health, substance abuse and mental health disorders such depression also have a high prevalence within the targeted HIV population. Recent 2023 CAHPS Report indicated more than 60.60% have hypertension and 30.60% have diabetes. Hypertension has increased 2.20% from 2022 and Diabetes has increased 1.60% since 2022. See additional information on medical, cognitive, co-morbidities and other health conditions in table below. PLWHA need coordinated and sustained chronic care model of care that focuses on engagement and continuity of care to obtain and maintain their physical and mental health at the most optimum levels that they can achieve for as long as possible in the presence of HIV disease. HIV disease does not have a cure; however, with life-long sustained engagement in treatment, PLWHA can lead long and productive lives.

H5852 California PHP Beneficiary Profile	2020 Plan Total	2021 Plan Total	2022 Plan Total	2023 Plan Total	2022 National Average
Overall Health					
<i>Excellent/Very Good</i>	27.60%	24.40%	24.50%	25.40%	34.30%
<i>Good/Fair/ Poor</i>	72.40%	75.60%	75.50%	74.60%	65.70%
Overall Mental Health					
<i>Excellent/Very Good</i>	34.70%	29.10%	32.30%	32.70%	53.80%
<i>Good/Fair/Poor</i>	64.20%	70.90%	75.50%	67.30%	46.20%
Spent one or more nights in a hospital	8.20%	7.00%	11.60%	14.20%	10.20%
Delayed/not filled RX because could not afford it	6.70%	6.50%	NR	NR	1.80%
Told you have the following condition					
<i>Heart Attack</i>	0.00%	11.00%	6.20%	NR	9.10%
<i>Angina or coronary heart disease</i>	10.10%	0.00%	8.50%	15.40%	14.10%
<i>Hypertension or high blood pressure</i>	55.20%	59.00%	58.40%	60.60%	63.40%

<i>Cancer other than skin cancer</i>	13.50%	12.20%	14.00%	16.40%	14.20%
<i>Emphysema, asthma or COPD</i>	15.20%	20.00%	20.00%	19.60%	19.50%
<i>Any kind of diabetes or high blood sugar</i>	23.40%	28.50%	29.00%	30.60%	30.70%
Disability Status					
<i>Serious difficulty walking or climbing stairs</i>	32.90%	34.70%	31.90%	31.30%	30.50%
<i>Difficulty dressing or bathing</i>	12.50%	13.50%	15.90%	16.10%	10.70%
<i>Difficulty doing errands alone</i>	23.40%	28.50%	25.10%	24.70%	17.30%

Factor 3: Identify Population Demographics.

The demographic, social, environmental factors and living conditions for the PHP population in LAC are illustrated in the AHF Plan's Consumer Assessment of Health Plans Survey (CAHPS) for MY 2023 in the table below.

H5852 California PHP Beneficiary Demographics	2020 Plan Total	2021 Plan Total	2022 Plan Total	2023 Plan Total	2023 National Avg.
Gender (sample)					
<i>Male</i>	92.50%	90.40%	92.30%	94.40%	NA
<i>Female</i>	7.50%	9.60%	7.70%	5.60%	NA
Age (sample)					
<i>18-64</i>	49.70%	52.90%	49.00%	44.10%	NA
<i>65-74</i>	42.20%	38.00%	39.20%	41.80%	NA
<i>75 or older</i>	8.10%	9.10%	11.90%	14.10%	NA
Race/Ethnicity (sample)					
<i>White</i>	67.60%	68.40%	69.80%	68.50%	84.70%
<i>Black or African American</i>	27.00%	26.40%	26.70%	28.90%	11.60%
<i>All others</i>	11.50%	5.20%	NR	NR	2.50%
<i>Hispanic or Latino</i>	35.70%	43.70%	39.90%	39.30%	9.60%
Education					
<i>High school or less</i>	38.90%	40.70%	33.30%	35.30%	46.50%
<i>Some college or more</i>	61.10%	59.30%	66.70%	64.70%	53.50%
<i>College graduate or more</i>	16.00%	20.10%	16.70%	NR	NR
Currently lives at home	63.10%	64.80%	69.30%	NR	NR
Uses the Internet at home	75.60%	80.90%	76.90%	79.00%	70.50%

Of note is the very high rate of male beneficiaries in the plan (94.4%), the high rate of enrollees less than 65 (44.10%) which means these enrollees are on permanent disability and the steady continued elevated rate of Hispanic enrollees (39.30%) and Black/ African Americans (28.90%) which is consistent with the rate of HIV/AIDS in this ethnicity group corresponding to LAC Public Health data. Although there was a slight drop in the Hispanic population rate (-0.6%) there was a 2.2% increase in the Black/African American enrollee rate from 2022 to 2023. Low Income enrollees constitute 74.1 % which makes these enrollees dual illegible for Medicare/Medicaid.

LAC has several communities that are disproportionately affected with high incidence of HIV. Contributing factors to HIV/AIDS disparities include poverty, homelessness or transient housing, education, discrimination, food insecurity, mental health and substance abuse issues, low health literacy, cultural and language barriers, and marginalization due to minority status, disability, sexual and gender identity.

Complexity factors are compounded by personal beliefs such as internalized HIV stigma and shame and/or beliefs about illness that run counter to being engaged in care. Income and education are both linked to a person's health behaviors, such as smoking, diet, and exercise, as well as a person's inclination to access medical care, seek or forgo screenings and doctor visits, and ability to adhere to treatment guidelines. Throughout the literature, social determinants are considered root causes of illness and mortality and key to understanding health disparities. Studies show that persons with less income and education do not use health services in the same way that wealthier and better-educated peers do. People with lower socioeconomic status use significantly less preventive care, including screenings, vaccinations, and primary care visits.

Factor 4: Define Unique Characteristics of the SNP Population by plan type.

PHP is a Chronic Special Needs Plan. PHP builds on AHF's 35+ history of providing care and services to Persons Living with HIV/AIDS (PLWHA) to identify the unique characteristics of the population and remove additional barriers to care. As has been noted, the PLWHA are exquisitely sensitive to being identified as someone who is HIV positive. Because of this fact, PHP built its SNP and operations to support the enrollees' desire for privacy, confidentiality, and at times anonymity. The PHP primary care network is a staff model plan where the AHF PCPs are HIV experts and are employed by AHF (the PHP parent company) and the network PCPs are HIV experts in private practice. The PHP formulary is designed to have all antiretroviral drugs, which are exclusively sole source branded medications, on the first tier to ensure the lowest cost to the enrollee.

PHP's Provider Relations and Contracting Division obtains information from the PHP HIVPCPs to reach out to subspecialty providers who have experience in HIV within their subspecialty and other providers who are fully accepting of persons with HIV/AIDS being cared for within their office, facility, or home health services. PLWHA have a long history of not being accepted by the community, but unfortunately, they also have a long history of not being accepted by medical, behavioral health, dental and ancillary health service providers. Because of this fact, PHP's goal is to coordinate care and make sure all providers within the PHP network will welcome individuals with HIV/AIDS effectively and efficiently. The lower the perception of judgment or fear by the enrollee, the higher the adherence to the ICP, which improves the quality and safety of care and the enrollees' care experience.

An informed program design enables AHF to support the needs of people living with HIV/AIDS (PLWHA). Findings are considered in defining program structure and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency). In addition to the Demographic and Beneficiary Profile tables above, the Health Outcome Survey (HOS) assist the Plan in identifying the unique characteristics of our population served. Significant highlights from the most recent HOS that demonstrate additional unique characteristics of our population besides predominantly male, disabled with mental health or substance abuse diagnosis include the following:

- 45.9% of the enrollees have 4 or more comorbidities.
- 31.3% have 14-30 Physically Unhealthy Days
- 25.8% have 14-30 Mentally Unhealthy Days
- 29.2% have 14-30 Days with Activity Limitations
- 63.3% are overweight.

It is interesting to note that HIV patients are now experiencing overweight issues and all the issues that come with greater weight such as diabetes, heart problems, and hypertension. This is also due to not being able to eat a healthier diet due to socio-economic factors such as poverty and homelessness, etc.

MOC 1 Element B: Subpopulation—Most Vulnerable Enrollees

MA organizations offering SNPs must coordinate the delivery of specialized benefits and services that meet the needs of the most vulnerable beneficiaries among the three target special needs populations as defined in § 422.2, including frail/disabled beneficiaries and beneficiaries near the end of life. The plan must include a complete description of its most vulnerable enrollees that differentiates between the general SNP population and the most vulnerable enrollees, as well as detail additional benefits beyond those available to general SNP enrollees. The plan must include a complete description of the services tailored for enrollees considered especially vulnerable using specific terms and details. PHP demonstrates how the following factors are addressed.

Factor 1: Define Most Vulnerable Enrollees

The most vulnerable enrollees within the SNP population are those scoring with a Severity Level of "High" during the initial Health Risk Assessment (HRA). This group also includes those enrollees who are unable to be reached or refuse the HRA. However, via review of the medical records, claims and encounter data and other data sources such as pharmacy data the enrollee is deemed "High" severity until an HRA can be completed with the enrollee or enrollee designated representative.

The two most important factors for length and quality of life for PLWHA are access to HIV primary medical care and adherence to antiretroviral therapy. Without access to knowledgeable HIV care, with inappropriate care, or care that is not delivered in a culturally sensitive manner, PLWHA will experience not only significantly higher morbidity (e.g., opportunist infections such as Pneumocystis pneumonia, mycobacterial infections; opportunist cancers such as Kaposi's sarcoma and lymphoma; HIV dementia; HIV wasting, cardiomyopathy and cardiac disease specifically related to HIV, increased complexities of managing other co-morbid medical conditions such as hypertension, diabetes, hyperlipidemia, pulmonary disease) but significantly higher mortality rates. In addition to higher mortality rates, the presence of multiple complex medical conditions, issues with behavioral health and depression also have a high prevalence within the targeted HIV population.

Because persons with HIV need a coordinated and sustained model of care that meets the changing needs of its enrollees, PHP has developed a model of Care Coordination which includes Population Health, Disease Management and Complex Care Management. The Care Coordination model takes components of both Population Health and Chronic Care allowing flexibility in the management of an HIV population. The flexibility of this approach allows enrollees' needs and health to be at the most optimum levels of care, in the presence of HIV disease, which is treatable for long periods of time.

PHP's Care Coordination model encompasses Population Health and Care Management. The model represents a collaborative, focused team and health home approach combined with population data analysis. It is supported by RNCTMs, Care Partners/Coordinators, Data Analysts, Utilization Nurses and Coordinators, Medical Social Workers, Community Health Workers, Pharmacists, Primary and Specialty Care Providers, and referrals to mental health providers as needed.

Factor 2: Identify demographic characteristics of the most vulnerable enrollees.

The average age of the PHP enrollee is highly skewed since approximately 85% are in the age group 18-64 as sampled in the latest CAHPS Survey. This age group percentage decreased by 5% over the past year from 49% to 44% in 2022. This represents a three-year total decline of 9% in the 18-64-year age group. The age group of 65-74 jumped to 41.8% in 2023. This represents a 4.00% increase in the 65yr – 74yr age group since 2021. The over 75 age group went from 9.1% in 2021 to 14.1% in 2023. The average patient is living longer and may experience greater illness due to comorbidities. Note that enrollees under 65 are on Medicare due to disability. With aging and already existing disability, comes the potential of increased co-morbidities as indicated in the most recent health outcomes survey showing 45.9% of enrollees with 4 or more co-morbid conditions. This makes access to care crucial as well as medication adherence. Fortunately, the plans infrastructure accommodates these issues by promoting 4 provider visits a year to include HIV viral load labs which are performed in the physician office. Physician offices are also strategically located so that, in most cases, a pharmacy is on the premises. In addition, the enrollee can opt for mail-order pharmacy or other pharmacy in the network. The last HEDIS data demonstrated 97.7% of the plan's enrollees had at least one primary care visit during the measurement year 2023 and 79.1% had three or more visits with their primary healthcare provider. Internal statistics show plan enrollees average a little over 3 visits each year either in person or via telehealth. It is clear that this level of engagement in care, which includes care management support, maintains viral load suppression and extends life. When enrollees are less engaged in care, viral loads can increase quickly, PHP focus on acting quickly to prevent any further disengagement. Other factors such as gender can be challenging when dealing with enrollees in transgender contemplation phase or those already self-identified as transgender but without appropriate male to female or vice versa surgical procedures. For example, male to female may or may not need a cervical cancer screening depending on if the operations to place a cervix was performed. Ethnicity may be a barrier when home remedies are deemed of higher value than Western medicine.

Language barriers can usually be overcome with certified translators and a certified vendor (such as Language Line), which PHP uses. However, if coupled with ethnicity barriers from family and enrollee's friends; providers and care management have developed ways to communicate with respect to the enrollee's belief system and support system while trying to incorporate current treatment guidelines. Deficits in health literacy can aggravate this situation so innovative approaches are constantly discussed at the Interdisciplinary Care Team (ICT) Meetings. HIV positive individuals with poor socioeconomic status are often the least likely to obtain care because of issues surrounding privacy and fear of stigmatization. Contributing factors to HIV/AIDS disparities include poverty, homelessness, education, discrimination, late presenters to care, mental health and substance abuse issues and marginalization due to minority status, disability, sexual and gender identity, and others. Complexity factors are compounded by personal beliefs such as internalized HIV stigma and shame and/or beliefs about illness and treatment that run counter to being engaged in care. Many of the most vulnerable clients PHP serves are dealing with mental health and/or substance abuse issues. Many live under extreme conditions of poverty.

Factor 3: Correlation between demographic characteristics and clinical Requirements

Unique to the HIV/AIDS population is the fact that most enrollees are men. Roughly 94.4% of the PHP enrollees are men. Nearly, 70% of these enrollees live alone. These individuals are at high risk for isolation, depression, lack of support and being overwhelmed as they deal with their illness, navigating the health system, secrecy of their HIV diagnosis, secrecy of being homosexual, learning the tools of self-empowerment in their life and making independent health care decisions. PHP is designed to support enrollees with a full array of not only medical and behavioral health benefits, but with a team of HIV experienced physicians, RN care team managers, care coordinators/partners, medical social workers, and community health workers linked in HIV community support services. The care management staff work in concert with the HIV PCP, the enrollee, enrollee support structure, and the community to address the issues that are barriers to care and the achievement of improved health outcomes (e.g., RNCTM coaching and support for family or partner disclosure of HIV diagnosis).

PHP staff provides emotional support for those experiencing stigma and discrimination around their HIV status, because if ignored, these issues can manifest in denial of one's status, engagement in risky behaviors, and avoidance of treatment and care. PHP finds that the intersection of HIV infection with the diagnoses of co-morbid conditions (Hepatitis C co-infection, mental illness, and/or substance abuse) contribute to poor

adherence to medications and inability to keep medical and other appointments, thereby contributing to suboptimal health outcomes.

As a part of Health Risk Assessment (HRA), the RN Care Team Manager (RNCTM) identifies severity levels for those persons with high medical or psychological acuity, substance abuse and use disorder(s), adherence to therapy issues and social determinants of health, e.g., housing, shared living with individuals who do not know they are HIV positive, transportation to medical providers.

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria	Low - Population Health Management	Moderate -Disease Management	High/Complex - Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months	Active substance use/addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless

Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (Q8 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

Persons with an acuity level of High, on a scale 1 to 3, 3 being highest acuity/vulnerability, are identified as complex care management which includes closer scrutiny and focused care management. Pertinent factors are late presenters to care, high viral and low CD4 counts, adherence to antiretroviral medication, co-morbid conditions, dual diagnosis, etc. Elements of the identification process include:

- The care management software assigns an acuity scale determination based on the HRA interview data collected. Final acuity level is determined by the RNCTM based on the health risk assessment results, and other factors such as HIV Viral load and CD 4 count; medication adherence; hospitalizations and ER use; care level/adherence, presence of uncontrolled co-morbid conditions, enrollee level of comprehension of self-care management and social determinants of health.
- Level 3/High acuity enrollees are considered most vulnerable and assigned to complex care management where they receive direct management by the RN Care Team Manager. The RNCTM then provides guidance to the entire care team for follow up on care plan interventions.
- Each enrollee has access to the PHP Care Team. An RNTCM assesses the results of the HRA and assembles the ICT and ICP that will meet the specific needs of the enrollee, e.g., if the enrollee has behavioral health issues, the Behavioral Health Professional (BHP) will be a member of the ICT as well as the HIV PCP and other support staff.

Factor 4: Establish Relationships with Community Partners

PHP continuously monitors its HIV special needs population for vulnerability and special needs. PHP is experienced and positioned to bring enhancing plan and community-based services to those who are frail and disabled. Dedicated care for PLWHA results in deep ties to the HIV community and support services necessary to provide comprehensive coordinated care. PHP has established relationships with the AIDS Service Organizations, Medicaid Waiver Service providers, and Ryan White programs in the PHP service area and beyond. These relationships support the collaboration for provision of community services such as AIDS Drug Assistance Program (ADAP), Housing Opportunities for Persons with AIDS (HOPWA) and other services described below.

Examples of RNCTM and ICT special services to enhance care coordination and improvement/maintenance of the best health possible given the most vulnerable enrollee's disease course and co-morbid conditions include, but are not limited to the following:

- RNCTM/ Care Partner weekly/biweekly/monthly pill box fills for frail HIV home bound patients with impaired IADLs and limited care giver skills/support, e.g., blind patients, HIV dementia, cognitive disorders, working partner/spouse, etc.
- Pill counts to monitor antiretroviral and other co-morbid chronic medication adherence.
- Home visits for safety assessment, care plan follow up, and verification of transition of care plan effectiveness.
- Assistance with application for low-income subsidy benefits
- Assistance with application for AIDS Drug Assistance Program (ADAP) to obtain assistance for HIV essential medications.
- Assistance with Ryan White Part B application for Medicare Part C deductibles and copays.
- Assistance with Medicaid reapplications to ensure continuity of Medicaid benefits in the dual population of our chronic care special needs plan.
- Coordination with home and community-based Medicaid HIV/AIDS Waiver programs to obtain in home support, home delivered meals, pest control, massage therapy, in home supportive mental health services, etc.
- Coordination with federally funded HIV/AIDS Ryan White non-duplicative supplemental services, e.g., in home support, legal aid, home-delivered meals, peer support groups, adherence support and HIV sensitive social activities.
- Assistance with accessing federally funded Housing Opportunities for Persons with AIDS (HOPWA) housing for patients who are homeless or at risk for becoming homeless.
- Accessing Ryan White funded utility payment support programs when eligible.
- Coordinated Care Management with patient, HIV-PCP, ESRD nephrologist(s) and dialysis center to assure HIV sensitivity, care coordination, transportation assurances, patient and family/significant other education on end stage renal disease, diet, shunt care, exercise, hydration, hygiene, etc. and in-home services to support the post-enrollment development of end stage renal disease.
- Coordinated Care Management with Behavioral Health Providers to facilitate an integrated Individualized Care Plan that addresses the whole enrollee, medical and behavioral health together.
- Coordinated Care Management with HIV-PCP enrollee, family, and hospice provider (when elected by the patient) for end-of-life care and support thereof.

RNTCM collaborates with the PCP, and enrollee/enrollee support system to encourage access to hospice. In the absence of hospice, the RNTCM works closely with the enrollee, family/significant other and their PCP to support their end-of-life choices, e.g., durable medical equipment, home health for pain.

- management, pastoral care coordination for people who request support and do not have their own personal pastoral support.

MOC 2 Care Coordination

MOC 2 Element A: SNP Staff Structure

Regulations at 42 CFR § 422.101(f)(2)(ii) -(v); 42 CFR § 422.152(g)(2)(vii)-(x) require all SNPs (Special Needs Plans) to coordinate the delivery of care and measure the effectiveness of the MOC delivery of care coordination. Care coordination helps ensure that the health care needs, preferences for health services, and information sharing across health care staff and facilities are met over time for each SNP enrollee. Care coordination maximizes the use of effective, efficient, safe, high quality patient services (including services furnished outside the SNP's provider network) that lead to improved health care outcomes. PHP views these elements as being of equal importance and essential in the program's development. In this section, PHP demonstrates that all seven elements address PHP's care coordination activities comprehensively.

Factor 1: Define administrative staff roles and responsibilities.

Enrollment and eligibility verification is performed by:

Member Services

Director of Enrollee Services and Call Center Operations (Employed) (DES/CCO) is responsible for supporting the AHF enrollee Service Agents by connecting their daily activities to the Mission and Core Values of the organization and a positive enrollee experience. The DES/CCO is responsible for effectively and efficiently leading the department to deliver services that ensure the enrollee/client and internal/external providers encounter positive experiences. Through the creation, implementation, and evolving maintenance of a successful member services program, Enrollee Services strongly impacts providing a seamless, positive experience essential for retention and growth. The DES/CCO is responsible for meeting AHF, CMS, DHCS, and over fifty-five Ryan White-funded contractual, regulatory, compliance and quality standards as they related to enrollee services, enrollee benefits and protections. The Enrollee Services Department is a dynamic department which provides a variety of services to the organization's health plans and other AHF business lines and services. As such,

The DES/CCO contributes to the organizations success by effectively managing complex and highly regulated processes, i.e.,

- Ensures an effective call center operations by monitoring, analyzing, and overseeing the call center program and training of agents.
- Effective implementation of the complaint and grievance support process
- Accurate disbursement of enrollee benefit and service information and timely fulfillment of enrollee materials,
- Continuing education of self, Enrollee Service and Sales Agents and other Care Management and Medical Provider staff in the policies and changing requirements made by the regulatory and accrediting agencies.
- Maintenance of the regulatory, contractual and accreditation requirements of the Member Service Department.

Enrollee Services Representatives (Employed) responsible for:

- Providing plan information to current and prospective enrollees and active problem solving for enrollees with questions or issues with plan benefits. MSRs refer all grievances to the Grievance System for intake, investigation and follow up.
- Answers inquiries from current and prospective enrollees about plan benefits, provider networks, covered services, grievance/appeal procedures, cost sharing, formulary, etc. Educates dual-eligible enrollees on covered services, i.e., which services are covered by Medicare (primary) and those covered by Medicaid (secondary) and how to access needed services.
- Records instances of Medicare Secondary Payer (MSP) and Coordination of Benefits (COB) and advises enrollees when MSP/COB is reported to the plan by CMS.
- Certain MSRs are responsible for processing enrollment applications and verifying eligibility prior to submitting the enrollee application to CMS for review and approval.
- Conducting SNP diagnosis confirmation activities.

Enrollee Service Enrollment and Eligibility Analyst (Employed)

- Enrollment and disenrollment processes.
- Validation of special need diagnosis, i.e., HIV positive.
- Verification of enrollment and continued verification and tracking.

Claims:

Verification and processing of Claims is performed by:

Director of Claims Operations - (To be hired) The Director of Claims Operations is responsible for overseeing management positions that ensure day-to-day claims review, payment, appeals, and denials are occurring as outlined in policy and procedures, standard operating procedures, and waste reduction tactics. The Director of Claims Operations directs the configuration of the Claims processing system, to ensure AHF is compliant for Medicare and Medicaid health plans, Ryan White Care Act (RWCA) Medical Subspecialty Referral payment programs, wellness, and prevention (i.e. sexually transmitted disease testing) programs. The Director of Claims Operations oversees the management of the claim's suspense/error files and provider dispute and appeals process. Ensuring that processes and system in place allowed for collaborative problems solving and are system focused, not reliant on individuals. The Director of Claims Operations is responsible for the development and execution of claims and related policies and procedures, working collaboratively with management/staff of Claims and other Care Management.

Associate Director of Claims Operations (Employed) is responsible for the oversight and management of all AHF claims payment processes and outcomes for all business lines. Responsible for maintaining continuous compliance to all state and Federal regulatory statutes and guidelines. The Associate Director of Claims Operations creates claims policies and procedures and develops and updates staff training materials in conjunction with the claims manager. He/she stays current on Medicare and applicable state Medicaid and industry payment methodologies. He/she oversees plan and benefit setup in the organization's claims adjudication system, Health Suite. He/she works in collaboration with finance, information technology, provider relations and contracting to ensure appropriate payments to providers and administration of benefits for covered services. He/she oversees and manages the payment process for claim adjudicated from the claims system (HealthSuite) to electronic payment to providers.

Claims Investigators/Examiners (Employed) are responsible for processing claims accurately and within the time frames established by policy and Medicare Advantage guidance. The Claims Investigators/Examiners are responsible for researching claims when needed and reporting to management and addressing provider disputes related to claims payments.

Credentialing

Director of Medical Staff Office and Credentialing (Employed) is responsible for the credentialing of providers and delegated provider groups that compose AHF's health plan and Ryan White Care Act (RWCA) program provider networks, and providers who compose AHF's medical staff.

The Director of Medical Staff Office and Credentialing develops and implements the organization's credentialing system that meets national credentialing standards and best practices and standards required by the Centers for Medicare and Medicaid Services (CMS), California Department of Health Care Services, Florida Agency for Health Care Administration, and state-issued standards where AHF operates a healthcare center or where AHF will operate a health plan in the future. He or she is responsible to conduct delegated group audits to ensure that groups with which AHF is contracted meet credentialing standards.

Manager of Medical Staff Office and Credentialing (Employed) is responsible for overseeing the day-to-day operation of the Credentialing Department including oversight, training and development of Credentialing staff and reporting department productivity to leadership.

Credentialing Specialist (Employed) is responsible for collecting credentialing information and preparing files for review by the Credentialing Committee. The following types of providers are credentialed/ re-credentialed at the Credentialing Committee:

- Primary Care Providers, Specialty Care Providers, Ancillary health service providers
- Health Delivery Organizations
- Review of provider files from delegated groups
- Others as needed.

Provider Relations and Contracting

National Director, Contracting and Provider Relations (Employed) is responsible for developing, engaging, nurturing, monitoring, and training provider networks that serve AHF's managed care health plans, programs, and Ryan White Care Act (RWCA) grants. These comprehensive networks provide care to AHF's Medicare Advantage and Medi-Cal (Medicaid) enrollees, RWCA clients and medically indigent patients in the areas where AHF has located HIV Primary Care Health Care Centers within the domestic United States. The National Director develops the organization's provider recruitment and retention strategy and tactical plan. The National Director is responsible for effectively and efficiently negotiating competitive and cost-effective contracts with hospitals, nursing facilities, home health agencies, ancillary health

service providers, medical groups, independent physician associations (IPAs), and independent providers such that the networks meet enrollee/patient need and CMS, DHCS, expansion state, and/or RW-funded program provider network and contract language requirements. The National Director of Contracting and Provider Relations plays a significant role in the national expansion of AHF Healthcare Centers by developing charity and locally funded specialist networks to support clinic specialty referral needs and by acquiring and negotiating competitive third-party commercial insurance contracts for AHF's domestic Healthcare Centers.

Associate Director, National Grants Specialty Networks & Operations (AD)

(Employed) is responsible for developing, engaging, nurturing, monitoring, and training provider networks that serve a regional segment of PHP California Plan and Ryan White Care Act (RWCA) grants. These comprehensive networks provide care to AHF's Medicare Advantage, RWCA clients and medically indigent patients in the areas where AHF has located HIV Primary Care Health Care Centers within a regional segment of the domestic United States. The Associate Director develops the organization's provider recruitment and retention strategy and tactical plan. In addition is also responsible for effectively and efficiently negotiating competitive and cost-effective contracts with hospitals, nursing facilities, home health agencies, ancillary health service providers, medical groups, independent physician associations (IPAs), and independent providers such that the networks meet enrollee needs and regulatory compliance. Additional responsibilities include developing and maintaining provider relationships through a systemic routine of contact over and above the initial contact associated with provider concerns. Outlined but not limited to:

- Conduct outreach to prospective providers with the purpose of recruiting them to the organization's network.
- Manages and oversees contract negotiations, securing credentialing paperwork and contracting documentation for all newly recruited providers.
- Identifies new Provider Relations opportunities with Practitioners and Enrollment report needs to Executive Leadership during the beginning stages of the contracting process and throughout the process.
- Negotiate new and existing contracts and other agreements with providers with parameters established by Executive Leadership. Function as a liaison between internal and external customers regarding the managed care plans.

- Maintain current provider information in the organizations provider database to ensure accuracy of the organization's provider directories and ability to properly adjudicate claims.

Senior Provider Relations Representative (Employed) is responsible for developing, engaging, nurturing, monitoring, and training provider networks that serve PHP California Medicare Plan providers. The Senior Provider Relations Manager executes the organization's provider recruitment and retention strategy and tactical plan. In addition, is responsible for effectively and efficiently negotiating competitive and cost-effective contracts with hospitals, nursing facilities, home health agencies, ancillary health service providers, medical groups, independent physician associations (IPAs), and independent providers such that the networks meet enrollee/patient need and RW-funded program, CMS and/or DHCS provider network and contract language requirements

Provider Relations Representative (Employed) is responsible for supporting the Manager and Director in network expansion/maintenance activities and conducting provider trainings and orientation. He or she executes the provider orientation according to the Provider Orientation Checklist.

Program administrative oversight functions are staffed as follows:

- **Chief of Managed Care – Division Head** (Employed) is the Chief Operating Officer and executive management of the Care Management Division. The Chief is responsible for the overall oversight of the plan management and compliance with regulatory and Medicare Advantage Part D guidance and contract. The Chief oversees the fiscal, administration and division operations to assure that enrollee protections are in place and enforced, compliance with plan rules are implemented and maintained, regulations and guidance are practiced and that care, and services are delivered in a high quality, fiscally responsible manner. Key responsibilities include:

Strategic direction and oversight of the following:

- Resource allocation
- Contract compliance
- Plan operational performance.
- Compliance with regulatory requirements
- Budgeting, financial performance.
- Patient Safety Plan operations are based upon evidence-based standards.

- Oversees all department operations, including Quality, Utilization & Care Management.
- Strategic direction and oversight to the organization.
- Resource allocation.
- Contract compliance.
- Plan operational performance.
- Representation of Care Management Division as a member of AHF Senior Management
- Communicates Senior Management's strategic plan and goals back to Plan staff for implementation and prioritization.
- Monitors the fiscal performance of the Plans, acts when appropriate to maintain fiscal integrity of the Plans.

Health Plan Administrator (Employed) is responsible for oversight of the Enrollee Services, Provider Relations, and Credentialing Departments. Additional responsibilities include the integrity and accuracy of the Plan website, and the development and obtaining approval for enrollee marketing materials. The Health Plan Administrator is responsible for the implementation of following:

- Change in Benefit Structure notification, Quality Management/Model of Care program updates, Health education information dissemination process, annual update of enrollee materials, i.e., EOC, provider and pharmacy directories, formulary, etc.; enrollment information/form, covered services and limits, cost sharing, rules for using the plan, etc.
- Provides direction and oversees the Member Services, Provider Relations, and Credentialing departments.
- Oversees development, approval, and production process of plan collateral for current and prospective enrollees (i.e., evidence of coverage, formulary, provider and pharmacy directories, plan brochures).

Director Health Equity and Education Program Manager

(HEO/EPM(Employed) is responsible for the oversight, development/ implementation of services,, resources and for enrollees/clients so that all have a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language or other factors that affect access to care and health outcomes. In addition to enrollees of PHP, the HEO/EPM ensures that education on these services is available and given to plan staff and network providers.

Manager, Care Management Operations (Employed) is responsible for the day-to-day supervision of the Care Coordination/Care Partner/Utilization Management Coordinators roles and responsibilities. With a thorough understanding of the processes, workflows and systems used in the overall operations of the Population/Care Management program, the Manager monitors the daily performance of the authorization coordinators for accuracy and timeliness and prioritizes requests based on standard or expedited requests, ensuring CMS compliance standards are met. The Manager ensures Individual Care Plans are processed and uploaded to the provider EMR and monitors signatures/reviews of providers. The Manager is a direct report to the National Director of Care Management.

Director of Risk Adjustment (Employed) is responsible for leading the enterprise-wide Risk Adjustment Program and ensuring that risk exposures and opportunities are identified with the key objective of optimizing revenue integrity and accuracy. The Director of Risk Adjustment (DRA) adheres to the AHF-PHP Compliance Program, including following all regulatory and AHF policy requirements. The DRA is accountable for the operating result and ultimate outcome of Risk Adjustment program. The DRA provides leadership and guidance for overall Risk Adjustment programs as well as identifying and application of best practices to ensure efficacy and accuracy of risk adjustment programs. The DRA develops and regularly updates risk adjustment policies and procedures.

Senior Director of Finance and Claims Operations (SDFCO) (Employed) Senior Director Finance and Claims Operations oversees the Care Management division budget, financial performance monitoring and liaison with AHF Department of Finance. The SDFCO is responsible for oversight of the Provider Data Management departments which encompasses oversight of RAM operation and issues, assuring the department management builds documented processes and checklists for Provider Data staff as they relate to Medicare, Medicaid, industry standards and Ryan White guidance, regulations and contractual compliance of claims processing as outlined in the requirements for vendor notifications, payment, provider disputes, provider/enrollee appeals, claims payment accuracy, stop-loss reporting process to our reinsurer and timeliness process. The SDFCO collaborates with the Compliance Department in audit activities to assure timely and correct operations.

Compliance Officer (Employed) for the health plan is responsible for monitoring and reporting on the compliance of the health plan directly to the Chief Executive and the Board. The Compliance Officer develops a Compliance Program that oversees the proper execution of plan duties, enforcement of enrollee rights, and adherence by plan employees and contractors to the rules, regulations, and Medicare Advantage Part D guidance. Key responsibilities:

- Develops and maintains an annual compliance work plan.
- Reports compliance activities to the senior executive and the Board. Responsible for review and update of division wide Policies and Procedures.
- Implementation and monitoring of the Compliance Program
- Chairs the Compliance Committee
- Creates and coordinates compliance educational training programs/sessions.
- Monitors contractual services to assure contractor adherence.

Associate Director of Data and Information Architecture (Employed) is responsible for collaborating with all areas of the health plan to assure that the flow of information and data is maintained to facilitate enrollee health management and reporting of health plan activities to the appropriate internal departments and external agencies, e.g., CMS. Key responsibilities include:

- Oversees maintenance and sharing of provider data.
- Assures HIPAA adherence with electronic medical record system and exchange of information.
- Assures data transmission to CMS/DHCS/OIR/DMHC and other HIPAA compliant entities are made on a routinely.
- Coordinates resources needed for data projects such as HEDIS, data validation and other required reporting activities.
- Assures that health data management systems are in proper working order to collect and report information.
- Maintains knowledge of CMS data management standards

Factor 2: Identify clinical staff roles and responsibilities.

Clinical Oversight, (including quality improvement) and Care Coordination are performed by:

Plan Medical Director (Employed) is responsible for the oversight of the clinical programs and quality of care delivered to the Plan enrollees. The Medical

Director serves as the Clinical Director of the Quality Program. The Plan Medical Director oversees the Utilization Management Program and assures that all services are monitored and authorized or denied according to evidence based standards and community practice. Qualifications include maintaining an M.D. or D.O., appropriate state-issued Medical License(s), Board Certification in Infectious Disease, AAHIVM certification or equivalent experience outlined by the AAHIVM.

- Oversight Responsibilities:
 - Chair of Quality Improvement/Health Equity Committee
 - Chair of the Pharmacy and Therapeutics Committee
 - Enrollee Chair of the Credentialing Committee
 - Chair of Utilization Management Committee
 - Identifying Clinical Quality Improvement Projects
 - Organization determinations, redeterminations, and appeals
- Participates as a member of the Interdisciplinary Care Team (ICT).
- Collaborates with the Director of Care Coordination to assure enrollees receive plan benefits that meet the needs of the enrollees within plan approved evidence-based guidelines and Medicare Advantage standards.
- Ensures Medicare Advantage rules, regulations and guidance are followed for Organizational Determinations, Coverage Determinations, Grievance processes and Appeals processes.
- Promotes provider adherence to InterQual and other evidence based clinical practice guidelines.
- Conducts medical chart review.
- Maintains clinical knowledge in HIV/AIDS medicine and intimate knowledge of the Department of Health and Human Services HIV/AIDS guidelines and of general medicine and disease specific national guidelines.
- Reviews claims/utilization data to assess for appropriateness of services.
- Reviews pharmacy claims and utilization data to assess for appropriateness of services.
- Identifies opportunities to address over and underutilization of services.
- Reviews approval or denial of services against established clinical practice guidelines
- Reviews Key Utilization performance indicators to identify trends monthly.
- Reviews, determines, and issues all denials in care.

- Assures denial documentation is complete and signs sufficiently detailed denial letters.

National Director of Care Management, Utilization and Risk Management

(Employed) The National Director of Care Management, Utilization and Risk Management is a Registered Nurse and is responsible for the oversight of the day-to-day operations and supervision of the Care Coordination Department including Population Health, Disease Management, Complex Care Management and Utilization Management. This position contributes to the Care Management Division success by effectively managing the key initiatives of the Population/Care Program, Care Coordination, Care Management, to ensure improved patient outcomes as well as compliance with CMS guidance, contractual, and Federal and State regulatory requirements. The National Director evaluates, plans, and monitors the execution of clinical training for new and existing staff related to plan initiatives, contract and regulatory requirements, plan policies and procedures, clinical updates and other information needed to perform their duties effectively and competently. The National Director also promotes collaboration and teamwork amongst department personnel, other AHF departments, the community resources and service providers. The National Director oversees all aspects of the Care Coordination Utilization Review Departments, collaborating with the Chief of Care Management and Medical Director to develop, update and implement policies and procedures, guidelines and action plans as the need necessitates per changes in the department. In addition, the Director:

- Monitor the PHP Contract Deliverables as they pertain to the Care Management and Utilization Management programs of Care Coordination. Ensures the Model of Care is followed and understood by the Care Coordination team so that procedures are effectively executed and in compliance.
- Provides, at minimum, weekly updates to the Chief of Managed Care and is a member of the Care Management Executive Council.

The National Director oversees the Risk Management of the Health Plan including grievances, complaints, and appeals, as well as AHF's HealthCare Centers nationwide, Quality of Care issue and process, potential internal quality improvement issues, root cause analyses and/or other assigned investigations. This position benefits AHF by managing risk designed to make AHF medical care and services safer, promote effective coordination of care, promote preventive care, assist Healthcare Centers and the communities PHP serves support better health,

reduce costs of care through utilization management, and promote person-centered care.

Clinical Operations Manager (Employed) responsible for the oversight of the day-to-day operations and supervision of the staff who are in the Population/Care Management Department, i.e., RN Care Team Managers, LVN/LPN Care Partners, Care Coordinators, Community Health Workers, Medical Social Workers. The ADCMs responsibilities include, but are not limited to:

- Coordinates staff schedule to assure effective coverage of all Care Coordination functions within their region.
- Collaborates with the National Director of Care Management, Utilization and Risk Management to assure and maintain (and when necessary, implement) effective monitoring and management of the program to ensure the Model of Care is understood and followed by the team.
- Participates in weekly Interdisciplinary Team Rounds, develops appropriate agenda, and ensures follow through of action plans pertaining enrollee challenges, resources, and education.
- Collaborates with the National Director of Care Management, Utilization and Risk Management to develop, update and implement policies and procedures, guidelines and action plans as the need necessitates per changes in the department.
- Monitor staff documentation and activities against regulatory and program requirements and ensure requirements are met.
 - Monitor the performance of staff completion of Initial and Annual Health Risk Assessments (HRAs).
 - Comprehensive Medication Reviews for all Initial HRAs
 - Targeted Medication Review when clinically necessary.
 - Transition of Care processes
 - Individual Care Plan Development, interventions, and goals
- Enrollee encounters (direct and indirect) In person visits (i.e., Enrollee, Provider, Community Resources)
- Ensures staff has a clear understanding of processes by providing semi-annual training sessions.
- Ensures all required Health Education courses are successfully completed by staff.
- Monitors and evaluates through one-to-one reviews staff reviews, quality audits of the performance of the Population/Care Management staff against established productivity and quality guidelines. Conducts

1:1 meeting with assigned staff monthly for licensed personnel. Provides timely educational feedback and initiates individual or group training as needed per department guidelines and expectations. Provides timely educational feedback in addition to providing individual or group training as necessary per department guidelines and expectations.

- Monitors activities and outcomes against established regulatory and contractual requirements.
- Monitors and evaluates through one-to-ones, staff reviews, quality audits of the performance of the Population/Care Management Program staff against established productivity and quality guidelines.
- Participates in Contracting and Provider Relations activities as necessary to develop and maintain provider networks based on enrollee needs and staff input.

National Director of Quality (Employed) is responsible for the development and maintenance of the organization's Quality Improvement Program. The National Director of Quality assures that the health plans follow the model of care, rules, regulations, and Medicare Advantage-Part D guidance as they relate to quality of care, enrollee rights and the monitoring and evaluation of the Special Needs Plan Model of Care (SNP MOC). Key responsibilities include:

- Implements a relevant quality improvement program.
- Analyzes utilization data.
- Oversees contracted vendor for CAHPS.
- Oversees internal staff who conduct internal staff and provider surveys.
- Evaluates the effectiveness of the model of care program.
- Reviews analysis and reports prior to submission to any internal committee or external regulatory agency. For example:
 - Submission of HEDIS results on IDSS tool.
 - Submission of CMS SNP structure and process analysis on ISS tool.
 - Submission of QIPs to CMS for review and approval.

National Associate Director of Quality (Employed) is responsible for assisting with the development and maintenance of the organization's Quality Improvement Program working closely with the National Director of Quality to ensure that the Health Plan follows the Model of Care rules, regulations, and Medicare Advantage-Part D guidance. This includes quality of care, enrollee rights and the monitoring and evaluation of the Special Needs Plan Model of Care (SNP MOC). The National

Associate Director is responsible for the day-to-day operational leadership of the QI department. This includes collaborating closely with the National Director of QI, as well as with other enrollees of the Managed Care and Department of Medicine Senior and Executive Leadership Team. This position benefits AHF by managing QI day-to-day operations designed to make AHF medical care and services safer, promote effective coordination of care, promote preventive care, help healthcare centers and the communities we serve support better health, reduce costs of care through utilization management, and promote person-centered care.

QI Project Manager/QI Analyst (Employed) is responsible performing activities that either support or directly perform the following:

- Data collection and analysis for the measures discussed in Section 4
- Developing reports for discussion by the Quality Management Committee and the Utilization Management Committee and other committees as assigned.
- Maintains current knowledge of HIV/AIDS and evidence-based treatment standards.
- Completes a minimum of two recommended AIDS related in-services, trainings or one conference per year.

Quality Project Manager (Employed) is responsible for submitting HEDIS and CAHPS results to NCQA and CMS for public reporting, Star Rating, etc.

Care Coordination and Direct enrollee care and education on self-management techniques are performed by:

Primary Care Provider (PCP) (Employed or Contracted) is responsible for the medical management and development and oversight of the individual enrollee's medical treatment plan. The PCP is member of the Interdisciplinary Care Team (ICT) and contributes to the development of the enrollees' individual care plan (ICP). PCPs are either AAHIVM-certified or meet practice requirements as outlined by AAHIVM or IDSA-HIVMA HIV experienced provider criteria and maintain a current MD or DO license. The PCP meets direct ongoing care of at least 20 HIV patients over the preceding 24 months and has 30 credits of HIV-related

Category 1 CME within the preceding 24 months. Additional responsibilities and oversight include:

- Participates as a member of the Interdisciplinary Care Team (ICT).
- Oversees the enrollees' medical plan of care and provides input/review as it relates to the Individualized Care Plan (ICP).
- Provides clinical care to enrollees.
- Performs medication reviews.
- Provides education on techniques to self-manage chronic conditions.
- Retrieve consultation and diagnostic reports from specialists and update the plan of care with the enrollees at the next visit.
- Implements the medical care and pharmacotherapy plan as established by the interdisciplinary team.
- Triage medical care needs.
- Performs the initial and continuing evidence based medical assessments/interventions and medical plan of care activities during the enrollees' enrollment in the health plan.

Registered Nurse Care Team Manager (Employed) (RNCTM) is responsible to coordinate the Interdisciplinary Care Team (ICT), oversees the Health Risk Assessment process, lead the development of the enrollee's individual care plan (ICP), implementation of ICP interventions, monitor enrollee progress in the attainment of ICP goals, provide direct educational support and coordinate group educational experiences with the Health Educator, and integrate the ICP with PHP Care Coordination team to produce a fully integrated approach to individual enrollee care coordination. He or she must maintain a current RN license.

Responsibilities and oversight include:

- Coordinates and leads the ICT.
- Coordinates care management between medical and behavioral health providers, enrollees of the ICT and the enrollee.
- Directs enrollees' care through the ICP.
- Educates the enrollee on self-management and supports the enrollee in empowering them to become active participants in determining their plan of care.
- Conducts a Health Risk Assessment (HRA) within 90 days of enrollment,
- Conducts an annual HRA within a year from the enrollees' last HRA.
- Conducts nursing assessments when there are significant changes in the enrollee's health status outside of the standard annual HRA.

- Assigns Acuity level (risk assessment) based upon the HRA which determines the minimum frequency of enrollee contacts (Severity Levels: Low, Moderate, High)
- Develops an Individual Care Plan (ICP) based upon the HRA, transition or change in health condition with input from the enrollee, enrollee family/support system where appropriate, medical providers, ICT, and allied health providers.
- Facilitates and monitors the implementation of the individualized care plan interventions and attainment of goals.
- Provides education and reinforcement of techniques to self-manage chronic medical and behavioral health conditions.
- Facilitates access to specialists and treatment as needed or when requested.
- Makes referrals to behavioral health providers and collaborates with behavioral health care management during ICT and as appropriate.
- Coordinates care across different settings and providers
- Works with enrollee to schedule or facilitate scheduling appointments and follow-up services when necessary.
- Assures care and pharmacotherapy are delivered as planned by the ICT.
- Triage enrollees' care needs.
- Identify and facilitate access to community resources and social services.
- Advocate, inform and educate enrollees on services and benefits.
- Conducts Medication Therapy Management Program processes (Comprehensive Medication Review) as part of an Initial Health Risk Assessment and as clinically necessary.
- Assesses enrollees' medication adherence and communicates needs to medical provider when necessary.
- Consults and collaborates with Plan Pharmacist as part of ICT and for medication concerns as needed.
- Collaborates with the UMRN and Medical Director during the Transition of Care (TOC) process. Educates enrollees on transition plans, and contacts or visits patients transitioning from acute care settings.
- Documents all enrollee encounters through session notes in the Care Management Software system.

Care Partners/Care Coordinators (Employed) Care Partners (CP)/Care Coordinators (CC) responsibilities are to assist the enrollee and Clinical Care Team (CCT) staff members in monitoring ICP intervention execution, coordinating outreach activities, following up on ICP interventions to maintain enrollee

engagement and scheduling clinical meetings and visits. The CP/CC are enrollee and clinical staff assistants that help support and facilitate the Model of Care Continuum of Care. Responsibilities include:

- Works in concert with Member Services in providing welcome and transition call to new enrollees within 30 days of enrollment.
- Mails Initial Health Risk Assessment Tool (IHRA) and Annual Health Risk Assessment Tool (AHRA) to enrollees and provides follow-up on mailed IHRA/AHRA.
- Completes reassessment data collection timely for the assigned enrollees.
- Participates as a member of the interdisciplinary care team (ICT).
- Provides collected data to the RNCTM for consideration as input to the Individual Care Plan (ICP).
- Reviews monthly claims for enrollee activity, reports to RNCTM.
- Ensures quarterly education material is sent to enrollees.
- Reviews the Hospital Information Exchange system (HIE) to review hospital admissions, reviews the authorization/referral software system for outpatient approvals and ensures that the ICT is aware of current and ongoing procedures/admissions.
- Ensures Preventative (Gap List) notices and relevant education are sent to enrollees.
- Reviews master encounter reports and conducts outreach activities to enhance enrollee adherence and engagement. Updates information in the care management electronic software system.
- Documents all enrollee encounters.
- Follows protocol for "Unable to Contact: when unable to reach enrollees for contact.
- Ensures Individual Care Plans are sent to PCP for upload/review and signature, documents status and progress. Monitors for completion and reports on those not signed within 30 days.
- Reports urgent enrollee issues to the RN Care Team Manager and Manager of Care Coordination

Medical Social Worker (MSW) (Employed) is responsible to work in concert with the RNCTM to identify the Social Determinants of Health (SDOH) and any other psychosocial needs during the Health Risk Assessment (HRA) process and based on the assessment information; provide input into the Individual Care Plan (ICP). The MSW collaborates with enrollees (and their families/support systems when appropriate or requested) to provide support and referral information to Behavioral Health Professionals (BHP), community resources and support groups

to meet the goals of the enrollee's ICP, resolve the challenges of Social Determinants of Health and/or Health Equity concerns.

Responsibilities include:

- Participates as a member in the Interdisciplinary Care Team (ICT).
- Provides psychosocial discipline knowledge and experience to the HRA and ICP.
- Provides resources and guidance on identified SDOH issues, counseling resources, and refers enrollees for additional Psychosocial/Behavioral Health support as appropriate.
- Works with Care Coordination Team to ensure Behavioral Health Provider referrals are implemented and followed through.
- Works with the Care Coordination Staff to provide referral and access to community services or those resources positively impacting Health Equity.
- Documents enrollee information in the electronic data base
- Develops and maintains a current repository of community services for use by the Interdisciplinary Care Team.
- If needed, locates, and refers spiritual/pastoral support for enrollees and their family as desired by the enrollee.
- Works with enrollees, as needed, to develop their Individualized Care Plan for successful interventions designed to achieve successful goals in mitigate social determinants, e.g., homelessness, financial aid referral, legal referrals, food insecurity.

Community Health Worker (Employed) (CHW) The CHW assists in reinforcing the purposes and services of the Population/Care Management program to the enrollee/enrollee support system and the impact the program and services would have. The CHW works collaboratively with the RNCTM, MSW, Care Partners/Coordinators and UM (Utilization Management) Team by:

- Assists enrollees in understanding their Individualized Care Plan, the reasons for interventions, utilizing resources aimed at achieving their goals for successful outcomes.
- Provides follow-up to concerns raised with the health management/care plans collaborating with both enrollees and providers.
- Supports enrollees to better manage their chronic health conditions and self-care by providing understandable teaching and available resources.

- Document contacts/ interactions, activities, and results in an effective manner in the Session Notes of the Case Management software system.
- Establish positive, supportive relationships with enrollees and provide feedback to team and providers.
- Help enrollees in utilizing resources, including scheduling appointments, and assisting with completion of applications for resources and/programs for which they may be eligible.
- Continuously expands knowledge and understanding of community resources, services, and programs.
- Works to re-engage enrollees who have dropped out of care or providing support to new patients who are determined to be at elevated risk of dropping out of care based on risk factor assessments, missed appointment data, and service utilization data.
- Works with HCC (Healthcare Centers) office administrators and PHP team to ensure enrollees are accurately and appropriately scheduled for all visits.
- Conducts in-person follow ups including hospitalizations and transitions of care, make phone calls, or send mail (where authorized) to enrollees for the purpose of reminding them of medical, care management, and external appointments (i.e., mental health, substance abuse treatment) to improve adherence and reduce no-show appointment.
- Builds peer-based trust with People Living with HIV and informing them about resources for living with HIV, the benefits and challenges of HIV care, and the scope of services available to them.
- Provides peer education around HIV treatment and care and aids with partner notification and testing of current and previous partners.
- Provides personalized assistance to help enrollees (re)enter and navigate systems of medical care, in collaboration with PHP team and other ICT members.
- Supports enrollees throughout the early part of their care so they become fully engaged/ educated about care and self-advocacy/develop treatment self-efficacy.
- Assists enrollees in accessing other community resources to address aspects of their health and life that affect health outcomes, such as mental health and substance abuse treatment, domestic violence services, housing programs, and education and employment services.

Utilization Management RN (Employed) is responsible for reviewing utilization of plan services and utilizing evidence-based criteria to evaluate the indications and appropriateness of care as requested by Plan providers and enrollees. The Utilization Management (UM) Nurse is responsible for the reviews requests for services that require authorization for medical necessity and intensity of service against nationally recognized guidelines, e.g., InterQual, Local Coverage Determinations (LCD), National Coverage Determinations (NCD)

The UM Nurse oversees the following.

- Refers any service requiring authorization that does not meet the above guidelines to the Medical Director for medical necessity determination.
- Implements the appeals process when there are Medical Director denials, or modified benefit determinations and enrollee and/or providers appeal such determinations.
- Authorizes and/or facilitates access to specialists and treatment needed.
- Coordinates care across different settings and providers
- Document/facilitate the implementation of the Individualized Care Plan.
- Initiates the Transition of Care process when admission of enrollees to acute and/or skilled facilities occurs, or when authorizing services that transition care in the home setting such as home health or hospice.
- Monitors and updates daily inpatient census, distributes reports to appropriate staff and leadership.
- Monitors the Transition of Care process when admission of enrollees to acute and/or skilled facilities occurs or when authorizing services that transitions care to the home setting such as home health or hospice.
- Maintains current knowledge regarding inpatient status, clinical reviews, and discharge plans during daily rounds. Provides summary of each case during UM Rounds.

Authorization Coordinator(s) (Employed) maintains a thorough and current understanding of the Utilization Review process, including when to escalate a request to a clinically licensed staff. (Noted that Authorization Coordinator who possess an active LVN or LPN license may review authorization requests and escalate to Medical Provider or RN when necessary. The Authorization Coordinator is responsible for the accurate and compliant processing of referrals for enrollees and understands compliance standards as they pertain to CMS timeliness.

The Authorization Coordinator:

- Reviews delivery system queue for prompt processing
- Reviews Referral requests for accuracy and completeness,

assures all necessary data is present for compliant processing.

- Monitors telephone queue, provides courteous, professional customer services in interaction with enrollee, provider, and vendor telephone inquiries.
- Enters required data into the authorization software accurately and completely.
- Meets performance goal standards set by management.
- Completes and documents oral notification of all requests.
- Completes and documents written notification of all requests.
- Monitors notifications of inpatient admissions and creates accurate, appropriate Transition of Care documentation for UMRN review.
- Assists UM Nurse when contacting inpatient facilities to request needed clinical information, discharge dates, and other information specific to department needs.
- Monitors Health Information Exchange (HIE) or other available hospitalist list for pertinent information regarding inpatient cases.
- Reviews and monitors expedited (urgent) logs/designated database: monitors status of referral to ensure timely completion. Reviews and corrects all errors noted in the daily error report by Close of Business the day received.

Pharmacy Consultation functions are performed by:

Director of Pharmacy (Employed) is responsible to oversee PHP pharmacy services and utilization management of the formulary, monitor the plan's Pharmacy Benefit Manager's performance and compliance with Medicare Part D rules, regulations, and guidance. In addition, provides educational and program support to the Interdisciplinary Care Team (ICT), provides professional consultation to medical providers as it relates to pharmaceutical therapies and formulary management, participates in the MTMP (Medication Therapy Management Program) and consults on and with individual enrollees as it relates to their Individual Care Plan (ICP). The Director of Pharmacy is a licensed pharmacist, with a PharmD.

Responsibilities and oversight include:

- Participates as a member of the Interdisciplinary Care Team (ICT).
- Oversees formulary management, Pharmacy Benefits Manager contract with MedImpact, Part D and Part B adherence to CMS guidance and MTMP education for clinical staff.

- Ensures PHP formulary meets CMS requirements.
- Participates in the Medication Therapy Management Program
- Implements and maintains a drug usage review (DUE) process.
- Conducts medication reviews.
- Assists in medication review for drug – drug interactions.
- Oversees enrollment and new plan year pharmacy transition process.
- Maintains current clinical knowledge of HIV/AIDS, ARV medications and evidence-based treatment regimens.

Behavioral health counseling functions are performed by:

Behavioral Health Professionals (BHP) (Employed and/or contracted) are responsible for providing behavioral health services that meet the needs of the enrollees and are integrated with the medical plan of care to produce a comprehensive enrollee individual care plan (ICP). Behavioral health providers participate as a member of the Interdisciplinary Care Team (ICT) when indicated. Contracted staff is monitored and evaluated through the PHP Quality Improvement Program and Credentialing process.

Psychiatrist (Employed and/or contracted) maintains a current and valid MD or DO state license and is Psychiatry Board certified or Board eligible. He or she is responsible for:

- Performs psychiatric consultation, evaluations, and psychotherapy.
- Performs medication reviews.
- Provides education on techniques to self-manage behavioral health conditions.
- Retrieve consultation and diagnostic reports from specialists and update the plan of care with the enrollees at the next visit!
- Implements the behavioral health care and pharmacotherapy plan as established by the Interdisciplinary Care Team (ICT)
- Triage enrollees' behavioral health care needs.

Psychologist (Employed and/or contracted) maintains a current and valid doctorate-level license and is responsible for:

- Participation in CME concerning HIV and mental health issues bi-annually
- Conducts individual and group psychotherapy.
- Provides education on techniques to self-manage behavioral health conditions.
- Implements the behavioral health care plan as established by the interdisciplinary team.

- Triage enrollees' behavioral health care needs.

Therapist (Employed and/or contracted) maintains a master's-level clinical social worker or marriage and family therapist license. He or she is responsible for:

- Conducts individual and group psychotherapy.
- Provides education on techniques to self-manage behavioral health conditions.
- Implements the behavioral health care plan as established by the interdisciplinary team.
- Triage enrollees' behavioral health care needs.
- Participation in CME concerning HIV and mental health issues bi-annually.

Factor 3: Provide organizational chart.

Staff job titles and responsibilities in the administrative and clinical areas of Plan management are designed to describe not only their function, but to give insight into the portion of the Plan in which they execute their job responsibilities. PHP reviews each position for optimum departmental function and accountability. The chart below notes the distinctions. Administrative staff are found in the Enrollee Service, Claims, Compliance, Information Technology, and Provider Relations. Quality staff are found in Quality and Credentialing. The clinical staff are found in the Medical, Pharmacy, Behavioral Health and Utilization and Care Management Departments. Each job title is linked to the departmental function and the responsibilities related to that job within the department.

Each department Director and ICT member have PHP issued cellular smart phones that have phone as well as data capacity. Each Director and Care Team member is also issued phone chargers that can work off automobile charger adapters to assure that phones can be charged in the event of an electrical outage.

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services occurring in the PHP service area, system connectivity for staff would transfer to the redundant site and be restored to the affected site when power and communications were restored to the area in question.

PHP contingency policies remove barriers to care during and immediately following a declared disaster/emergency through its preemptive policies and procedures established for declared disasters/emergencies with the Pharmacy Benefit Management (PBM) Company, PBM network and AHF Pharmacies that are in various areas. For example, limits on refilling medications to soon be systemically lifted during the warning times and seven or more days after the declared disaster/emergency occurrence. Emergent care at any hospital never requires an authorization for PHP. Urgent care received out of network or out of area in the event of a declared disaster/emergency is also covered without a prior authorization within seven or more days of the severe weather event or local disaster, depending on the severity of the occurrence.

The Medical Directors and designated physician advisors of the Plan apply for and maintain licenses in each applicable state of operation to assure continuity of care and medical oversight can be provided in the event of a declared disaster/emergency.

The Medical Director, the National Director of Care Management, Utilization and Risk Management are licensed to practice in both California and Florida thus ensuring clinical review and decision making conforms to the requirements of the individual state.

PHP management maintains an automated, interactive emergency alert system. When a declared disaster/emergency occurs or is predicted (such as a weather event), the system contacts all staff to report general and area specific instructions. The system is interactive, and staff must respond to questions regarding safety and immediate needs. Information regarding areas that may be impacted, including hours of healthcare centers and/or closings are relayed. Strategy and planning are directed by the Global Director of Safety and Security with, at minimum, daily conference calls with leadership in and out of the affected areas.

Communications will be arranged by the Chief of Care Management, or designee with the assistance of IT to arrange to transfer calls to the unaffected locations or designated staff cellular lines. PHP management staff cascade information and assignments to the clinical and administrative staff to meet the enrollee communication needs, coordination of care, maintenance of access to pharmaceutical agents, and eligibility and benefit status to providers whether they are contracted or non-participating providers of emergency and urgent care to enrollees.

As a backup to the automated system, the Medical Director, Plan Administrator, National Director of Care Management, Utilization and Risk Management, Clinical Operations Manager, Operations Manager, and the Director of Pharmacy maintain staffing rosters to notify staff of worksite changes, schedule modifications and work from home contingencies should the automated system become incapacitated.

When key personnel are unavailable due to a declared disaster/, or the regional offices buildings are closed, communications and staffing coverage for the regional office will be pointed to the unaffected PHP administrative sites in West Hollywood, California or Los Angeles, California as decided by the Chief of Care Management or the most senior Plan Director not affected by the declared disaster/emergency.

Model of Care responsibilities for care coordination, provider network accessibility, are assigned by the Chief, Medical Director, Plan Administrator, National Director of Care Management, Utilization and Risk Management in that ascending order. The staff in the functional areas requiring coverage, e.g., medical oversight, member services, care management, pharmacy services, provider relations, network and contracting, etc. are assigned specific duties by their Directors and Managers. Schedules of work hours and assigned areas of responsibility are issued to all covering staff to assure that any disruption to the continuity of care is minimal, if at all, impacted for the enrollees and providers.

Factor 5: Describe MOC staff training.

Staff training for the Model of Care is conducted annually. The training is for all health plan staff and providers, employed and contracted. Note that this training for in-network and out-of-network providers will be discussed in MOC 3 Element C: MOC Training for the Provider Network. Training/testing is assigned via the organization's online education system (AHF University). In addition, training is conducted face to face, through conference calls and/or via web applications, online modules and electronically via email or fax.

The multi-disciplinary team of staff including the Medical Director, Plan Administrator, National Director of Care Management, Utilization and Risk Management, Provider Relations, Health Equity Officer/ Education Program Manager, National Quality Director, and others are trained to provide education to the staff and providers and are utilized to carry out such educational events as needed to meet the MOC educational goals.

The Medical Director is responsible for overseeing this training. The National Quality Director or designee ensures the evidence or attestation of attendance for the MOC Training is maintained. If for any reason, a staff enrollee or provider misses the training, they are required to complete it at another time within the first 90 days of the plan year.

The training materials consists of power points and/or web-based modules information in the MOC modules to include, but are not limited to the following subject matter:

- Review of MOC program purpose and measurable goals
- Review of Interdisciplinary Care Team structure, policies, and procedures.
- Grievance and appeals process.
- Utilization Management program requirements, policies, and procedures
- Care management program and process.
- Health Risk Assessments: Training in critical skills of assessment
- Individual Care Plan Development
- Clinical Practice Guidelines
- Transition of Care (TOC)
- Enrollee and Provider materials

The Model of Care training is designed to reflect the commitment of PHP to providing effective, efficient, safe, and high-quality care and services to enrollees and providers within the Plan.

The Utilization Management Committee (UMC), which consists of the Plan Medical Director, the Chief of Care Management, Director of Provider Relations, National Director of Quality, National Director of Care Management, Utilization and Risk Management, Plan Pharmacist develop and approve the Plan Model of Care.

The National Director of Care Management, Utilization and Risk Management Program, National Director of Provider Relations and National Director of Quality Improvement are responsible and accountable for oversight of the Model of Care training.

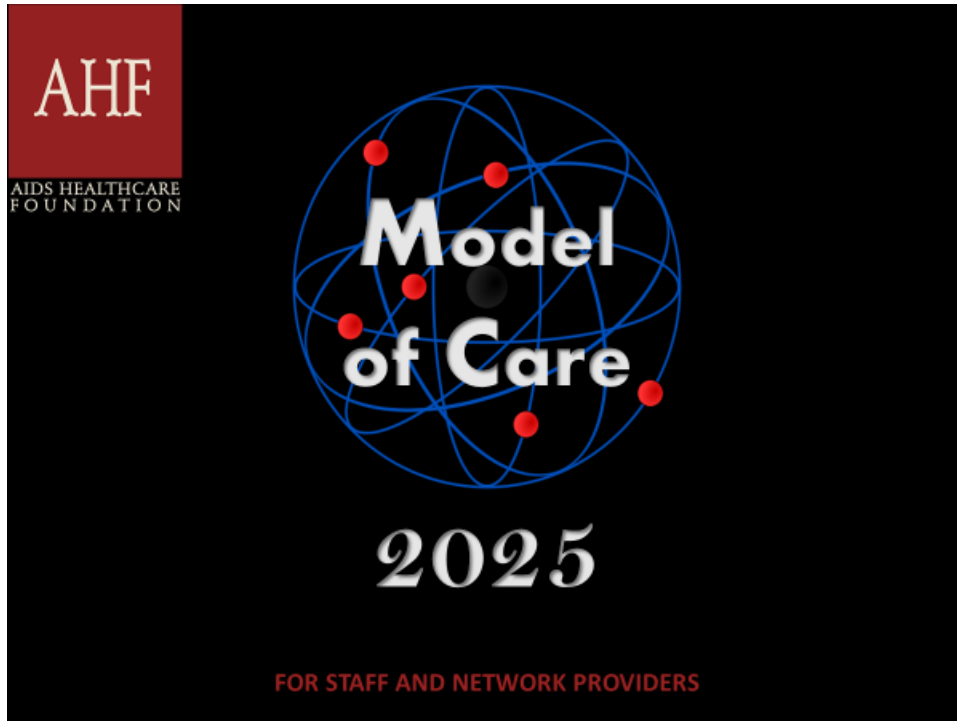
MOC training is conducted the education/competency MOC course module in AHF University (Internal Educational System) and also by using train the trainer sessions with the Plan RN Care Team Management staff and Provider Relations staff, who upon successful completion of the training, conduct MOC training sessions for Plan, staff

model and network providers. Provider Relations and Department leadership monitors the training, maintains the documentation of same and provides periodic reports QMC on the performance and training compliance of program participants.

MOC Training Program Module examples:

- Meeting the needs/providing Care to PHP's Special Population of HIV+ enrollees
- Issues and Barriers to Care Encountered by Persons Who are HIV Positive
- Adherence to Plan of Care/Medication Management relevant to each enrollee.
- Review of HIV/AIDS specific MOC Program purpose and measurable goals
- MOC performance standards
- Interdisciplinary Team purpose and structure.
- Grievance and appeals
- Utilization Management
- Population Care Management Program
- Community Collaboration
- Health Risk Assessments both Initial and Annual
- Transitions of Care (changes in conditions)
- Individualized Care Plan and the foundation of the Care Plan
- Identifying the members and roles of the Interdisciplinary Care Team.
- Clinical Practice Guidelines

The training materials are presented as a video course with post course testing for employed staff. An example of the education presented in the Video Course is below. For contracted staff, Provider Relations uses targeted hand outs and PowerPoint interactive presentations of program modules. Examples of such Power Point presentation modules are pictured below:



What's this Model of Care (MOC) all about? Why do we have to have one?



1. Medicare Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focus on certain vulnerable groups of Medicare beneficiaries which includes care for seniors and persons with disabilities (SPD).
2. **AHF PHP is a C-SNP (the "C" is for "chronic" condition) that focuses on the vulnerable group with HIV/AIDs.**
3. The Social Security Act requires that every Special Needs Plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).
4. **Therefore AHF PHP has a MOC!**

What is a MOC?



- The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- The MOC is a written document. It must ensure the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

What must be in the written MOC?

- NCQA assesses MOCs from SNPs according to detailed scoring guidelines published by CMS.
- The MOC requirements comprise the following standards:
 - MOC 1 - Description of the SNP Population.
 - MOC 2 - Care Coordination.
 - MOC 3 - SNP Provider Network.
 - MOC 4 - Quality Measurement & Performance Improvement.
- AHF PHP received a score of 97.5% on its written SNP Model of Care Program from NCQA/CMS for 2024.



AHF's MOC – What You Need to Know

- Every member in our Plans has at least one chronic condition HIV/AIDS.
- Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
- The model of health service delivery is a one which combines Chronic Care Disease Management and Population Health.
- QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.
- It's teamwork by all staff at every level.



MOC 1 - Description of the SNP Population

Every member in our Plans has at least one chronic condition - HIV/AIDS. Examples of some of the other co-morbidities of this population are in the table below based on 2022 data.

PLAN	Positive Depression Screen	Diabetes DX	Hypertension DX	Coronary Artery Disease	Multiple ADL Impairments	Multiple chronic conditions	Spent a night in the Hospital
MAO H5852	16.7%	35.7%	70.1%	10.3%	13.3%	83.3%	14.2%

Cultural, linguistic and special needs sensitivity training is conducted annually with monthly reminders via our CHORD publication to all who encounter or may encounter interaction with members.

MOC 2 - Care Coordination Overview

- Starts with identifying chronic disease status by using the Health Risk Assessment (HRA) by the RN Care Team Manager (RNCTM)
- Severity Level (SL) is calculated from HRA results (SL 1, 2 or 3 or Low, Medium, High)
 - Members assigned SL 3 (High) are placed under **Complex Care** Management
 - Members assigned SL 2 (Medium) are placed under **Chronic Disease** Management
 - Members assigned SL1 (Low) are placed in **Population Health** Management
- A Care Plan, which includes member goals, is established and shared
- Interdisciplinary Care Team Meetings are held to coordinate care & discuss best options for care and its delivery
- Ongoing support – working the care plan – teaching self management to member
- Annual re-evaluation of member

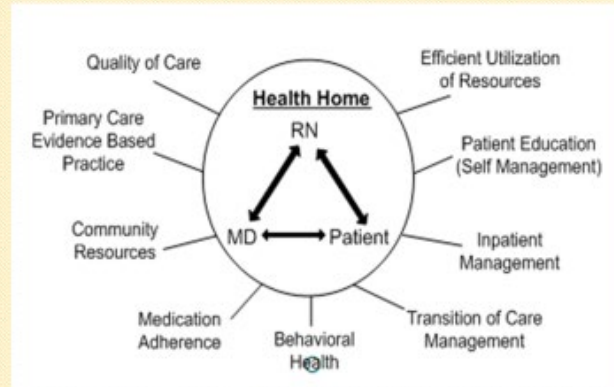
MOC 2 - Care Coordination Severity Level Definitions

- **Population Health Management (Low - SL 1)** Addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. (NCQA Resource Guide)
- **Chronic Disease Management (Medium - SL 2)** Ongoing care and support to assist individuals impacted by a **chronic** health condition with the medical care, knowledge, skills and resources they need to better manage on a day to day basis.
- **Complex Care Management (High - SL 3)** Designed for care of individuals with multiple chronic conditions, limited functioning and behavioral and social needs. Complex case management is a subset of case management aimed at members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.

MOC 2 - Care Coordination Severity Determination Guidelines

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria (Severity Level)	Low	Moderate	High/Complex
	Population Health Management	Disease Management	Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse within last 3 months	Active substance use/addiction disorder
Depression Screening PHQ-9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (08 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

MOC 2 - Care Coordination Patient-centered Medical Health Home



A valuable concept that facilitates the achievement of Care Coordination and Population Health Management goals is the **patient-centered medical health home (PCMH)**. The PCMH is a model of care that builds relationships between members and their care teams and streamlines care coordination.

MOC 2 – Care Coordination SNP Administrative Staffing

- Chief of Managed Care
- VP of Care Management
- Plan Medical Director
- Health Plan Administrator
 - National Director, Contracting and Provider Relations
 - Associate Director, Contracting and Provider Relations
 - Director of Medical Staff Office and Credentialing
 - Director Member Services + Call Center Operations
 - Member Service Enrollment & Eligibility Analyst
 - Health Equity and Education Program Manager
- Compliance Officer
- National Quality Director
 - Associate Director of Quality
 - Quality Data Analyst QI
 - Quality Project Managers
- Director, Risk Adjustment
- National Director, Managed Care Operations + Program Development
 - Associate Director of Claims Operations
- Associate Director of Data and Information Architecture
- Senior Director, Finance and Claims Operations

MOC 2 – Care Coordination SNP Clinical + Provider Staffing

- Primary Care Providers
- National Director, Care Coordination and Clinical Risk Manager
- Registered Nurse Care Team Manager
- Manager of Care Coordination
- Medical Social Workers
- Community Health Workers
- Behavioral Health Professionals
- Care Partners/Care Coordinators
- Director of Pharmacy
- Utilization Management RN
- Authorization Coordinators

MOC 3 - Provider Network Adequate + Specialized

The organization must have an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population.

- AHF Primary Care Physicians
- Network Primary Care Physicians
- Specialists
- Provider Contracts
 - Vision
 - Skilled Nursing Homes
 - Home Health
 - DME
 - Dental
 - Hospitals
 - Lab
 - Radiology
 - PT, OT & ST
 - Hospice



MOC 3 - Provider Network MOC Training

Code of Federal Regulations (42CFR §422.101(f)(2)(ii)) require SNPs to conduct MOC training for their network of providers.

- Training is provided initially and on an annual basis.
- Attendance at training must be documented.
- PHP uses a multidisciplinary team to implement the comprehensive training program.

MOC 4 - Quality Measurement & Performance Improvement Overview

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC. The AHF QI Plan outlines a coordinated and integrated system for organization-wide assessment and improvement. This is accomplished by:

- Using comparative data to focus on areas of greatest opportunity for improvement to establish goals, measures and benchmarks.
- Working collaboratively to develop or enhance mechanisms for patient safety, infection control and oversight.
- Evaluate and assess effectiveness of QI Plan via measurement outcomes and accomplishment of goals
- Create interdisciplinary performance improvement initiatives based on gaps in data; unmet benchmarks.
- Dissemination of results and performance improvement initiatives across the organization.

MOC 4 - Quality Measurement & Performance Improvement Model of Care Dashboard

For the SNP members, their unique needs are considered as evidenced by the MOC Dashboard of measures

For the SNP members, their unique needs are considered as evidenced by the MOC Dashboard of measures

PHP Model of Care Dashboard – 2023 Based on 2022 Data (Selected Sample)				
Measure	Data Source	2022 Result 2021 Data collection	2023 Result 2022 Data Collection	Change
% enrollees with Viral Load Suppression <200 copies/ml each year	Data Warehouse	88.35%	88.00%	-0.35%
% enrollees with at least three visits each year	Data Warehouse	79.10%	93.00%	+13.90
% enrollees who received appropriate lab test for kidney disease in the measurement year	STAR Ratings HEDIS	98%	99.00% (measure changed)	+1.00%
% Enrollees with diabetes who received a retinal eye exam with result in the measurement year	STAR Ratings HEDIS	57.00%	69.00%	+12.00%
% Enrollees with diabetes whose HgA1c level was <9 in the measurement year	STAR Ratings HEDIS	80%	75%	-5.00%

MOC 4 - Quality Measurement & Performance Improvement Data Used to Evaluate if MOC Goals Met

PHP participates in both CMS required activities and internally developed activities that monitor quality of care and service. These measures are regularly reported out at least annually to the QMC, EOC, the Provider Meetings, ICT Meetings, and All Staff Meetings.

The following outline summarizes the key components:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcome Survey (HOS)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- Quality Improvement Project (QIP)
- Performance Improvement Project (PIP)
- Chronic Care Improvement Project (CCIP)
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and Reporting of Part D Medication Therapy Management Data
- Grievance Aggregation and Category Stratification
- Initial Assessment and Reassessment Timeliness
- Star Ratings
- Internal Initiatives and Key Indicators

Questions?

An electronic copy of the Model of Care is available to all every year.

Contact your Director/Associate Director of Care Coordination (staff) or Provider Relations Representative (providers) for more information.

Factor 6: Maintaining training records:

MOC training is completed via AHF University/HealthStream, the organization's web-based educational system. Initial MOC training is required for all newly hired Plan staff during their 90-day orientation period. The Model of Care (MOC) training is also conducted annually for all employed and contracted staff. For employed staff, once the MOC training is completed, the system generates a Certification of Completion of the MOC training is issued and becomes part of the staff enrollee's completed courses in the educational system. The system tracks completions and provides an alert to staff and management of the need to complete MOC training with specific deadline dates. A Report is generated showing MOC training completion (as well as other required courses). For contracted staff attendance at all training is documented in an electronic log for web-based presentations. The Compliance Office oversees all training compliance from AHF University in a detailed report of courses and completions. The National Director of Quality reviews the reports at a minimum annually and works with the Health Education Program Manager and departmental directors and managers to target those staff members pending completion.

Below is an example of a completed Model of Care training record with scoring which is housed in the educational software system (AHF University)

The screenshot shows the user interface for the 'AHF Models of Care' course on the AHF University platform. At the top, the AHF University logo is displayed. Below it is a navigation menu with options: Connections, My Team, To Do, Completed, Profile, Catalog, Event Calendar, and Help. The course title 'AHF Models of Care' is prominently displayed in a blue header, along with a 'Certificate' button. Below the header, the course status is 'Completed' and the estimated time is '11m'. Underneath, there are two tabs: 'Learning Activities' and 'Overview'. The 'Learning Activities' section lists two items: 'AHF Models of Care' (ONLINE, STATUS: Completed) and 'Attestation' (TEST, STATUS: Passed, SCORE: 100%), both marked with green checkmarks.

Factor 7: Address incomplete or deficient training:

Continued employment for new employees with the Plan is based upon successful completion of the introductory period and the successful completion of all orientation processes, including MOC training.

For employees outside of the introductory period, annual training completion and compliance are tracked within the organization's web-based education system, HealthStream. Non-compliant staff enrollees are reported to their manager and subject to progressive discipline action and termination if necessary. This is the same process followed for annual training. Contracted staff who do not complete their MOC training are given additional scheduling choices/venues.

If training is not completed within the additional allotted time, disciplinary action is initiated. Staff who remain non-compliant will receive disciplinary action in the form of a written warning which may lead to further disciplinary action up to and including termination if not resolved. In addition, the contracted noncompliance is monitored by the Compliance officer, reported to their supervisor and is subject to a Corrective Action Plan with contract sanctions for failure to comply with CAP including removal of contracted staff or contract cancellation.

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

Regulations at 42 CFR § 422.101(f)(1)(i); 42 CFR § 422.152(g)(2)(iv) require that all SNPs conduct a Health Risk Assessment for individuals enrolled in the SNP. The organization's MOC must include a clear and detailed description of the policies and procedures for completing the HRA that addresses the following factors:

Factor 1: Conduct Initial and annual HRA assessments:

The HRA is completed within 90 days of enrollment and at least annually; and when there is a meaningful change in the enrollees' health (e.g., hospitalization, change in antiretroviral therapy). The HRA template is reviewed annually and, when necessary, updated by the ICT and Utilization Management Committee. The care management software system serves as the electronic health record for the Plan's care management activities. Initial and Reassessment HRAs are completed by the enrollee and the Care Coordination Team in the following methods:

- Face to Face,
- Video conferencing,
- Telephonically
- Direct mailer/return

The Health Risk Assessment collects, at minimum, the following information:

- Standard enrollee information, contact information, and demographic data.
- Employment and living environment information.
- Mental Health (e.g., depression screening) and Life Habits information
- Exercise, diet and nutrition, and activities of daily living.
- Medical history
- Medication Review and Adherence
- Pain history
- Substance Use assessment.
- Sexually transmitted diseases
- Food insecurity
- Housing and utility insecurity
- Transportation needs
- Interpersonal security

A sample of the Health Risk Assessment is shown below:

Health Risk Assessment



The information you provide to us on this form helps us develop a care plan with your primary care provider (PCP) and specialists. It also helps ensure your enrollment into PHP (HMO SNP) is easy as possible.

Name: _____ Birthdate: _____ Best Phone No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ What is the best day/time to reach you? _____

What is the best way to communicate with you? Best Phone No. USPS Mail Email Text

Sex: _____ Gender: _____ Sexual Orientation: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Primary Language: _____

Race: American Indian/Alaska Native Native Hawaiian/Pacific Islander Two or More Races

Asian White Other _____

Black/ African American

Height: _____ Weight: _____ Last Blood Pressure Reading: _____

What was your last viral load (VL) count? VL: _____ Date: _____

Do you have any food or medication allergies? Yes No If "yes," please list: _____

Do you have any other diagnosis other than HIV/AIDS?

- High Blood Pressure Diabetes Hepatitis C Asthma
- Heart Failure/Enlarged Heart COPD Obesity Kidney Dialysis
- Cancer Alcohol Use Depression Mental Illness
- Other Substance Use History of TB HIV Wasting Chronic Diarrhea
- Active HIV Opportunistic Infection Cognitive Impairment
- HIV Opportunistic Cancer in Remission HIV Opportunistic Infection under Prophylaxis

Please place an "X" in the cell that represents your answer to the following:	Yes	No
Have you ever felt you should cut down on your drinking and/or recreational or prescription drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you ever felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

How would you rate your overall health? (Select one.) Poor Fair Good Excellent

Please list your prescriptions, dosage and how often you take them: _____

Do you have any trouble refilling your prescriptions? Yes No

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.	Often True	Sometimes True	Never True
Within the past 12 months, you worried that your food would run out before you got money to buy more.			
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.			

Are you on a special diet? Yes No

What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).

Do you live alone? Yes No

Think about the place you live. Do you have problems with any of the following? (Choose all that apply)

- Pests such as bugs, ants, or mice
- Lead paint or pipes
- Oven or stove not working
- Smoke detectors missing or not working
- Mold Lack of heat
- Water leaks None of the above

Any recent vision changes? Yes No

Any recent hearing changes? Yes No

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Yes No

Over the past 2 weeks, please place an "X" in the cell that represents your answer:	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Stay in the house most or all of the time				

Please place an "X" in the cell that represents your answer to the following:	Yes	No
Have you had any problems with urine leakage?		
Do you have unprotected sex?		
Have you been treated for an STD in the last 12 months? If "yes," which one(s): _____		
In the previous month, have you gone to urgent care?		
Were you seen in the emergency room in the last six (6) months?		
In the last 12 months, have you stayed overnight as a patient in hospital? If "yes," which hospital? _____		
Have you seen your PCP in the last six (6) months? Who is your primary care provider (PCP)? _____		
Are you receiving any other services, i.e., dialysis, physical therapy, medical equipment, etc.? If "yes," what services? _____		
Have you had any problems with balance or walking?		
Are you physically active (e.g., walking, stationary bike, treadmill, etc.)?		
Have you fallen (without having been pushed) in the last three (3) months?		
Have you ever spent time in youth correctional facilities, jails, or prisons?		

What is your smoking status?

Current (Every Day) Current (Some Days)
 Previous Never

Do you use any of the following to get around?

None Cane Walker Wheelchair
 Prosthetic Device Powered Vehicle (Scooter) Other: _____

Please place an "X" in the cell that represents your answer to the following:	Yes	No
Have you had a flu shot in the last 12 months?		
Have you had a shot for pneumonia in the last five (5) years?		
Have you had the first two COVID shots?		
Have you had any COVID booster shots?		
Have you had any other shots in past year?		
Have you had any problems with short-term memory? (e.g., what did you have for dinner last night?)		
Have you had any problems with your long-term memory? (e.g., where were you born?)		
Do you have trouble understanding instructions?		
If you have pain, on a scale of 0-10, what is your pain level? (0=no pain, 10=the most pain you have ever felt): _____ Where is your pain: _____		

Rate the following activities with an "X" in the cell that represents your answer:	No Trouble	Need Some Help	Need Help
Bathing			
Getting dressed			
Getting to and from the toilet			
Shopping			
Preparing meals			
Feeding yourself			
Using the telephone			
Housekeeping			
Laundry			
Managing medications			
Managing household finances			

Methodology:

To begin the Health Risk Assessment conversation, PHP uses different communication methods to ensure the HRA is available to all new enrollees and each continuing enrollee annually.

Options are designed to offer a variety of communication methods. These include:

- Inclusion of the initial HRA in enrollment information
- A separate mailing of the HRA to each enrollee (mailed every 3 weeks as part of optimum opportunities for enrollee participation.
- A link to the HRA on the PHP website
- Outreach by telephone, text, and/or email (with enrollee approval) by Care Coordination staff.

In addition, a member of the Care Coordination Team personally reaches out and welcomes enrollees which includes gathering information for the HRA. Once completed, the HRAs are reviewed by the RNCTM who will analyze and begin implementation of addressing goals and needs through the Individual Care Plan (ICP) .

For those enrollees who do not return their HRA, engagement calls (at minimum 3 calls on different days, different times) are made on a continuous basis each month and the traditional mailing of the HRA, as noted above, will also continue. Outreach calls by the Care Coordination team that result in direct encounters with enrollees follow the process of gathering information for the HRA, where it is entered into the care management software system. The RNCTM is immediately notified through this system and begins review, analysis, and implementation of ICP. When the Care Coordination team successfully contacts an enrollee and during the conversation and an RNCTM presence is needed, the RNCTM is linked to the enrollee through several methods. (i.e., a warm transfer from another team enrollee, a scheduled call or visit at enrollee convenience)

The same processes are utilized for enrollees who are due for their annual HRA. When there is a significant change in health condition such as hospitalization, change in antiretroviral medication regimen, physical instability, the RNCTM will conduct an HRA, update the ICP and complete the Transition of Care process. The Care Coordination team utilizes the Health Information Exchange (HIE) so that enrollee status changes are known as close to real-time as possible and appropriate action can be taken. If, after the processes described regarding continuous outreaches (calls, texts, emails, home visits) are completed, and the Care Coordination team is still not able to contact the enrollee, an "unable to contact" letter is sent to the enrollee. During this process, the RNCTM and Care Coordination team will coordinate efforts with the PCP (i.e., scheduled provider visits) to maximize the chance to reassess the enrollee and update the enrollee ICP.

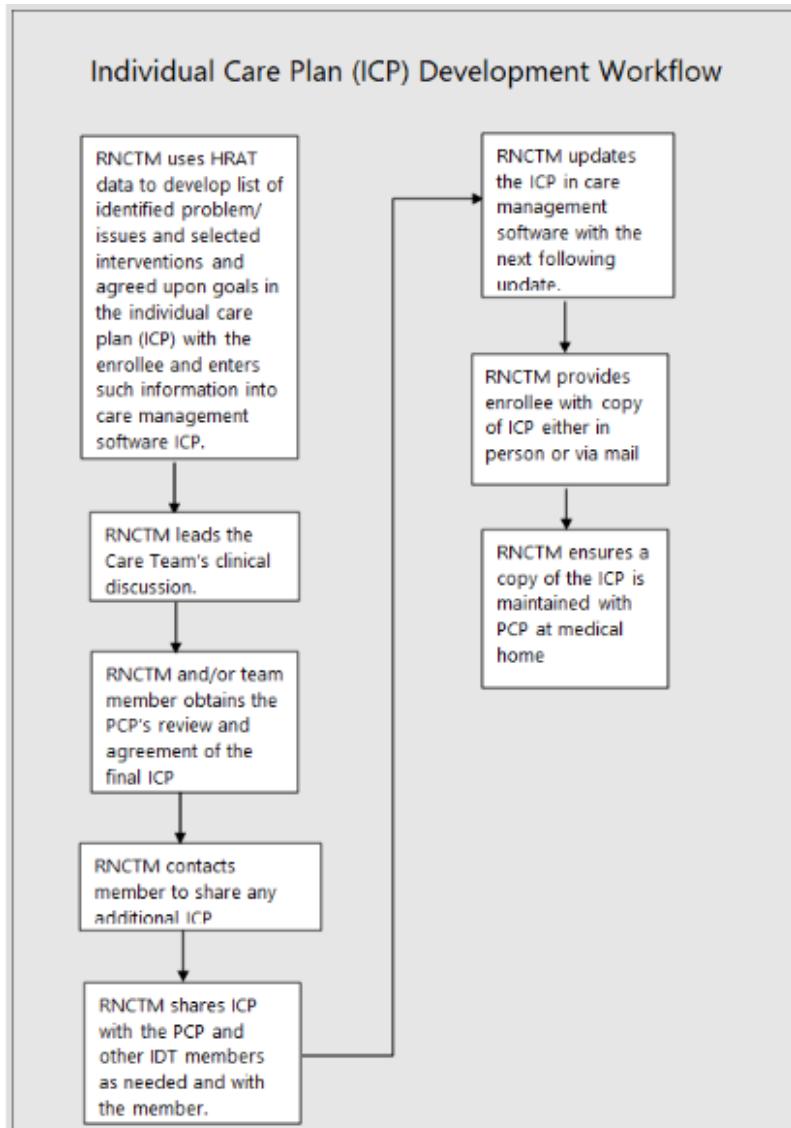
Once information is gathered, as noted, the RNCTM is notified through the case management software system and the HRA is linked to the RNCTM for review. The RNCTM will reach out to the enrollee to discuss the information. During this encounter, the RNCTM will address the enrollee's questions, provide education, resources, and care management nursing support. During this conversation with the enrollee, the RNCTM will discuss the enrollee's own healthcare goals and incorporate them into the Individual Care Plan (ICP). The resulting ICP then becomes the blueprint for care management of enrollee.

Factor 2: Use of HRA information to develop the ICP

Regulations at 42 CFR 422.101(f)(1)(i) require that SNPs address the results of the initial assessment and annual reassessment of each individual enrolled in the plan in the ICP and the results of each subsequent assessment must be incorporated into the enrollee's ICP plan. PHP will demonstrate this as follows:

PHP uses the HRA to initially develop and subsequently update the Individualized Care Plan (ICP) for each enrollee. The RNCTM and Care Coordination team conduct telephonic and, where necessary, home visits or enrollee designated venue and/or PCP office outreach to complete assessments within 90 days of enrollment in the plan, annually thereafter, and when there is a significant change in the enrollees' health status.

The initial HRA information informs the care planning process. The ICP development and dissemination of ICP to the enrollee and the Primary Care Provider is outlined in this workflow diagram.



HRAT= Health Risk Assessment Tool, IDT=Interdisciplinary Care Team

When PHP is notified by the hospital, the PCP, the enrollee or their family/significant other or through the Health Information Exchange (HIE) that a significant health event including but not limited to a hospital admission, a change in antiretroviral medication regimen, initiation of new chronic medications for a new condition, or and significant change in health, the RNCTM assigned to the Transition of Care or change in health condition will outreach to the enrollee to assess for any additional care plan development needs.

As mentioned, the HIE vendor provides PHP with real time information regarding Emergency/Hospital/Skilled facility admission status which is monitored and communicated to the PHP team. The RNCTM will then act upon the information from the HIE either through direct contact with the enrollee or family/significant other

and provide individual care management based on the information obtained including updated HRA and ICP.

The information collected on the HRA is entered into the care management software system. It then analyzes the information and determines the enrollee’s acuity level based on an internally developed algorithm. The RNCTM reviews the HRA and utilizing the guideline severity leveling grid below, along with the software analysis and clinical expertise, assigns a final Acuity Determination and develops an individual care plan (ICP) Noted that if the RNCTM’s clinical expertise differs from the software analysis, the RNCTM will discuss with National Director of Care Management, Utilization and Risk Management and/or Medical Director and document the reasons for the decision to change it.

The information obtained from the HRA and the ICP is shared with the enrollee prior to the finalization of the ICP. The enrollee provides his/her input and may also establish personal goals that the RNCTM incorporates into the ICP. The enrollee receives a copy as does the PCP. The HRA and the ICP are documented in the care management software system. The enrollee’s Care Coordination team has access to the care management software system via HIPAA compliant privileges where they document enrollee progress, contacts, and all care coordination activities that support the enrollee in meeting goals contained within the ICP.

The RNCTM tracks the data collected from the HRA, completed Medical Record review, the medical and pharmacy claims system to identify opportunities to add specialized interventions, services, or more refined interventions on behalf of the enrollee.

The Care Team works with the enrollee to address health and/or psychosocial issues identified in the HRA and incorporated into the ICP. The PCP and RNCTM collaborate and work through the Care Team and enrollee to execute the ICP interventions and monitor progress toward goal on the intervals set by the RNCTM based on the Acuity Determination tool shown below for reference.

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria	Low - Population Health Management	Moderate -Disease Management	High/Complex - Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months

Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months	Active substance use/addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (Q8 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

Provision for reassessment, when warranted by change in health status/transition.

As noted, enrollees will have additional assessments and ICP development when there is a significant change in health condition or care transition. The RNCTM will contact the enrollee to discuss change and, if warranted, engage in care plan development to address the change. Equally, during a transition of care (TOC), the RNCTM will engage in care plan development to address the transition including any new conditions or updates to existing care plans for conditions addressed during the transition.

The Care Team attempts to visit the enrollee during the transition, but if discharge has already taken place, the transition team and/or RNCTM will contact the enrollee directly to assure the discharge plan has been effectuated. The RNCTM provides pre (when applicable) and post teaching and instruction to the enrollee so the enrollee understands the condition that resulted in admission, the pre (when applicable)/post


hospitalization care plan, signs and symptoms to report to their PCP and/or admitting physician or surgeon, comprehensive medication review that included medication reconciliation of post discharge medications and pre-admission medication regimen, medication indications, dosing and frequency of medication administration. The RNCTM reviews the enrollee level of understanding, knowledge of care and complication prevention and reporting, assures follow up PCP and specialist appointments are made, and stays connected with the enrollee according to the TOC Individual Care Plan during the 30 days post discharge transition of care period. The RNCTM collaborates with the facility discharge planner and medical provider to ensure the coordination of care is successful from inpatient to outpatient status.

Provisions for enrollees that cannot/do not want to be contacted or complete the HRA.

Enrollees who refuse to consent to an HRA are informed that their refusal has no effect on their ability to access services. The enrollee is also informed that their assigned RNCTM will document refusal of HRA in software system and will remain available to the enrollee for assistance with care coordination and any issues which the enrollee may need assistance in accessing care. It is further explained that plan benefits and services will not be affected by their refusal to participate in the HRA process. Annual reminders of preventive health measures, quarterly enrollee newsletters, and all other services will continue. Claims reports will be monitored for PCP and medication adherence, hospitalizations, or any health events that may lead the care team to attempt additional outreaches to enrollees that initially refused assessment to offer assistance and education.

As noted above, for those enrollees that do not refuse but have not completed an HRA or a successful outreach attempt, the Care team documents in the care management software system the attempts made to engage the enrollee. As noted, the Care Team makes three outreach attempts at different times, different days and then mails an unable to contact letter on the third unsuccessful attempt. The Care Team continues its outreach as described earlier, and participation will be encouraged throughout the enrollee's health plan enrollment. The Care Team will use soft care management techniques such as preventive care reminders, adherence to medical visit reminder calls, Health Information Exchange (HIE) information for contacts such as post emergency room visit, and hospitalization contact to initiate opportunities for reengagement and care coordination support. For additional insight into the enrollee's HIV knowledge and readiness to change, the RNCTM also requests the enrollee to complete a Level of Knowledge survey during the Initial Health Risk Assessment. The RNCTM uses this tool to assess the enrollees' knowledge upon enrollment, and at minimum, the next annual assessment. The RNCTM will establish any necessary care plans to address HIV knowledge deficit.

Below is an example of the Level of Knowledge Follow up survey:



Member Follow-Up Survey

Member Name _____ Date _____

Please check one of the answers for each question:

Questions	Answer Choices		
	YES	NO	DO NOT KNOW
1. I understand the difference between HIV and AIDS.			
2. I know my CD4 count and what it means.			
3. I know my Viral Load and what it means.			
4. I understand how and when to take my medication.			
5. I am taking my medications on schedule all of the time.			
6. It is alright if I miss a dose of medication as long as I take it by the next day.			
7. I am satisfied with the amount of information I receive on HIV or AIDS.			
8. I am happy with the medical care I am receiving.			
9. My nurse helps me understand how to live with my illness.			
10. I know who and how to call for assistance any time I need it.			
11. I am able to reach my provider after 5:00 pm or on weekends/holidays.			
12. I am able to access transportation to/from my medical care provider.			
13. I am able to get into my provider's office within a day if I am sick or in need of care.			
14. I understand how to prevent HIV transmission.			
15. I understand what safe sex is.			
16. I know where I can get condoms.			
17. I know how to use condoms.			

For Office Use Only

Patient ID _____ Initial Survey Six-Month Survey

RNCM _____ Region _____

Factor 3: Dissemination of HRA Information to the Interdisciplinary Care Team

The RN Care Team Manager (RNCTM) is responsible for disseminating the HRA results to the Interdisciplinary Care Team (ICT) by utilizing any one of the numbers of different methods listed below: It is noted that an HRA is completed not only initially and annually, but also for any significant change in the enrollee's health status (decline in health, hospitalization etc.) therefore, during the ICT, the RNCTM gives a verbal

summary of the HRA results during the ICT meeting which occurs either face to face or through video conferencing.

The RNCTM also shares with the ICT the ICPs developed through information gained during the HRA. This is shared either physically/verbally or through electronic means via direct upload to the software system. Written updates are provided to the ICT team at the time of any HRA by the RNCTM via secure email to the ICT team at time of reassessment or for any change in health condition including Transitions of Care. The RNCTM documents this process of communication and sharing of information including results and specific dates of communication with the IT team in the care management software system (e.g., ICP shared, ICP reviewed)

The ICT uses the HRA information to address issues/concerns/medical/ psychosocial and social determinants of health problems unique to the enrollee and to each of the ICT disciplines. By identifying these unique needs, the ICT is tailored to each enrollee and contributes to their individual needs. ICTs that are tailored to specific enrollee needs have been found to be more effective, efficient, and focused on the individual enrollee needs.

PHP has adopted a model of member-centered care in the composition of the ICT. The best clinical practices for the care of our enrollees with chronic illness were determined following a review of relevant literature. Evidence based practice models were thoroughly reviewed from publications such as the Robert Wood Johnson Foundation, AARP Public Policy Institute, American Society on Aging, Care Management Society of America and compendia from the Health Resources and Services Administration (HRSA) for establishing responsive and enduring programs for the care of people living with HIV/AIDS and other chronic illness.

Factor 4: Explain HRA methodology and communication plan.

The Health Risk Assessment (HRA) is designed to gain an understanding of how the enrollee views his/her health and knowledge thereof. It includes the following:

- Standard enrollee information, contact information, and demographic data.
- Employment and living environment information.
- Mental Health (e.g., depression screening) and Life Habits information
- Exercise, diet and nutrition, and activities of daily living.
- Medical history
- Medication Review and Adherence
- Pain history
- Substance Use assessment.
- Sexually transmitted diseases
- Prosthesis
- Prior hospitalizations and/or ED visits

- Social determinants of health (race, ethnicity, stigmatization, education, housing, food security, transportation, interpersonal security, etc.) SDOH questions are sourced from CMS – The Accountable Health Communities Health-Related Social Needs Screening Tool

The rationale used by PHP for the reviewing, analyzing, and stratifying of the HRA results is the responsibility of the RN Care Team Manager (RNCTM) . The information collected on the HRA is entered into the care management software system which then analyzes the information and determines the enrollee’s acuity level based on an internally developed algorithm. The final Acuity Determination is reviewed by the RNCTM for validation. The severity level guidelines listed in prior factors is shown again here for convenience and provide minimum contact frequency.

Acuity Determination Frequencies	
Severity Level	Minimum Contact
Level: Low - Population Health	Quarterly outreach
Level: Moderate - Disease Management	Outreach every 8 weeks
Level: High - Complex Care Management	Monthly outreach

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria	Low - Population Health Management	Moderate -Disease Management	High/Complex - Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months	Active substance use/addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply

Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (Q8 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

If the Severity Level of the Acuity Determination guideline which is determined by the care management software system differs from the RNCTM’s clinical judgment, the RNCTM may over-ride the system and enter the level that is clinically most appropriate for the enrollee along with documentation of reasons for override. The severity levels stratification assures the minimal level of contact and follow up for the enrollee to assure those enrollees have plan contact for health monitoring and ICP updates on a routine basis in addition to the ICP interventions. The Acuity Determination reflects the enrollee’s health status, and it is a way to monitor progress or regression of health and health events over time so patterns and interventions for improvement can be captured and acted upon.

The RNCTM is a registered nurse with HIV experience and/or specific education who has been trained on the chronic care/care management concepts, use of clinical practice guidelines, and communication skills. To assist the RNCTM in reviewing, analyzing, and stratifying the HRA results, collaboration is available and encouraged with the following staff:

- **Plan Medical Director** is available for any input in stratifying the enrollee and assessing clinical needs. The Plan Medical Director is a licensed medical practitioner (MD or DO) is a part of the ICT, provides clinical oversight, and may be involved in the care plan development and/or evaluation.
- **Medical Social Worker** provides input for the social needs of the enrollee. The social worker is a BSW or an MSW who collaborates with the team to provide insights that help in developing psychosocial interventions.
- **Pharmacist** for any input in the pharmaceutical needs. A HIV experienced licensed clinical pharmacist (PharmD) is part of the team to provide input in the care plan development and medication therapy management program. The HIV pharmacists assist the team in developing interventions around medication adherence, polypharmacy, drug-drug interactions, etc. The HIV pharmacist

provides individual consultation and education as determined by the Individual Care Plan.

- **National Director of Care Management, Utilization and Risk Management**, a Registered Nurse with extensive clinical nursing care management experience and is available to the RNCTM to support the Care Coordination team, provide guidance and clinical rationale .
- **Clinical Operations Manager**, Registered Nurse responsible for the day-to-day clinical operations of the RNCTM staff, Care Plan partner(s), Medical Social Worker and CHW.

Based on the above collaboration, the plan and rationale for the review, analysis, and stratification takes place for each enrollee in a comprehensive, enrollee-centered methodology. The stratification of the enrollee's health status allows the RNCTM and ICT to tailor the care management according to the severity level and ICP identified goals, while, allocating the appropriate resources and services according to enrollees with the greatest need.

The HRA and the ICP are communicated to the enrollee, the enrollee's PCP, and other ICT members. The RNCTM meets with the enrollee and reviews the findings and ICP. The enrollee reviews and is invited to incorporate his/her individual goals into the ICP. The RNCTM provides the enrollee with a copy of the ICP created by the RNCTM and generated by the care management software system. The RNCTM ensures the PCP receives the HRA and Individual Care Plan for review. The PCP can make requests for edits or additions to the ICP as the primary gatekeeper of the enrollee's healthcare. The RNCTM will incorporate any requests by the PCP and ensures both the PCP and the enrollee have a final copy. The PCP signs off that he or she has reviewed the ICP. the enrollee's healthcare. The sign off is an attestation of agreement with ICP.

MOC 2 Element C: Face-to-Face Encounter

Regulations at 42 CFR § 422.101(f)(1)(iv) require that all SNPs must provide for face-to-face encounters for the delivery of health care, care management or care coordination services. Face-to-face encounters must occur, as feasible and with the individual's consent, on at least an annual basis beginning within the first 12 months of enrollment. The face-to-face encounter must be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy, PHP demonstrates as follows:

Factor 1: Detail face-to-face essentials

Methods by which the Plan obtains the enrollee's consent to face-to-face encounters (In-person and/or virtual).

Consent for face-to-face encounters is obtained during the enrollment process and discussed again during the Welcome Call and subsequent outreach. Enrollees may give verbal or written consent or decline via verbal or written communication.

PHP has implemented options to complete the face-to-face encounter which is part of the HRA Assessment Policy and Procedure and standard of practice for the plan. The options include but may not be limited to:

- In the enrollee's home
- At the enrollee's primary care provider office
- At a safe location of the enrollees choosing such as a pharmacy or park
- In an institutional setting
- Virtually, via a HIPAA Compliant real-time interactive telephone application or computer application

Enrollees who decline any of the face-to-face options are given the option for telephone discussion, or mail-in/return. Whichever option is chosen, it is clearly documented in the HRA software system.

If the enrollee declines telephone, mail, or any other mutually discussed alternative for the completion of an HRA, or simply chooses to refuse to consent to an HRA, the enrollee is informed that their refusal has no effect on their ability to access services. The enrollee is also informed that their assigned RNCTM will document the decline or refusal of face-to-face HRA in software system and will remain available to the enrollee for assistance with care coordination and any issues which the enrollee may need assistance in accessing care.

It is further explained that plan benefits and services will not be affected by their refusal to participate in the HRA process. Annual reminders of preventive health measures, quarterly enrollee newsletters, and all other services will continue. Claims reports will be monitored for PCP and medication adherence, hospitalizations, or any health events that may lead the care team to attempt additional outreaches to enrollees that initially refused assessment to offer assistance and education.

For those enrollees that do not refuse but have not completed an HRA or a successful outreach attempt, the Care team documents in the care management software system the attempts made to engage the enrollee. As noted, the Care Team makes three

outreach attempts at different times, different days and then mails an unable to contact letter on the third unsuccessful attempt. The Care Team continues its outreach as described earlier, and participation will be encouraged throughout the enrollee's health plan enrollment. The Care Team will use soft care management techniques such as preventive care reminders, adherence to medical visit reminder calls, Health Information Exchange (HIE) information for contacts such as post emergency room visit, and hospitalization contact to initiate opportunities for reengagement and care coordination support.

***Methods by which the Plan ensures that encounters occur within the first 12 months of the enrollment and at least annually thereafter.
(also described in MOC 2 Element B Factor 1)***

To begin the face-to-face or other type of encounter, PHP uses different communication methods to ensure the HRA is available to all new enrollees and each continuing enrollee annually. Options are designed to offer a variety of communication methods. These include:

- Inclusion of the initial HRA in enrollment information
- A separate mailing of the HRA to each enrollee (mailed every 3 weeks as part of optimum opportunities for enrollee participation.
- A link to the HRA on the PHP website
- Outreach by telephone, text, and/or email (with enrollee approval) by Care Coordination staff.

In addition, a member of the Care Coordination Team personally reaches out and welcomes enrollees which includes gathering information for the HRA. Once completed, the HRAs are reviewed by the RNCTM who will analyze and begin implementation of addressing goals and needs through the Individual Care Plan (ICP) .

For those enrollees who do not return their HRA, engagement calls (at minimum 3 calls on different days, different times) are made on a continuous basis each month and the traditional mailing of the HRA, as noted above, will also continue. Outreach calls by the Care Coordination team that result in direct encounters with enrollees follow the process of gathering information for the HRA, where it is entered into the care management software system. The RNCTM is immediately notified through this system and begins review, analysis, and implementation of ICP. When the Care Coordination team successfully contacts an enrollee and during the conversation and an RNCTM presence is needed, the RNCTM is linked to the enrollee through several methods. (i.e., a warm transfer from another team enrollee, a scheduled call or visit at enrollee convenience)

Attempts to coordinate and complete a face-to-face encounter begins at enrollment. This include coordinating a face-to-face encounter for the HRA or encounters for an

Acuity/severity level contact or follow-up. Face-to-face is the preferred method for the plan, however, it may not always be feasible. As noted, other communication methods such as telehealth (HIPAA approved) or telephone (HIPAA verified) may be used when FTF cannot occur. The encounter attempt process includes three calls to the enrollee and if unsuccessful, a letter is mailed to the enrollee. During this time, methods to locate alternative numbers/addresses etc. for the enrollee also take place. The plan utilizes an internal master information list combining all systems with information about the enrollee addresses and phone numbers (i.e., Pharmacy fills, provider visits). An enrollee of the Care Coordination team will drive to the last known addresses. Information is also obtained through a vendor service offering the last officially known addresses, numbers, contacts. As noted above, if, after at least three separate and distinct contact encounters are completed, with no successful results, the enrollee is sent a letter through traditional mail to the last known address. These letters are logged and tracked- any returned mail is used to update information regarding viable addresses. The enrollee is enrolled in a subset of the Care Management program called "Unable to Contact." Enrollees in category are monitored via the Care Management software system and are followed using the same described methodology. All attempts by care management to contact the enrollee are all documented in the session note model of the software. In addition, the RNCTM will work closely with provider offices to be present when enrollees are attending a medical appointment.

The same processes are utilized for enrollees who are due for their annual HRA. When there is a significant change in health condition such as hospitalization, change in antiretroviral medication regimen, physical instability, the RNCTM will conduct an HRA, update the ICP and complete the Transition of Care process. The Care Coordination team utilizes the Health Information Exchange (HIE) so that enrollee status changes are known as close to real-time as possible and appropriate action can be taken. If, after the processes described regarding continuous outreaches (calls, texts, emails, home visits) are completed, and the Care Coordination team is still not able to contact the enrollee, an "unable to contact" letter is sent to the enrollee. During this process, the RNCTM and Care Coordination team will coordinate efforts with the PCP (i.e., scheduled provider visits) to maximize the chance to reassess the enrollee and update the enrollee ICP. Once information is gathered, as noted, the RNCTM is notified through the case management software system and the HRA is linked to the RNCTM for review. The RNCTM will reach out to the enrollee to discuss the information.

Policies/procedures, objectives, and expected outcomes for the delivery of health care during the encounter:

Throughout its existence as a Special Needs Plan, PHP has implemented Policies and Procedures (P&Ps) outlining the Model of Care process of Care Coordination. The P&Ps

for Care Coordination are reviewed and updated on a bi-annual basis, or sooner if appropriate. The (P&Ps) are reviewed by the P&P Committee for change or approval. The approved P&Ps are then reviewed by the Utilization Management Committee, the Quality Management Committee which in turn reports to the Executive Oversight Committee. P&Ps are saved to the Care Management Division SharePoint system for easy access by all staff.

Policies and Procedures relevant to MOC 2 Care Coordination include:

CM 104.0 PHP Clinical Call Guidelines on-clinical, administrative staff will identify themselves as such by name and title and refer all clinical inquiries to a clinical professional (e.g., Registered Nurse Team Care Manager [RNTCM], Licensed Vocational Nurse (LVN), Clinical Manager of Operations, National Director of Care Management, Utilization and Risk Management or Medical Director.

CM115.0 PHP Care Coordination

PHP is committed to member-centered care that includes collaboration between the Interdisciplinary Care Team (ICT) and members, their families/allies/support system. The ICT consists of the PCP, RNCTM, LVN, Care Coordinator, Medical Social Worker, Pharmacist, Medical Director, and other specialties such as Behavioral health when appropriate. The Plan provides coordinated care to members with a goal of improved quality of health, reduce/prevent avoidable transitions and provide a range of referrals for services. The interdisciplinary care team (ICT) works proactively to discuss and coordinate care and educate members about available services. The needs of the HIV/AIDS population that the Health Plan serves are complex and numerous. To ensure adequate, appropriate and timely care services for its members, the Health Plan shall provide referrals for a range of series, which include but are not limited to referrals for: Mental Health and Substance Abuse Treatment, Dental and Oral Health Serviced, Housing Assistance, Transportation Assistance, HIV/AIDS Benefit Counseling, Specialty Care, Community Resources.

CM 130.1 PHP Chronic Care Management Program

This policy reflects the PHP Model of Care, which describes a comprehensive Chronic Care Program, promoting the principles of coordinated care management to address the continuing care needs of all Members. The Chronic Care Program incorporates a philosophy of building relationships among Members, caregivers, health care providers, the PHP Managed Care Utilization Management (UM)/Care Management (CM) Care Teams, Interdisciplinary Care Teams (ICT), and the community to promote Members' self-management of their conditions and health care. The Registered Nurse Care Team Manager (RNCTM) serves a centralized role in facilitating seamless care coordination for the Members.

CM 139.1 PHP After Hours Nurse Advice Line

PHP will provide members with twenty-four (24) hour seven (7) days a week access to a

Registered Nurse via Nurse Advice Line (NAL) services. PHP will review calls made to the NAL, notify providers, and provide follow-up monitoring.

CM 140.3 PHP Use of Clinical Based Guidelines

PHP uses preventative and clinical practice guidelines (CPG's) from recognized sources relevant to the populations served for the provision of acute, chronic and behavioral health services as listed in this policy.

CM 175.0 PHP Medication Therapeutic Management Program (MTMP)

All enrollees of the Health Plan are enrolled in the Medication Therapy Management Program (MTMP) on an opt-out basis. Persons living with HIV and/or multiple chronic diseases and taking multiple Part D drugs and/or undergoing antiretroviral medication management are eligible for the program. The MTMP qualifications are outlined in the Health Plan's Contract Year Submission Templates for CMS contracts H5852.

CM 176.0 PHP Employee Licensure Verification

All licensed employees of PHP receive a background check and licensure verification upon hire and as the state licensing board require. The verification is made directly with the state licensing agency, e.g., Board of Nursing, Medical Board, Board of Pharmacy, etc. to the Human Resources Department.

Objectives and expected outcomes for the delivery of health care during the encounter.

Objectives for the face-to-face meeting include improved enrollee self-care, improved engagement of enrollee with care and relationship building with entire care team. For face-to-face encounters, the Plan policies and procedures reflect objectives including the following: based on the assessment results.

- Move the patient along the continuum of care via motivational interviewing techniques.
- Complete care plan goals or at least facilitate progress to completion.
- Update care plan with new goals, edits or completion.
- Facilitate accessing resources for enrollee, as needed.

Factor 2: Describe qualified personnel.

PHP staff who may conduct the face-to-face encounter:

PHP utilizes the RNCTM and other appropriate Interdisciplinary Team (ICT) members such as the Medical Social Worker and/or Community Health Worker when conducting a face-to-face visit. The PCP may also be part of this encounter when the encounter takes place in the provider's office. For Behavioral Health issues self-referred by enrollee or otherwise, PHP collaborates with the Behavioral Health vendor RN Care Manager who will work with enrollee and report on the encounter in the ICT. The RNCTM will document the Behavioral Health RN report in the Care Management System.

All software systems used by PHP including, but not limited to, the Care Management Software System (eQHealth), Enrollment (HealthSuite), EMR (AthenaOne and others) Health Information Exchange (Point, Click, Care) which meets the confidentiality of health information and personally identifiable information of the plan enrollees.

Factor 3: Verify qualifying encounter.

PHP verifies data collection including participation in a qualifying face-to-face encounter through via claims data and reports. The care management system functions as a data warehouse and is integrated with the medical records and claims data. The claims and encounters can be viewed directly or in report format. Consent for any virtual based encounter is obtained verbally and documented in the encounter care notes. In-person consent is implied via mutual consent of time and place, also documented in the care notes. To ensure initial and annual face-to-face encounters are performed, the Care Management software generates a daily dashboard for the RNCTM weekly indicating which encounters are due and which encounters will be coming due in the next 5 days and the near future. Changes in health status are reported through the HIE, through hospital admission data, notification by any health team enrollee with direct knowledge and thorough collaboration with PCPs.

Factor 4: Specify clinical functions and assessments:

PHP identifies the following types of clinical functions and assessments that may be performed during the required encounter. These include but are not limited to:

- Engaging with the enrollee to manage, treat and oversee (or coordinate) their health care such as furnishing preventive care included in the ICP.
 - The interventions created and implemented in the ICP include preventative care measures such as annual mammograms, colon-rectal screening. Enrollees receive teaching and assistance with understanding the need for preventative testing, finding a network specialist and if necessary assistance with making appointment and follow-through to resulting specialty report to the PCP.
- Annual wellness visits and/or physicals.
 - Enrollees are monitored the RNCTM and Care Coordination team for retention in care which include four appointments with the provider on an annual basis including the annual wellness visit and subsequent follow-up appointments.
- Completion of a Health Risk Assessment (HRA), such as the one annually required for all SNPs under the current regulation at 42 CFR § 422.101(f)(1)(iv)

- As described in MOC 2 Element B: Health Risk Assessment, PHP has policies, procedures and workflows in place which provide the necessary tools and reports so that the completion of the annual HRA occurs.
- Individual Care plan review or other similar care coordination activities.
 - As noted in MOC 2 Element B: Health Risk Assessment. The RNCTM, Enrollee and Provider review and agree upon the ICP. The Care Coordination team ensures the enrollee reviews information and resources relevant to the successful outcome of the goals of the ICP.
- Health related education whereby the enrollee receives information or instructions critical to the maintenance of their health or implementing processes for maintaining the enrollee's health, such as the administration of a medication.
 - PHP distributes a quarterly enrollee newsletter with pertinent information relating to living with HIV. The outreaches completed by the enrollee's RNCTM or Care Team are designed to gather current information about the enrollee's health since the last contact and to address any challenges or concerns regarding their health. As noted in the Plan Pharmacist's role description, Medication reviews (MTMPs) are conducted and during the outreach calls, targeted medication review and teaching conversations will occur if appropriate.
- Preventative health discussions plan and follow-up.
 - Enrollees receive information regarding their preventative health measures by the RNCTM. The Case Management Software system provides real time information about measures currently due. The RNCTM assists the enrollee with addressing these measures using teaching/education, locating a specialist relevant to the measure and if necessary, assisting the enrollee in the making of the appointment.
- Setting of appointments for vaccines, lab work and/or specialty medical or ancillary health care services.
 - The RNCTM and Care Coordination Team collaborate with the enrollee's provider team so that services due occur in a timely basis.
- Medication review including refilling prescriptions.
 - As noted in the Plan Pharmacist's role description, Medication reviews (MTMPs) are conducted and during the outreach calls, targeted medication review and teaching conversations will occur if appropriate. RNCTMs collaborate with both the Plan Pharmacist and point of service Pharmacy staff whenever a concern regarding a prescription refill is

needed. Reports are available to the Care Coordination team regarding refills, medication changes, etc.

Factor 5: Address Identified Health Concerns

The RNCTM who is conducting the face-to-face encounter is responsible for handling all health concerns of active or potential health issues. This includes collaboration with the provider, the Medical Director, or other members of the ICT team. If there is a limitation by the scope of practice, such as prescribing a medication, the RNCTM is responsible for making the appropriate call, referral, or other communication to coordinate this care. The RNCTM will collaborate with the PCP for immediate concerns to be addressed, for urgent matters that cannot wait, the RNCTM or Care Team enrollee who is witnessing a life-threatening event will call 911, wait with the enrollee and then contact the PCP. This would then be reported to the ICT team and become part of the health change status and transition of care protocol would be established. This would then be further validated through the Health Information Exchange system used by PHP.

Factor 6: Care Coordination Activities

How PHP conducts care coordination activities through appropriate follow-up, referrals, and scheduling. The Care Coordination team maintains established contact protocols based upon either the enrollee's acuity rating as determined by their Health Risk Assessment Tool (HRA) and Individual Care Plan (ICP) intervention schedule. Referrals and status of authorizations are available to review by the Care Coordination team via the Care Management Software System authorization module. There is also a report tracking timeliness and referral decision. Plan enrollees are notified of referrals requiring prior authorization which have been approved via mail and verbally. Enrollees can contact their RNCTM, or other members of the Care Coordination team or Member Services for assistance. RNCTMs who anticipate an issue with appointment scheduling may call the enrollee to assist. For preventative health measures, annual wellness visits or other QI focused effort, Care Management staff may contact the enrollees who are on a gap list via phone, letter, text, or email (if enrollee agrees to text or emails) and will assist enrollee with scheduling procedures or test.

MOC 2 Element D: Individual Care Plan (ICP)

Regulations at 42 CFR § 422.101(f)(1)(ii); 42 CFR § 422.152(g)(2)(v) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP. PHP has developed and implemented an ICP addressing the following:

- Detail the essential components of the ICP.

- Description of the process to develop the ICP, including the applicable staff involved and how often the ICP is modified as enrollee health care needs change.
- Identify the personnel responsible for development of the ICP, including how enrollees and/or caregivers are involved.
- Detail how the ICP is documented and updated, and where it is maintained. Describe how updates and modifications to the ICP are communicated to the enrollee and other stakeholders.

Factor 1: Describe essential components of the ICP.

The enrollee's self-management goals, objectives, and personal healthcare preferences.

The RNCTM and the enrollee will identify the most important personal health preferences from the enrollee's perspective. Using this strategy, the ICP can be tailored specifically to the enrollee needs and preferences thus increasing their participation in addressing those problems and achieving those goals which are most meaningful.

A description of services specifically tailored to the enrollee's needs. In continued collaboration, the RNCTM will work with the enrollee to establish a clear understanding of all the services available and how they will help achieve the goals listed. The RNCTM will further analyze the HRA and collaborate with the PCP and other ICT enrollees when appropriate and focus on problems, not already identified, or discussed that are impacting the enrollee's health status, and work together to provide target interventions.

Role of the enrollee's caregiver: The enrollee and/or caregiver are involved, whenever possible, in the development of their ICP. Together, insights are provided to the rest of the team and incorporate personal goals and commitments into the ICP.

Identification of goals (met or not met) The ICP will function as a roadmap, directing the improvement of their health status and quality of life. The goals of the ICP can be reviewed by the RNCTM in collaboration with the enrollee, the PCP, and other ICT enrollees at any time to evaluate the enrollee's progress but specifically at the timeframes set in the ICP.

If the enrollee's goals are not met, the MOC must describe the organization's process for reassessing the current ICP and determining the appropriate alternative actions as well as providing the update(s). If, during this review, the goals are not met, the RNCTM, in the same manner used as in the development of the ICP, a discussion takes place to discuss what barriers exist that impact the enrollee's ability to achieve existing goals and how best to change or remove the goals occurs. Working

together, the RNCTM, the enrollee, the ICT and PCP, if warranted, agree on a new care plan with interventions to assist in a successful outcome towards the goal.

Factors 2: Describe the ICP Development Process

Individual Care Plans are developed through the information obtained in the HRA. The information is then reviewed, analyzed, and discussed with the enrollee to develop an ICP that reflects the enrollee's own goals. It is important that the enrollee is engaged in this development and the RNCTM encourages the enrollee (and caregivers) to participate through motivational interviewing techniques, listening to the enrollee's concerns and promoting engagement in care. Conditions that would apply to further tailoring and development include but are not limited to:

- Attainment of the enrollee goal for the specific issue.
- Significant health events or medication regimen changes.
- New issues or enrollee-directed intervention
- ICT assessment of ICP recommendations for intervention
- Annual HRA reassessment results
- Creation of a new goal due to inability to effectuate the intervention and or attain the original goal.

Whenever a new ICP is created, the ICT, including the enrollee and the PCP review the ICP. The ICP is shared with the PCP and the enrollee as described previously.

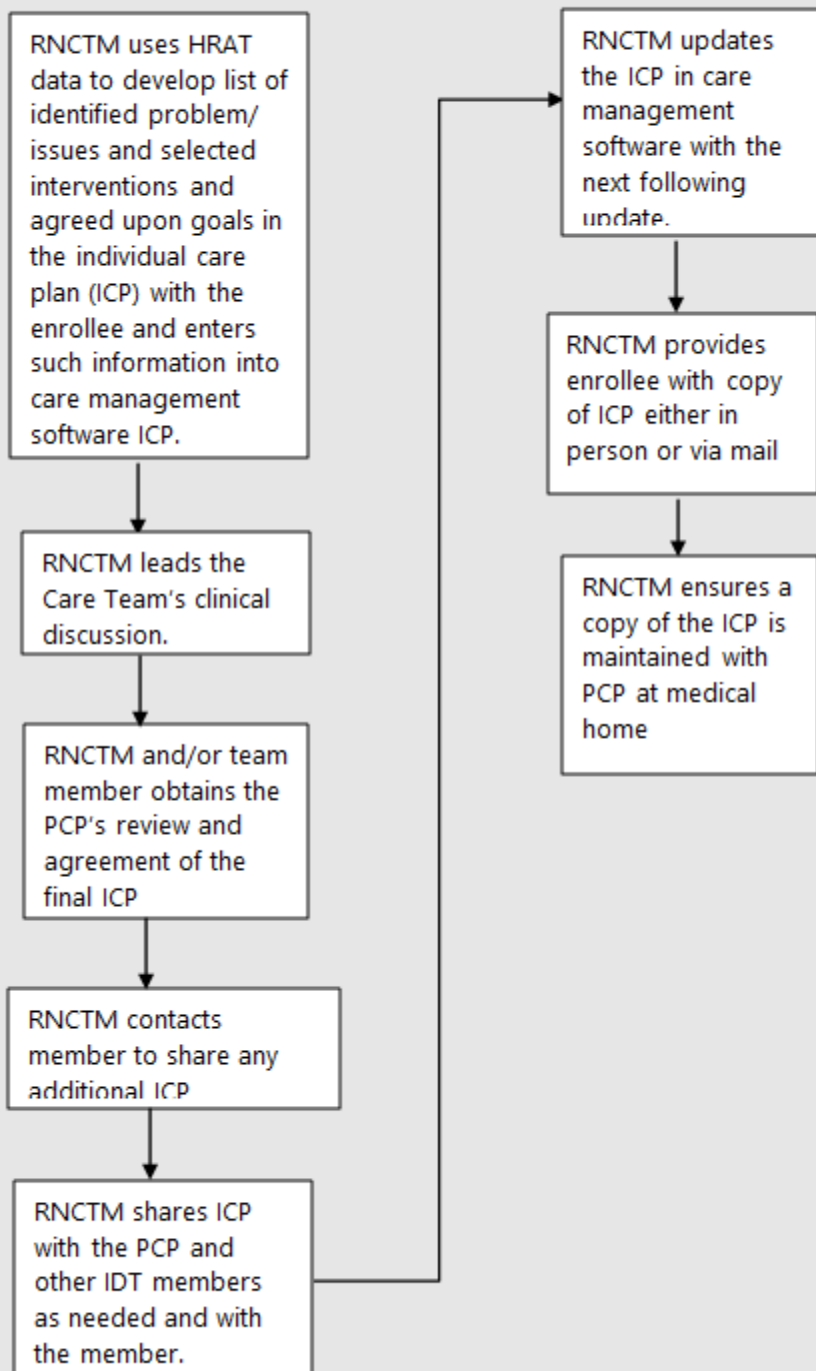
The RNCTM develops the ICP in collaboration with the enrollee during the assessment process and works with them to address the personal health preferences and most meaningful problems, goals, and interventions of the enrollee. By engaging the enrollee in the development of the ICP and working to address specific issues important to their care, there is a greater opportunity to work toward self-management and successful outcomes. Using this same strategy, along with the RNCTM and enrollee, the ICT and other pertinent specialists collaborate to cover all problems contributing to the health status of the enrollee as needed. The ICP is developed at the time of the initial assessment (within 90 days of enrollment in the plan) and continues to be reviewed by the same process any time the enrollee experiences a change in health status, a transition from one care setting to another and, if warranted, at the time of contact based on the acuity/severity level determined by the HRA and/or the ICP intervention timeframes.

Below are the acuity frequency determination and criteria and the ICP development workflow diagram.

Acuity Determination Frequencies	
Severity Level	Minimum Contact
Level: Low - Population Health	Quarterly outreach
Level: Moderate - Disease Management	Outreach every 8 weeks
Level: High - Complex Care Management	Monthly outreach

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria	Low - Population Health Management	Moderate -Disease Management	High/Complex - Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months	Active substance use/addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (Q8 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

Individual Care Plan (ICP) Development Workflow



HRAT=Health Risk Assessment, ICP=Individual Care Plan, IDT=Interdisciplinary Care Team

Factors 3: Detail personnel responsible for ICT development.

Enrollees and/or caregivers are encouraged to participate in the ICP process throughout the care continuum. Personnel involved in the development, monitoring and evaluation of the care plans are as follows:

- **RN Care Team Manager (RNTCM):** This individual is a licensed registered nurse with HIV experience and/or specific education who has been trained on the chronic care management concepts, use of clinical practice guidelines, and communication skills.
- **Primary Care Provider (PCP):** The enrollee's assigned HIV PCP is involved in the development and approval of the ICP. PCPs in PHP's network are licensed physicians who are HIV specialists as evidenced by their meeting the definition of an HIV specialist as defined by the AAHIVM-American Academy of HIV Medicine.
- **Specialty Care Provider:** Specialists are licensed physicians who have completed advanced education and clinical training in a specific area of medicine. When appropriate, there is input from the enrollee's specialist in the development of the ICP.
- **Medical Director:** The Plan Medical Director provides clinical oversight and may be involved in consultation of care plan development and/or evaluation. They are licensed medical practitioners with board certification in Internal Medicine.
- **National Director of Care Management, Utilization and Risk Management** provide oversight of the nursing process critical to care plan development and are licensed registered nurses with experience in HIV care.
- **Clinical Operations Manager** provide first level oversight to the RNCTM of the process by which care plan development takes place and is a licensed Registered Nurse with experience in HIV care.
- **Enrollee/Caregiver:** The enrollee and/or caregiver are involved, whenever possible, in the development of their ICP. They provide insights to the rest of the team, as well as incorporating their goals and commitments into the ICP.
- **Medical Social Worker:** The medical social worker is Bachelors or Master's prepared and provides insights that help the team in developing psychosocial interventions. The social worker provides information on the enrollee's current living condition, needed community resources, or other issues to compliance with medication adherence, self-care, and medical care.
- **Pharmacist:** A HIV experienced licensed clinical pharmacist is part of the team to provide input in the ICP development and medication therapy management program. The HIV pharmacists assist the team in developing interventions around medication adherence, polypharmacy, drug-drug interactions, etc. The HIV

pharmacist provides individual enrollee consultation and education as determined by the ICP.

- **Behavioral Health Professional:** A licensed BHP who provides behavioral health care and insight into the development of the enrollee's ICP when the HRA reveals issues requiring the intervention or significant consultation by a BHP, e.g., positive depression screen, substance abuse issues, signs, and symptoms of mental illness.

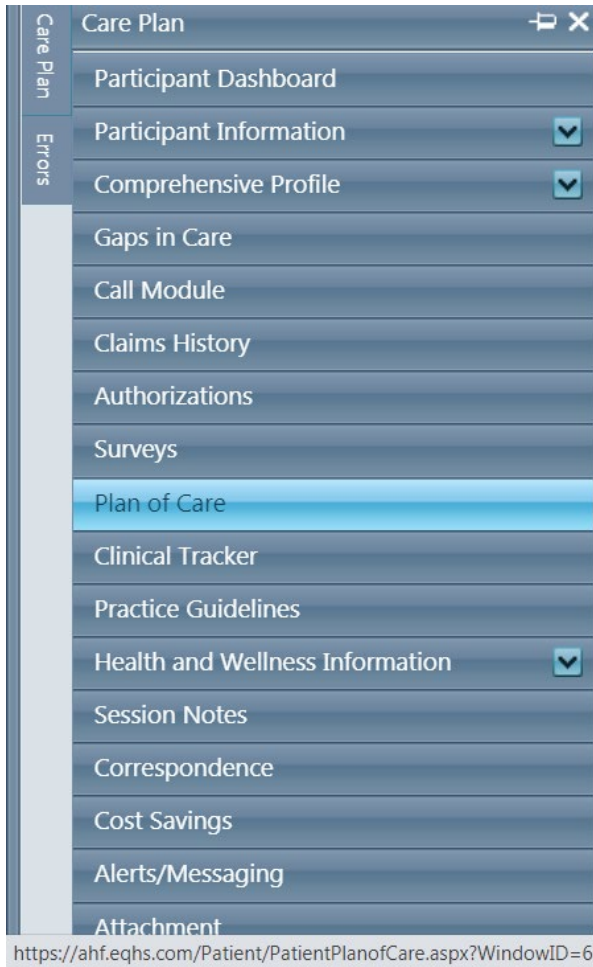
The RNCTM also shares with the ICT the ICPs developed through information gained during the HRA. This is shared either physically/verbally or through electronic means via direct upload to the software system.

Written updates are provided to the ICT team at the time of any HRA by the RNCTM via secure email to the ICT team at time of reassessment or for any change in health condition including Transitions of Care. The RNCTM documents this process of communication and sharing of information including results and specific dates of communication with the IT team in the care management software system (e.g., ICP shared, ICP reviewed)

The ICT uses the HRA information to address issues/concerns/medical/ psychosocial and social determinants of health problems unique to the enrollee and to each of the ICT disciplines. By identifying these unique needs, the ICT is tailored to each enrollee and contributes to their individual needs. ICTs that are tailored to specific needs have been found to be more effective, efficient, and focused on the individual enrollee needs. PHP has adopted a model of member-centered care in the composition of the ICT.

Factor 4: Specify ICP documentation and maintenance.

ICPs are documented and updated in the care management software system. An example of the system is shown as reference. Please note this example may be subject to system updates. The ICP is uploaded to those EMRs which are accessible by the plan and sent electronically or by fax (provider's preference) so that it is accessible to the provider. When requested, the enrollee and/or their caregivers receive a copy of the ICP. For those that do not want a copy, they are informed that the ICP is available upon request, should they change their mind. The ICP becomes part of the ICT discussion during weekly meetings and is either physically/verbally or electronically shared with ICT enrollees for collaborative discussions.



Electronic Case Management system noting location of Plan of Care

A redacted Individual Care Plan as documented in the Care Management software system is shown below:

1/24/2025
[Redacted]
[Redacted]
[Redacted]
Provide: List of community resources who may be able to assist - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft
ISSUE: Emergency room visit in the last 6 months
GOAL: Reduce emergency room utilization
INTERVENTIONS (Description - Target Complete Date - Actual Completion Date - Outcome - Assigned To - Barriers)
Educate: Appropriate utilization of emergency room. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft
Assess: Root cause of visit. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft
ISSUE: Enroll in Early Cancer Detection
GOAL: Enroll in Early Cancer Detection
INTERVENTIONS (Description - Target Complete Date - Actual Completion Date - Outcome - Assigned To - Barriers)
Enroll in Early Cancer Detection - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

ISSUE: Food insecurity, at risk for insufficient nutrition and adherence to treatment plan due to said insecurity

GOAL: Address food insecurity

INTERVENTIONS (Description - Target Complete Date - Actual Completion Date - Outcome - Assigned To - Barriers

Educate member on governmental and community resources, e.g. SNAP, Food pantry, etc. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

Assist member in applying for public and charitable food assistance. Provide transportation to application appointments. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

ISSUE: High Blood Pressure

GOAL: Administer: Hypertension survey

INTERVENTIONS (Description - Target Complete Date - Actual Completion Date - Outcome - Assigned To - Barriers

Administer: Hypertension survey - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

ISSUE: Identify non-adherence to medication regimen reasons

GOAL: 100^ adherence

INTERVENTIONS (Description - Target Complete Date - Actual Completion Date - Outcome - Assigned To - Barriers

Report adherence issues to MD - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

Explore daily reminder service as necessary. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

Educate member on specific ARV adherence and recognizing barriers before they lead to missing doses. - 11/21/2024 - 11/21/2024 - Resolved - Douglas Beecroft

Factor 5: Describe ICP updates and modifications.

The RNCTM is responsible for communicating the ICP and the ICP updates/modifications to the PCP and the enrollee and/or enrollee's caregiver, the ICT team, network providers, when appropriate to care and others involved in the enrollee's team/support system. The RNCTM utilizes several methods to communicate the ICP that include but are not limited to:

Members and/or their caregivers

- Communicates the ICP face to face, video conferencing or telephonically at the time of development.
- Written or electronic copy of the ICP
- Education on their current health status, the ICP interventions and goals and how it impacts overall quality of life These measures can then be implemented to improve their health outcomes and achieve the enrollee's health and personal goals.
- Documents communication of the ICP in the care management software system electronic care management record

Interdisciplinary Care Team

The core ICT for all members in the PHP Plan are the enrollee, the PCP and the RNCTM. Additional members are added through the initial and follow up Health Risk Assessment and care planning processes. Current ICPs are closed and new ICPs are developed according to a range of factors. Updates and modifications are implemented in many ways, including but not limited to:

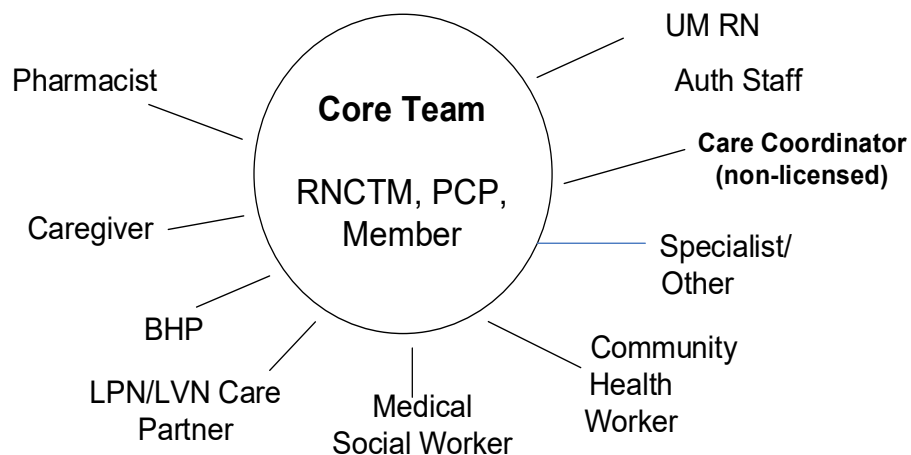
- Provides written documentation of the ICP and a verbal summary (at the time of development) during team meetings.
 - Emails/Faxes (Secure) of the ICP if the ICT meeting is held telephonically and provides a verbal update during the conference call.
 - In addition to the written documentation, the RNCTM provides a verbal update (telephonically or face to face) if there are significant concerns with the enrollee's health at the time the ICP is being developed or revised so the provider can take the necessary steps to positively impact the enrollee's health.
 - The RNCTM documents communication of ICP and date of communication in the care management software system.
 - The RNCTM accomplishes the ICP development by analyzing the information collected in the HRA within 90 days of enrollment in the plan and obtaining additional input into the HRA and ICP from the HIV primary care provider (PCP).
 - The assigned RNCTM is the Interdisciplinary Care Team (ICT) coordinator and is responsible for developing and communicating the ICP with the enrollee and other participants of the ICT.
- Applicable network providers** (Primary Care Provider, Specialist Providers)
- Emails/Faxes/Uploads a copy of the ICP at the time of development and requests input and signed attestation of ICP reviewed.
 - Provides a verbal update (telephonically or face to face) if there are significant health concerns at the time the ICP is being developed/revised so the provider can take the necessary steps to positively impact the member's health.
 - Documents communication of ICP and date of communication in the care management software system.
- Other SNP personnel or stakeholders as necessary** (internal communication within the Care Management Organization)
- The ICP is communicated by the RNCTM either telephonically or in writing (secure Fax, email, mail) as necessary to appropriate individuals who are participating in the care of the individual member.
 - The ICP is documented and available to those with specific staff privileges in the care management software system.

MOC 2 Element E: Interdisciplinary Care Team (ICT)

Regulations at 42 CFR § 422.101(f)(1)(iii); 42 CFR § 422.152(g)(2)(iv) require all SNPs to use an ICT that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the SNP. PHP describes the critical components of the ICT as addressed in Factors 1-4.

Factor 1: Detail ICT Membership:

PHP demonstrates through the Model of Care that at the core of the Interdisciplinary Care Team (ICT) is always the enrollee and the enrollee caregiver (when requested by the enrollee), the HIV Primary Care Physician (PCP) and the Registered Nurse Care Manager (RNCTM). Upon enrollment into PHP, the enrollee is assigned to a PCP and an RNCTM to conduct the initial HRA thus establishing the ICT from the first day of active enrollment. The diagram below depicts the structure and other team enrollees involved in the ICT as informed by the Health Risk Assessment Tool (HRA).



Within 90 days of enrollment, the RNCTM reaches out to the enrollee and completes the HRA. The RNCTM analyzes the HRA results and shares the ICPs developed based on the HRA with the PCP directly for review and approval. Other ICT enrollees are added based upon individual needs.

Examples of building an ICT that is tailored to an enrollee's needs follow:

- Enrollee with a positive depression screen would trigger the inclusion of the staff Medical Social Worker and a potential referral to a Behavioral Health Professional (BHP) in that individual enrollee's personal ICT.
- PCP would like a targeted approach to simplify the enrollee's complicated medication profile. The clinical pharmacist would be actively involved in

the ICT so all clinical expertise can be considered in developing and monitoring the pill burden and tailored to the ICP.

The RNCTM is responsible coordinating the ICT to assure communication, implementation, monitoring, and evaluation of the Individualized Care Plan (ICP) occurs on an organized basis. The RNCTM establishes the ICP and delegates activities to carry out the plan to enrollees of the Care Team (i.e., Care Partners, Care Coordinator, and the Medical Social Worker). The Medical Social Worker and the Community Health Worker are additional resources for the enrollees and enrollee caregivers as well as the teams for linkage to community resources and other areas of enrollee interest.

The ICP progress is evaluated on a continual basis. The RNCTM coordinates the ICP interventions and documents the enrollee progress to goal. As goals are met, evaluation timeframes are reached, or new goals are created to address previous goals not met, the RNCTM consults with the ICT enrollees. For PHP, ICT is a regularly scheduled weekly meeting or may be called ad hoc to address a health condition and ensure appropriate care plan development.

BBA 2018 provisions: ICT enrollees are licensed clinical professionals specializing in HIV/AIDS care. Non-licensed enrollees such as Medical Social Workers require the necessary education (BSW/MSW) as do the other non-licensed staff (validated by Human Resources) . As a Special Needs Plan for HIV/AIDS, PHP staff receive yearly training via AHF University as well as in person or online seminar, conference opportunities so that their expertise in this target area remains current.

Factor 2: Describe ICT roles and facilitation of enrollee participation:

In the PHP Model of Care, the enrollee is encouraged to work in partnership with and be a member of the Care Team. All enrollees who enroll into the Plan are assessed by a RNCTM. The initial HRA process introduces the enrollee to the RNCTM directly whether the enrollee completes it through the noted available options of link, mail or in the enrollment process. The RNCTM will review the HRA information completed by the enrollee or will complete with the enrollee during the in-person assessment. Regardless of the method, the enrollee and the RNCTM work together through the HRA answers, address concerns and develop an ICP. If the initial HRA cannot be completed in person, the RNCTM will complete either by video conferencing or telephonically with documentation as to reason it was not completed in person. This is designed to assist the enrollee to identify and articulate important aspects of care, express knowledge of disease and progression, and adherence with medications and care appointments. The initial HRA interview with the RNCTM is designed to empower the enrollee to be an active enrollee of their Care Team. The Level of Knowledge Survey assesses the

enrollee’s knowledge of illness and disease progression, satisfaction with care and medication adherence and provides an opportunity for teaching and enrollee empowerment in understanding their health conditions. Principles of the Nursing Process are incorporated in every encounter.

A stratification model shown here notes that enrollees with higher acuity receive more frequent care interventions such as increased in person or telephonic interactions with the ICT.

Acuity Determination Frequencies	
Severity Level	Minimum Contact
Level: Low - Population Health	Quarterly outreach
Level: Moderate - Disease Management	Outreach every 8 weeks
Level: High - Complex Care Management	Monthly outreach

The RNCTM can also conduct conference calls or secure web-based meeting between the ICT and the patient if face-to-face meetings are not warranted or not possible. If live interactions are not possible or warranted, the ICT team enrollee will communicate with the patient either by encrypted e-mail, text, and/or written correspondence.

PHP has extensive clinical experience working with people living with HIV/AIDS and other co-morbidities. Listening to and communicating directly with the enrollee and caregivers is the first step to preparing them to self-manage his/her own care. Best practices document a successful team membership once a patient can identify their own needs and articulate the circumstances of their care. This is a process. The RNCTM incorporates the patient and/or care giver into the ‘Care Team’ by providing health education and resources for empowerment such as health journals and Advance Directives instruction as well as other ICT posted activities.

Once the enrollee is introduced to the Care Coordination team, the RNCTM and other team enrollees work to ensure the enrollee understands available resources and the importance of communication. The enrollee can discuss health issues directly with the enrollees of the Care Team. The Care team is available to respond to calls during business hours and can engage the RNCTM to call the enrollee within one business day, as well as a nurse advice line that is available after business hours, weekends, and holidays. Enrollees who call after normal business hours will receive a message to call the 24-hour Nurse Advice Line, or if it is an emergency, to hang up and call 911. The enrollee may also wish the RNCTM to represent them at the Care Team meetings. The RNCTM facilitates weekly Care Team meetings to introduce the new enrollees, establish trust and model team participation. This may be a first-time experience for new enrollees, participating in their own care. The PHP Model of Care prepares the enrollee for successful team participation through the initial RNCTM assessment, clinic activities

such as educational series available to all patients and availability of team enrollees when the patient is at their medical provider's office.

Factor 3: Evaluate enrollee outcomes:

The ICT uses health care outcomes such as changes in Acuity/Severity levels, Labs, Transition of Care and the HRA itself to monitor the outcomes of the enrollees. The ICT will then work with the enrollee to evaluate and manage the changes or adjustments to their healthcare. Once the enrollee understands their own identity as self-care manager and Care Team, relationships with team members can be built and be supported to articulate health and psychosocial needs. Tools such as Health Journals, Health apps, etc. can be utilized to focus on important issues and provide the language that the enrollees may need to articulate their needs. Participation for the enrollee can be choosing to be in attendance or delegate the RNCTM to be their voice to the team. The notification is the responsibility of the RNCTM as well as other team enrollees such as the Care Team partner, Community Health Worker, and the Care Coordinator. Notification will be primarily telephonic but may include email, texts, faxes or mailed notices.

Due to the extenuating psychosocial needs and fear of disclosure and discrimination, the PHP program offers these multiple communication outlets to foster enrollee involvement in the ICT. PHP ICT members who speak the enrollee's primary or favored language are assigned to RN Care Managers for the HRA and ICP process. If a Care Team enrollee is not available or the preferred language is not spoken by the RNCTM, PHP contracts with interpreter services (e.g., AT&T language line, ASL services for hearing impaired).

Frequency of review of enrollee outcomes after initial assessment is driven by the assigned Acuity Level and the ICP. This Acuity Level is determined by the program based on clinical findings during the HRA. If the enrollee is admitted to an acute care stay, skilled facility, LTC or rehab acuity, reassessment occurs to identify clinical changes, barriers to successful transition of care, medication changes, etc. that warrant an Acuity Level and ICP change. The patient may also decide that significant health concerns have accumulated necessitating inclusion at a scheduled Interdisciplinary Care Team meeting and the RNCTM would make all arrangements for their attendance.

Factor 4: Describe communication plan.

- PCPs and enrollees/caregivers receive copies of the ICP from the RNCTM. The ICT has access to the care management software system and the PCP EMR – per HIPAA protocols and specific privilege levels.

- The ICT can review the HRA, ICT and Session Note modules to stay informed of the plan of care and enrollee progress at any time through a virtual private network connection.
- The RNCTM coordinates the dissemination and gathering of information for the ICT enrollees who are in network PCP offices. Copies of HRAs, ICP and ICT minutes are supplied in the format requested by the network PCP (e.g., faxed or delivered paper, encrypted electronic file, CD).

PHP's communication plan promotes the regular exchange of enrollee information within the Interdisciplinary Care Team as follows:

The ICT members:

- Meet throughout the ICP to conduct analysis of the ICP based on the measurable goals, identify barriers to care, and develop intervention to improve quality.
- Meet at minimum, monthly, or more often as outlined in the enrollees' ICPs, to conduct a comprehensive review of health trends of patients and overall clinical performance (based on the measurable goals).
- Conduct case rounds on a weekly basis to discuss individual care management cases. This can include a subset of ICT enrollees, including care managers, Plan Medical Director, MSWs, and other providers (when appropriate for the cases under review), notate meeting action items to distribute to the team enrollees for follow up, as necessary.
- As a part of the ICT Meetings, Behavioral Health cases are presented and discussed for additional clinical guidance. The team focuses on achieving optimal treatment planning decisions, patient education, and recommendations. This addresses specific mental health issues related to hospitalizations, post hospital discharge care and community care.

As when an PHP enrollee joins the ICT and is assisted by members who speak their favored or primary language, overall communication for enrollees who speak a language other than English, PHP has several RNCTMs who are bilingual in Spanish and/or Creole. Whenever possible, enrollees who speak those languages are assigned to RN Care Managers for the HRA and ICP process. For other languages or if a bilingual Care Team enrollee is not available, PHP contracts with interpreter services (e.g., AT&T language line, ASL services for hearing impaired). Enrollees who experience language barriers due to medical conditions affecting speech are encouraged to use their preferred form of communication (e.g., text message, typing, writing, ASL). Whenever possible the primary caregiver for enrollees with communication barriers and any enrollees with cognitive impairments are engaged to ensure that the enrollee understands and/or can be

recalled when necessary. The ICT utilizes the care management software system for documentation of all activities. The EMR (Electronic Medical Record) is the primary communication among staff clinicians in the medical provider's office. Access to both systems is limited based on HIPAA compliant user roles. Plan Staff and providers communicate with each other via face to face, teleconferencing, email, flags (notification within EMR) phone, and/or faxes.

PCPs and enrollees receive copies of the ICP from the RNCTM. The ICT has access to the care management software system and the PCP EMR per HIPAA protocols and specific privilege levels. The ICT can review the HRA, ICT and Session Note modules to stay informed of the plan of care and enrollee progress at any time through a virtual private network connection. The RNCTM coordinates the dissemination and gathering of information for the ICT enrollees who are in network PCP offices. Copies of HRAs, ICP and ICT minutes are supplied in the format requested by the network PCP (e.g., faxed or delivered paper, encrypted electronic file, CD).

PHP enrollees receive their ICP each time an HRA or change of condition occurs. In addition, all their medical record, ICPs and HRAs are available to the enrollee upon request. The format of transmission to the enrollee is at their discretion (i.e., mailed in a paper format, confidential fax, encrypted e-mail. As part of their self-empowerment, the enrollee receives education about the necessity to bring any discharge documents and their discharge instructions to their follow-up PCP and or specialist appointments. To reinforce, RNCTM and/or UM Nurse contacts the discharging facilities to obtain discharge summaries, medication lists, and discharge plans and shares with providers by scanning into care management software and electronic medical records. For providers who are unable to receive scanned/uploaded records, information is faxed/mailed/hand delivered.

MOC 2 Element F: Care Transition Protocols

Regulations at 42 CFR § 422.101(f)(2)(iii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x) require all SNPs to coordinate the delivery of care. PHP describes the care transition protocols as addressed in factors 1-6.

PHP recognizes that improving quality and safety during transition of care movement is fundamentally different from improving quality and safety in a single setting. PHP's care transition quality aims to facilitate the bringing together two or more disparate

organizations who are culturally, linguistically, and socially accepting of persons with HIV/AIDS, the medical provider, the enrollee and family and the Health Plan to provide a match between an individual's care needs and his or her care setting.

Factor 1: Facilitate continuity of care:

For PHP transition process occurs before, during and after a transition. In the case of PHP, the Transition of Care program begins long before there is an enrollee need when PHP developed protocols and processes to maintain continuity of care in transitions, including but not limited to the following:

- Building its network of providers and facilities to assure that HIV/AIDS stigma is minimized and eliminated when enrollees access services.
- Educating **all** enrollees, regardless of their acuity status, about the PHP transition process between the various types of healthcare settings needing transition continuity of care, *i.e., home, home health care, acute hospital, skilled nursing facility, custodial nursing facility, outpatient/ambulatory/surgery centers.*
- Participating in the Health Information Exchange (HIE) in California in order to be informed, in as close to real time as systems allows, that PHP is made aware of an enrollee transition status. This notice, may, at times, be before a formal transition notice to or from a healthcare setting is received from the enrollee/care giver or facility.
- Collaborating with the healthcare setting or enrollee/care giver notification of PHP to the transition to/from a healthcare setting of the enrollee
- Preparing an elective pre-planned procedure/treatment plan that is developed with the enrollee/care giver/medical provider/PHP care manager which addresses the continuity of care transition plan in the individual care plan (ICP).

With the network in place, the HIE information communicated, the Transition of Care program then begins with the patient centered approach and cross-setting communication and collaboration for the enrollee. The PHP UMRN, RNCTM and Medical Director collaborate with the attending facility physician/provider and/or the HIV PCP, the facility discharge planning staff, and the accepting facility admission staff when admitting to a second facility or enrollee/care giver as circumstances dictate. Most importantly, the needs of the enrollee and/or their family support system are understood by the RNCTM and the Interdisciplinary Care Team (ICT).

For Transitions that do not result in an inpatient admission (i.e., ER visit, Observation), the HIE information is utilized the RNCTM and Care Coordination team so that those events are addressed and appropriately followed up by the Care Coordination Team.

The goal of the Transition of Care program is to reduce fragmented and unsafe care, reduce complications and readmission by improving an enrollee or family's ability to employ self-management and reduce potential failures or significant variations in the discharge plan that would necessitate readmission/reengagement with the healthcare system. An inpatient care episode of any kind, Acute, Skilled, Rehab or Behavioral Health, for a patient with HIV can result in a significant decline in that patient's overall well-being if not managed properly before, during and immediately following the inpatient episode.

The UMRN and RNCTMs work together to share information with the healthcare setting, enrollee, and each other. Whenever possible, the enrollee is visited by the RNCTM or member of the Care Coordination Team during an inpatient admission and a coordinated follow-up visit with the PCP is facilitated. The Care Team works to schedule appointments with the PCP within 7 days of discharge whenever possible (but no more than 30 days).

Discharge information, medication reconciliation and expectations following discharge are reviewed with enrollee and/or family and assessed for understanding. Enrollees are contacted post discharge by the Care Team to assure the discharge transition of care plan is being effectuated as planned. ICT members are notified of transitions and discussed during UM rounds.

Factor 2: Identify care transition personnel

The ICT work together to coordinate planned and unplanned care transitions. This includes sharing the individual care plan (ICP) between settings, review of discharge plan and orders, oversight of the implementation of those orders by the RNCTM and Care Team Medication reconciliation, scheduling of post hospitalization or other appointments are made. Community Health Workers are available to facilitate successful completion of appointments and barriers are overcome. Those involved in the transition include but are not limited to:

- Enrollee
- Caregiver(s)
- PCP
- Specialist(s), when indicated.
- Medical Director
- Director/Associate Director of Care Coordination
- Regional Manager
- UM NURSE
- RNCTM
- Medical Social Worker

- Community Health Worker
- Facility discharge planner

Factor 3: Transfer ICP elements and describe the transition process.

The PHP transition of care program is based on the Four Pillars® of “The Care Transitions Program which address:

1. Medication Self-Management
2. Dynamic patient-centered record
3. Primary Care and Specialty Care Follow-up
4. Knowledge of Red Flags that Indicate Worsening Conditions

Medication Reconciliation and Self-Management is primary goal for all PHP enrollees, not only those in transition and is an ongoing process for our enrollees. The importance of medication adherence, particularly antiretroviral (ARV) adherence, is a paramount concern in this population. A comprehensive medication reconciliation review is completed with all enrollees and/or care giver(s) immediately during and following an inpatient episode. This review is completed face to face, whenever possible, reviewing each individual medication for its purpose, dosage, frequency, route, time of day taken, interactions, contraindications and signs and symptoms of any complications, aka “Red Flags”. Alterations in or lack of supplying the enrollee with ARVs or other prescribed medications is immediately reported to the HIV PCP. The inpatient facility administration is contacted to assure that the ARVs are delivered to the enrollee in the manner prescribed by the PCP and/or attending hospitalist.

Dynamic patient-centered record. The UM RN/RNCTM will update the Individual Care Plan and document in a Session note in the care management software system addressing issues identified and resolution. The Transition of Care process including all medications, interventions, education, etc. are updated in the care management software system.

Primary Care and specialist follow-up: The RNCTM meets with the enrollee to assure discharge plan was reviewed and understood. Within 3 days following of notification of the discharge home, the UMRN/RNCTM will complete a confidential post discharge call/visit to the enrollee, to ensure the enrollee's discharge plan has been carried out successfully; ensure the enrollee and care giver(s) understand their discharge instructions and durable medical equipment has been received and understood how to use as outlined in the discharge plan. The UMRN/RNCTM will ensure that the enrollee has a follow up appointment with their physician and specialists as appropriate and ensure that there are no unexpected issues. If appointments are not scheduled, The RNCTM or a member of the Care Team (Care Coordinator, Community Health Worker)

will facilitate scheduling the appointment and transportation, if necessary, for the enrollee.

Red Flags. In addition to the “Red Flags” related to medication, the UMRN/RNCTM will review the discharge instructions with the patient and/or care giver, assessing their understating of the indications to seek urgent or emergency treatment. The UMRN/RNCTM will review signs and symptoms of complications and exacerbation of this or a potential exacerbation of any of their other chronic conditions during this time. For example, for an enrollee discharged with a diagnosis of CHF (Chronic Heart Failure), the RNCTM would educate the enrollee to take daily weights at the same time each day; cardiac and diuretic medication management, monitoring and understanding their fluid and salt intake and to watch for signs and symptoms fluid retention, shortness of breath or symptoms of pneumonia.

Factor 4: Describe access to enrollee personal health information.

Enrollees sign an authorization form upon enrollment to allow their personal health information to be shared with their caregivers. The Member Handbook explains that per member’s rights and HIPAA, providers can share personal health information. The plan also has policies and procedures for changing enrollee’s request for sharing information with caregivers. The enrollee simply needs to call enrollee services for a new form and indicate the change with enrollee signature.

The HRA and subsequent updates and modifications are mailed to the enrollee/caregiver (when allowed) and either uploaded or faxed to the PCP. Transition of care protocols and continuity of care protocols, as previously explained, are in place to facilitate the communication of healthcare settings or specialists by the plan but will also be shared with the enrollee/caregiver if requested. The enrollee has access to their labs via their patient portal if they agreed to access. In addition, there is a policy and procedure to request a copy of the medical record. The RNCTM educates the enrollee on how to access documents, contact Enrollee services, however, is also there to make sure enrollee requests are completed quickly and efficiently. The plan tries to anticipate enrollee needs and supports the ready availability of the enrollees’ personal health information to facilitate care.

Factor 5: Describe approach to self-management activities.

Once the enrollee is introduced to the Care Coordination Team, the RNCTM and other team enrollees work to ensure the enrollee understands available resources and the importance of communication. New enrollees receive education on the following but not limited to:

- Medication and how to take it as prescribed.

- Viral load suppression lab test, meaning of results and frequency of test.
- Signs and symptoms of when to seek care from their provider.
- Other co-morbidities and their signs and/or symptoms and when to seek help their HRA, severity level, frequency of contacts.
- Their ICP, goals and progress report frequency
- Stress reduction through problem solving.
- Resources to contact at any time such as the RNCTM or Nurse Advice Line.

The RNCTM facilitates weekly Care Team meetings to introduce the new enrollees, establish trust and model team participation. The team is very much aware that participating in their own care may be a first-time experience for new enrollees and PCP focuses on preparing the enrollee for successful team participation throughout their Membership in the plan. The initial RNCTM assessment, clinic activities such as educational series, are available to all enrollees. This includes being present for meetings or case conferencing at their medical provider's visit. Once the enrollee understands their own identity as self-care manager and member of their own care team, relationships can be built upon with the PHP Care team and be supported to articulate health, psychosocial needs, and Social Determinates of Health.

Tools such as a Health Journal can be used to focus on prominent issues and provide the language that the patients need to articulate their needs. The development of the ICP addresses the enrollee's goals and provides education and resources utilizing brief interventions and support to reach their said goals. Achievement of successful or even partially successful goals reinforces the enrollee's own ability to self-manage their health and provides self-determination and engagement in care.

Factor 6: Describe notification process for designated point of contact.

The enrollee and/or their caregiver are informed from the beginning of their membership with PHP that an RNCTM will be assigned as their point of contact. The RNCTM establishes the relationship and reinforces it with the Care Team as additional points of contact. In addition, the ICT engages the enrollee facing any inpatient episode as early as possible to ensure a successful transition back into the community. For example, in the event of a prior authorized elective inpatient surgery, the UMRN or RNCTM will complete a pre-op call/visit to ensure the enrollee has all pre-admission testing completed; understands all pre-op instructions and the type of procedure scheduled; has reasonable expectations of the post-operative course, including the potential for placement post discharge; has adequate support prepared following discharge to home. This is documented in the Care Management Software system and Session Notes.

The Health Information Exchange (HIE) provides information about transitions that result in an admission and transitions to ER visits and Observations. This real time information is available to the RNCTM. The RNCTM can address these transitions with the enrollee, provide education, resources, updated ICP etc. designed to address and reduce ER or Observation transitions.

The UMRN and RNCTM work together to be sure the most current information and ICP is shared. As noted above the RNCTM remains the primary point of contact for the transition of care process for the enrollee and/or the designated care giver. The enrollee/caregiver and discharge planner are given the RNCTM and UMRN contact information for any assistance needed with the transition process. The RNCTM assesses the enrollee's current clinical condition, the enrollee/care giver knowledge of their condition, post discharge care requirements. The RNCTM and/or UMRN will red-flag condition changes to report to the PCP or specialist/surgeon, identify any barriers to a safe discharge and review the plan of care and proposed discharge plan.

The RNCTM shares pertinent information with the discharge planner to ensure a safe and timely discharge. For example, lack of family/social support; enrollee living in upper floors of a building without elevator access, or enrollee does not have adequate space for a hospital bed in their home and works with the discharge planner to assure barriers are addressed in the transition of care.

MOC 3: Provider Network

PHP provides specialized HIV chronic disease management focusing on care management, consumer empowerment, self-management, home safety, safer sexual practices, and prevention for positives (HIV), and transitions of care. PHP offers a network of healthcare providers who are contracted to provide health care services to SNP enrollees. PHP is responsible for ensuring that the Network is identified, described, and implemented so that providers are available by type, specialty and geographically situated to ensure timely access to care (routine, urgent or emergent) so Plan enrollees get needed care.

MOC 3 Provider Network Element A: Specialized Expertise

Factor 1: Describe specialized network.

The PHP primary care network is comprised AHF staff primary care providers with specialized HIV training and experience and network PCPs experienced in HIV medical care. AHF staff providers include MDs, DOs, mid-levels (PA and ARNP) and contracted network specialists. With over 33 years of experience in providing HIV/AIDS medical and care management services PHP capitalizes on the experience and

community/professional relationships necessary to build a health care network that serves the needs of Persons living with HIV/AIDS (PLWHA) and vulnerable populations.

PHP strives to meet the needs people living with HIV/AIDS (PLWHA) by meeting its mission of *"Cutting edge medicine and advocacy, regardless of ability to pay."* The Plan builds its network with Providers who understand the special needs of PLWHA and welcome them into their practices and care environments. Providers are patient advocates, sensitive, and empathetic, as well as highly skilled in primary HIV care and the specialties required to address health and social needs (e.g., infectious disease, psychiatry, psychology, social work, neurology, dermatology, dental). Providers partner with PHP to work with Plan enrollees to develop, implement, and execute individual plans of care designed to meet the acute, chronic, and transitional needs. PHP provides 24-hour access to Nurse Advice Line, Primary/specialty care, urgent care, and emergency care. The network offers acute care, skilled nursing, home health, hospice, and ancillary services. The network also provides services to overcome barriers to care and adherence to therapy, i.e., specialty pharmacy, transportation, home and community-based services, rehabilitation, and gym access as a supplemental benefit.

PHP monitor performance areas affecting network availability on a quarterly basis. To ensure adequate primary care and access to specialty care practitioners and providers, PHP has quantifiable standards for both the number and geographic distribution of network primary care and specialty providers. Provider Data is collected and assessed against these standards. The goal is to ensure the network is adequate to meet the needs of its PLWHA while also meeting state regulatory requirements, industry standards and to meet the standards across provider types in the 90th percentile. This is accomplished by achieving the following objectives.

- Evaluate the appropriateness of network availability standards.
- Identify high volume specialists.
- Measure practitioner availability.
- Evaluate performance against the standards.
- Identify any areas for improving practitioner availability.
- Develop interventions as appropriate for identified opportunities for improvement.

This approach permits PHP to focus on development areas where there is most need such as high-volume specialists such as, Ophthalmology, Oncology, Nephrology, Urology, Dermatology and Cardiology.

Primary Care Providers

- Network is comprised of primary care physicians who are experts in the field of HIV and AIDS. PCPs are either internal medicine, family practice or infectious disease physicians who are classified as HIV/AIDS experts as defined by the American Academy of HIV Medicine (AAHIVM) or the Infectious Disease Society of America, HIV Medicine Association (HIVMA).
- Mid-level providers affiliated with the AHF Healthcare Centers include Nurse Practitioners and Physician Assistants.
- If a new Plan enrollee identifies his/her current physician, PHP attempts to contract with the qualified HIV experienced provider to promote continuity of care.

Specialists

- Specialty providers who have experience in treating HIV/AIDS patients as recommended by the PCPs. PHP analyzes utilization data to determine the high-volume specialties required to service the enrollees for chronic co-morbid conditions including cardiology, oncology, endocrinology, ophthalmology, neurology, and dermatology. New enrollees identify their current physicians, and PHP attempts to contract with the provider to promote continuity of care.

Health Delivery Organizations (HDOs)

- Acute care facilities to provide acute inpatient care and some ambulatory services in geographic areas appropriate to the membership.
- Long-term care and skilled nursing facilities in geographic areas appropriate to the membership.
- Free standing acute rehabilitation hospitals for use when more focused rehabilitation is required.
- Acute Psych

Ancillary and Support Services

- Lab Corp as the national lab vendor
- AHF retail pharmacies as well as a contracted network of pharmacies through MedImpact, Pharmacy Benefit Manager (PBM).
- Physical, Occupational, and Speech therapists on an individual basis and accesses PT/OT/ST services through hospital associated specialty contracts as well as out-patient agreements.
- Affiliated AHF healthcare centers employ social workers who have expertise in working with HIV/AIDS.
- PHP contracts a full mental health network that represents behavioral health disciplines and includes acute and outpatient mental health services.

- AHF pharmacists and PHP Plan pharmacists are available for consultation as enrollees of the ICT.
- For dental services, PHP has a directly contracted network of dental providers, across all dental specialties who work with PLWHA.
- PHP contracts with Home Health and Hospice service providers to meet the home health support and end of life needs of our enrollees.
- PHP provides Plan enrollees access to an after-hours nurse advice line and an on-call physician 24 hours.

Factor 2: Include evidence of provider expertise

The PHP Credentialing Department researches each provider and health delivery organization credentials for review by the Credentialing and Peer Review Committee. The Committee reviews, approves and appoints or denies applications submitted by new providers. The Committee also reviews and approves or denies re-credentialing applications at minimum every 3 years. PHP conducts on site reviews of all Primary Care Physicians and high-volume Specialists prior to the credentialing meeting. Credentialing and re-credentialing policies meet federal and state requirements. The Accreditation Association for Ambulatory Health Care (AAAHC) reviewed and approved the PHP credentialing and peer processes.

The Credentialing Department reviews monthly the following primary sources:

- Provider License
- Provider DEA
- State Medical Board
- Medicare opt out listing.
- OIG Report for Medicare/Medicaid Exclusion
- System Award Management-SAM/terrorist lists

Annual Review of Providers

At the very least, the credentialing department will monitor the following elements on an at least annual basis:

Review all providers in the network against the Medicare and Medicaid exclusion lists and the OIG/GSA excluded parties' lists.

- DEA status
- License status
- Any Peer Review actions
- Board Certification Status
- System Award Management – SAM

Committee Structure

The Credentialing Committee and Peer Review Committee (CPRC) is responsible for oversight of activities of the Plan's Credentialing Program. Policies and procedures related to Credentialing are reviewed and approved by the CPRC. Functions of Credentialing Committee:

- Reviewing all practitioner applicants to ensure compliance with credentialing requirements and making recommendations for approval or denial. If denied, the appeals process is offered.
- Reviewing all practitioner applicants prior to re-credentialing meeting at least quarterly
- The Credentialing and Peer Review Committee is organized to approve or deny participation of all practitioners and institutional and ancillary providers who provide care to PHP enrollees..
- A subset of PHP clinical participants provides peer review services that integrate QI activities and peer review activities.
- Peer review activities are accountable for clinical decisions about care rendered and taking follow-up disciplinary action, as necessary, with the practitioner/provider.
 - Disciplinary action that involves restriction of clinical privileges or discharge from the Plan network due to clinical performance, suspected fraud, or other reportable behaviors is subject to a provider fair hearing and appeal process.
 - Providers who lose privileges/network membership after appeal are reported to the State Medical Board as designated by individual state regulatory requirements.
 - Peer review clinical participants help monitor individual performance and establish internal benchmarks for provider performance.
 - Cases referred to the committee come from any area of the organization, including:
 - AHF Health Care Centers
 - Managed Care Grievance and Appeals Department
 - Quality Management
 - Utilization Management

Chaired by the Medical Director, the CPRC includes the following membership.

- Regional Medical Directors
Dental Director
 - Medical Practitioners
(Physicians, Specialists,
Dentist, Mid-Level Providers)
 - Chief Medical Officer
 - Pharmacy Designee
 - Chief of Care Management
Division
 - National Director Contracting
& Provider Relations
 - Director of Medical Staff Office
and Credentialing
 - Manager of Medical Staff Office
and Credentialing
 - National Quality Director or
Designee
 - Other Department or personnel
as required.
-

Initial Credentialing Provider (Primary and Specialty Care)

The Credentialing Committee gives priority wherever possible to having Board Certified sub-specialists in the PHP Plan network. At the time of initial credentialing, the applicant must complete a Practitioner Application and any applicable attachments to the application. The application must be completed in its entirety, including a current and signed attestation signed by the applicant within 365 calendar days of the credentialing decision. A signature stamp or date stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation.
- Lack of present illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary action.
- Current malpractice insurance coverage.
- The correctness and completeness of the application.

If the medical provider is applying to be a Plan Primary Care Provider, an additional attestation regarding HIV/AIDS CME requirements and active HIV/AIDS practice with 20 current patients is also required.

The completed application will be processed upon submission. If the application has not been signed or if information provided on the application is incomplete, the practitioner will be notified in writing, and the missing information will be requested. If the practitioner does not provide the information in the time requested, he/she will be deemed to have withdrawn his/her application for participation. If the signature attestation will be older than 365 calendar days at the time of the credentialing decision,

the practitioner is required to update the attestation. The Credentialing Specialist will send a copy of the completed application with a new attestation form when requesting the practitioner update the attestation.

Practitioners are not eligible to apply for participation with PHP if:

- There are potential actions pending against their License by any state agency in the United States that disciplines practitioners (e.g., Statement of Chargers)
- Licensure is currently suspended, restricted, reduced, limited, sanctioned and/or on probation by any state agency in the United States that disciplines practitioners.
- Practitioner is currently censured or excluded (e.g., suspended or disqualified) by Medicare or Medicaid.
- Have objections to treating or providing services to persons with HIV/AIDS.

Provisional Credentialing

PHP recognizes that occasionally it can be in the interest of a patient to make a practitioner(s) available prior to completion of the entire initial credentialing process. In this case, the organization or its delegate has the option of provisional credentialing for practitioners applying to the organization for the first time. A practitioner may only be provisionally credentialed once. Practitioners who had been in the organization's network via a delegation arrangement are not eligible for provisional credentialing by the organization if the delegation arrangement is terminated or if the practitioner is no longer affiliated with the delegate.

The Credentialing Department reviews the following elements and factors for practitioners who have been provisionally credentialed prior to initial credentialing:

- Primary-source verification of a current, valid license to practice.
- Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Databank (HIPDB) query.
- A current and signed application with attestation.
- Professional liability insurance or bond
- Lack of sanctions or actions prohibiting participation in Medicare/Medicaid
- The organization may not hold practitioners in provisional status for more than 60 calendar days.

Health Delivery Organizations

The Credentialing Department conducts initial quality assessments of Health Delivery Organizations (HDO) applying for Network participation. Re-assessments are conducted of HDOs every thirty-six (36) months. The Credentialing and Peer Review Committee reviews information obtained in the quality assessments and makes the determination for participation.

Quality assessments are conducted on the following types of HDOs:

- Hospitals.
- Home health care agencies.
- Skilled nursing facilities/nursing homes.
- Free-standing ambulatory surgical centers.
- Behavioral Health facilities providing mental health or substance abuse services in an in-patient, residential or ambulatory setting.
- Urgent care centers.
- Clinical laboratories.
- Comprehensive out-patient rehabilitation facilities. (CORF)
- Out-patient physical therapy providers.
- Speech pathology providers.
- Hospice.
- End stage renal dialysis providers.
- Out-patient diabetes self-management training providers. (diabetic educators)
- Portable x-ray suppliers. (mobile units)
- Rural health clinics. (RHC)
- Federally Qualified Health Centers.
- Durable medical equipment.

Before contracting, PHP verifies the HDO has met the following criteria for network participation:

1. Meets all state and federal and licensing requirements.
2. Is in good standing with state and federal regulatory agencies.
3. Lack of sanctions prohibiting participation in Medicaid/Medicare
4. Professional liability coverage limits of at least \$1,000,000/\$3,000,000 which covers the facility and all providers practicing at the facility.
5. Reviewed, approved and in good standing by one of the accrediting agencies approved by PHP or a passing site survey by an accrediting agency, state, or federal government agency, or by PHP as described below.
6. Non-accredited Hospitals, Skilled Nursing Facilities, Free Standing Surgery Centers, and Behavioral Health Facilities must be either Medicare-certified or have passed a site survey by one of the accrediting agencies approved by PHP to

participate. The HDO must provide a copy of the most recent survey results, including HDOs corrective action plans (CAPs) to any survey deficiencies; and a copy of the letter verifying acceptance of the CAP by the survey agency. PHP verifies that the review was done and meets PHP standards.

PHP requires the following documentation from HDOs:

1. Completed PHP Health Delivery Organization Application
2. Copy of state license (if applicable)
3. Copy of the most recent accreditation survey or the most recent Medicare site survey including HDO's corrective action plan to any deficiencies and a copy of the letter verifying acceptance of the CAP by the survey agency.
4. Professional liability insurance declaration page showing dates and amount of coverage.
5. Copy of current DEA certificate (if applicable)
6. NPI number

Approved accrediting agencies accepted by PHP are the following:

- The Joint Commission (TJC)
- National Committee for Quality Assurance (NCQA)
- Commission for Accreditation of Rehabilitation Facilities (CARF)
- Accreditation Association for Ambulatory Health Care (AAHC)
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- The Community Accreditation Program, Inc. (CHAP)
- Accreditation Committee for Health Care (ACHC)
- The Compliance Team Inc.'s "Exemplary Provider Award program"
- Commission on Accreditation of Rehabilitative Facilities (CARF)
- Healthcare Quality Association of Accreditation (HQAA)
- National Association of Boards of Pharmacy (NABP)
- The National Board of Accreditation for orthotic Suppliers (NBAOS)
- American Board of Certification in Orthotics and Prosthetics (ABS)
- Board of Certification/Accreditation International (BOC)

Practitioners are re-credentialed at least every thirty-six (36) months. Six months before the re-credentialing due date, a re-credentialing packet is sent to the practitioner. This packet contains the following:

- Practitioner Attestations & Questions that include attestation by the applicant regarding:

- Reason for any inability to perform the essential functions of the position, with or without accommodation.
 - Lack of present illegal drug use
 - History of loss of license and felony convictions
 - History of loss or limitation of privileges or disciplinary action
 - Current malpractice insurance coverage
 - The correctness and completeness of the application
 - Current HIV/AIDS CME and practice status attestation
- The Practitioner Authorization and Release of Information Form

Practitioners are instructed to update the information and make corrections as necessary, answer all professional questions and sign and date the attestation and release of information statements. A signature stamp or date stamp is not acceptable on the attestation. If a practitioner fails to return the completed recredentialing packet to PHP within eight weeks, it will result in an administrative termination from the PHP network.

The completed application will be processed upon submission. If the application has not been signed or if information provided on the application is incomplete, the practitioner will be notified in writing, and the missing information will be requested. In the event the practitioner does not provide all information requested on the re-credentialing application, or all information requested by the Credentialing Committee within specified time parameters, the application will be deemed incomplete, and the practitioner will be so notified. An incomplete application will result in administrative termination from the PHP network.

Peer Review

Review of provider medical practice that focuses upon the quality of care. The peer review process includes monitoring of medical staff patient practice. Quality indicators are monitored along with issues considered sentinel events, e.g., misdiagnosis, medication errors, therapeutic misadventures, mortality review, etc. All peer review activities are confidential. All cases identified as quality of medical care issues are reviewed through the organization's Peer Review Process. The Peer Review Process is coordinated by the Quality Improvement Department and referred to the Credentialing/Peer Review Committee for review and action, as necessary.

- Cases identified with quality-of-care issues are referred to the QI Department for case review.

- Such cases may be identified through patient services, concurrent review, care management, risk management, audits, sentinel events, clinician referrals, allegations of substance abuse and other sources.
- Any clinical quality issue regarding enrollee care will be initially reviewed by a nurse in the Quality Improvement Department with oversight from a Plan Medical Director.

Factor 3: Updating Provider Information

PHP confirms at least every thirty-six (36) months that the HDO continues to be in good standing with state and federal regulatory bodies and if applicable, reviewed and approved by an accrediting body.

Reports are generated monthly for providers whose board certification is set to expire monthly. The Manager of MSO and Credentialing will notify providers who board certification is set to expire or has already expired. The provider will be required to resubmit their board certification information to PHP. Primary source verification will be done for all providers who board certification has expired. The Credentialing Department uses The Computer Assisted Credentials Tracking and Update System (Web-CACTUS (SAAS) maintains complete and current credentials files for all providers. CACTUS provides automated access and web links to external data sources (including ABMS, SAM, NPI, NTIS, OIG, NPDB (PDS/QRXS) and State License Boards)

Provider Data Integrity

Provider data is entered into Plan systems utilizing standard data entry guidelines, to promote consistency across records and ensure complete and accurate data entry outputs. Data is validated annually, utilizing a variety of methods to promote data integrity and accuracy for directories and referral rosters provided to PCPs, specialty providers, and UM. Additionally, provider data will be monitored and validated on a rolling schedule, with PCPs and high-volume specialists verified at least semi-annually and other providers annually. Directory data is an important component of this ongoing data integrity initiative and actual published directories will be utilized as part of the data validation monitoring activities in provider outreach to ask offices to verify their directory information over the phone.

Factor 4: Facilitate collaboration with the Interdisciplinary Care Team (ICT)

At the core of the ICT are the enrollee, provider, and RNCTM (Registered Nurse Care Team Manager). During the ICT, the RNCTM gives a verbal summary of the HRA results during the ICT meeting which occurs either face to face or through video conferencing. The RNCTM also shares with the ICT the ICPs developed through information gained during the HRA. This is shared either physically/verbally or through electronic means via

direct upload to the software system. The HRA provides insight into services needed and collaboration with providers in the PHP network occurs during the ICT.

Written updates are provided to the ICT team at the time of any HRA by the RNCTM via secure email to the ICT team, at the time of assessment/reassessment or for any change in health condition including Transitions of Care. The RNCTM documents this process of communication and sharing of information including results and specific dates of communication with the ICT team in the care management software system (e.g., ICP shared, ICP reviewed. Services rendered are addressed during the ICT and by notification in the Utilization Management Process.

Below is an example of an ICT Report written by the RNCTM describing the enrollee's experience and discussions with the Interdisciplinary Care Team.

Gender: MALE Age: 70 Severity Level: HIGH PCP Name: DR TOEQUE

Last PCP Visit: 11/14/24

Year Diagnosed: 2001

Current ARV Therapy: BIKTARVY

Date & Value of Most Recent VL: 11/19/24=<20

Date & Value of Most Recent CD4: 11/19/24=693

Comorbidities (including Current Clinical Status): Essential HTN (Lisinopril, well controlled 118/68 on 10/21/24); BPH (tamsulosin; PSA 2.8 10/23; uro referral); DMII (A1C=6.7 4/24); hx PE (Eliquis); saddle thrombus; falls

Gaps in care: DIABETES (EYE EXAM)-request sent to PCP; CKD (SPIROMETRY); COLORECTAL SCREEN-request sent to PCP. Member is declining.

(A) Assessment: Member was admitted to Hollywood Presbyterian on 10/22/24 for: generalized weakness; dehydration; fall

(P) Plan: Schedule post-discharge PCP appointment. Complete home visit and prevent re-hospitalization. Complete TOC process. Provide patient education regarding hospitalization and when to seek medical care.

(D) Diagnosis: At risk for urinary tract infections secondary to BPH and diabetes.

(I) Implementation: Member reported he had received both flu and COVID vaccines at HCC visit on 10/21/24, went home and to bed and then had fall. The ICT team discussed

reactions to immunizations, which can mimic infection response and cause transient weakness which was conveyed to patient.

The provider was informed through ICT that the PCP post discharge appointment scheduled for 11/14/24 and confirmed in EMR. Medication reconciliation complete, Pharmacist reviewed medications and RNCTM confirmed that the member is knowledgeable regarding drug regimen and stated adherence to all medications. Completed Transition of Care (TOC) process.

The Medical Social Worker reported that the SDOH issues such as food security were being addressed as member is receiving Project Angel Food, diabetic diet. Member has In Home Support Services worker assisting in organizing home environment (member has hoarder tendencies) and member reminded to keep clear pathways between rooms in apartment. Member requesting d/c of PT/OT services. Life Alert (PERS) is in place for member safety. Patient education given regarding when to seek medical care post discharge. Patient education given on how to obtain motorized scooters for safe mobility. RNCTM requested provider send a request to PCP for PT referral/evaluation.

(E) Evaluation: Member without readmission to hospital during TOC period.

Plan of Care Summary: Member severity level HIGH. Issues, Goals, and Interventions (IGIs) are added to reflect change in clinical status. Medication reconciliation completed. Will follow up with member per severity level to assess treatment plan adherence and adjust outreach frequency, as appropriate.

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

Regulations at 42 CFR § 422.101(f)(2)(iii)-(v); 42 CFR § 422.152(g)(2)(ix) require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols. PHP demonstrates their oversight of how network providers use evidence-based medicine, when appropriate.

PHP recognizes that use of clinical practice guidelines improves communication during care transitions by providing an improved process for making clinical decisions resulting in improved patient outcomes. This is achieved by:

- The Medical Director routinely reviews the HIV acuity report to determine if Primary Care Providers are achieving appropriate viral load suppression as consistent with the DHHS Antiretroviral Treatment Guidelines. The Medical
- When virologic failure is detected or suspected, the Medical Director performs a medical record review to determine if the medical provider has followed the appropriate treatment guidelines.
- Appropriate feedback, educational counseling and educational resources are provided by the Medical Director to the network provider as appropriate. The patient's RN Care Team Manager is also notified to contact the patient and address issues related to adherence and to assist the patient in remaining in care.
- The Medical Director reviews the SNP enrollee hospital admissions census on a daily basis. Enrollees hospitalized may require a higher level of care because their provider has not followed the appropriate clinical treatment guidelines, and/or the enrollee was not adherent to the Provider's care plan.
- The Medical Director reviews the relevant network provider's recent medical records to determine if the Provider utilized the appropriate clinical guidelines and protocols.

Factor 1: Monitor use of guidelines and protocols

The foundation and gold standard of the evidence-based medicine guidelines are from the U.S. Department of Health and Human Services (DHHS) expert panel for antiretroviral treatment, tuberculosis treatment, treatment, and prevention of opportunistic infections. These specific HIV/AIDS treatment guidelines are updated according to convening the DHHS expert panels (most recent updates below):

- Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, <https://clinicalinfo.hiv.gov/guidelines> Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection,

<https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/whats-new-guidelines>
Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States

<https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new-guidelines>Treatment of Tuberculosis,

<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/mycobacterium-tuberculosis-infection-and?view=full>

- Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents, <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines>
- Treating Opportunistic Infections Among HIV-Infected Pediatric Patients, <https://clinicalinfo.hiv.gov/en/guidelines/pediatric-opportunistic-infection/whats-new>
- Caring for Persons with HIV in a Disaster Area, <https://clinicalinfo.hiv.gov/en/guidelines/caring-persons-hiv-disaster-areas/guidance-non-hiv-specialized-providers-caring-persons>

The nationally recognized evidence-based guidelines include HIV/AIDS in the aspect to primary care and specifically for women. The following guidelines for HIV/AIDS primary care are utilized from the Department of Health and Human Services in the Health Resources and Services Administration (HRSA):

- Guide for HIV/AIDS Clinical Care. US Department of Health and Human Services, HRSA, HIV/AIDS Bureau – 12/06/2023
- American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care HIV/AIDS medicine changes rapidly mostly on a quarterly basis with four international meetings that provide additional clinical information during the interim of updates to the DHHS guidelines. International Scientific Meetings provide interim science about HIV/AIDS and are considered in developing Medical Policy as appropriate.
- ICAAC (Interscience Conference on Antimicrobial Agents and Chemotherapy)
- IDSA (Infectious Disease Society of America)
- IAS (International AIDS Society)

CROI (Conference on Retroviruses and Opportunistic Infections) Nationally recognized evidence-based guideline for co-morbidities manifested by PHP enrollees include but are not limited to:

- American Diabetes Association (ADA) Standards of Medical Care 2024
- American College of Cardiology/American Heart Association (ACC/AHA) Clinical Practice Guidelines 2023

- Global Initiative for Obstructive Lung Disease GOLD Standard Guidelines 2023
- National Comprehensive Cancer Network (NCCN) Guidelines.
- Specialty society guidelines, such as American Academy of Pediatrics (AAP); Centers of Excellence guidelines.
- U.S. Preventive Services Task Force, (USPSTF).
- American College of Obstetrics and Gynecology (ACOG) Guidelines.
- Behavioral health Clinical Practice Guidelines from the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP)
- Substance Abuse and Mental Health Services Administration, SAMSHA.Gov
- Medicare National Coverage Determination (NCD) guidelines or Medicare Local Coverage Determination (LCD) guidelines

Factor 2: Specify challenges and exceptions to guidelines.

PHP enrollees have a higher prevalence of comorbidities at an earlier age compared to the HIV negative population. Diabetes Mellitus, Dyslipidemia, and Cardiovascular disease screening is commonly performed more frequently in the HIV population. This includes fasting glucose, fasting lipids, and counseling on risk factor modification and tobacco cessation for our enrollees. In addition, PHP enrollees have high prevalence rates of mental health disorders, substance dependency, and social determinants of health issues such as homelessness and poverty that collectively are barriers to care and can disrupt the application of clinical practice guidelines and protocols.

The following are challenges where the use of clinical practice guidelines and nationally recognized protocols do not always address the needs of this vulnerable SNP population.

- Women and adolescents living with HIV/AIDS are 4 to 5 times more likely to develop cervical cancer compared to HIV negative women and adolescents with high-risk sexual behavior. The cervical cancer screening recommendations for women living with HIV/AIDS is every 6 months for the first year and then annually thereafter.
- People living with HIV/AIDS are more likely to develop anal cancer than the general population regardless of sexual orientation. Though there are no nationally recognized guidelines for screening for anal cancer, anal pap smears are routinely performed and are recommended for our enrollees to screen for anal cancer.
- Enrollees may struggle with treatment adherence while struggling with mental health or substance dependence disorders that impair their judgment or

emotional stability to the degree where they are no longer capable of self-care and compliance with prescribed treatments. In these circumstances, the RNCTM and PCP assist the enrollee with referrals to psychiatric services and detoxification and alcohol and drug addiction treatment. With the social worker's help, enrollees are referred to services available in the community including assistance with housing through Housing Opportunities for Persons with AIDS (HOPWA), food stamps, and other services.

The modified clinical practice guidelines discussed here are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT as follows. PHP's Medical Policy and Procedure Review is done in collaboration with the AHF Medical Policy and Procedure Committee. This Committee is a multispecialty group of leading AHF physicians (including Physician specialty consultants to add clinical input as required) who review the nationally recognized guidelines at a minimum annually or as new updates are written or revised.

- This Committee decides the appropriateness of the clinical practice guidelines or nationally recognized protocols as it pertains to these special need populations. Modifications to the clinical guidelines and protocols are codified in the PHP Medical Policy and Procedures following the approval of Committee enrollees via a majority vote.
- Subsequently, the PHP Medical and Policy Committee reports to the Medical Staff, Medical Directors Committee and Medical Executive Committees regarding the content of the nationally recognized guidelines and other population specific P&P's approved by the Committee.
- The updated Plan medical policy and procedures, which are made available on-line through the AHF and PHP intranet and via email or announcement at staff meeting to RNCTM and relevant PHP staff enrollees.
- Relevant modifications to the guidelines and protocols are e-mailed to contracted network medical providers with e-mail addresses who have requested such updates.
- Medical providers without electronic mail may receive treatment updates and recommendations via regular mail, fax or physically provided by the Registered Nurse Care Team Managers in the respective offices.

Relevant information in the updated Plan Medical policy and procedures are reviewed by the RNCTM and used to develop appropriate ICPs. As mentioned, the ICPs are shared with enrollees, with the ICT and providers.

Factor 3: Detail the decision to modify guidelines.

Decision to modify clinical practice guidelines or nationally recognized protocols are based on evidence that some part of the guideline/protocol contradicts or sets up a potential adverse event for a HIV enrollee. The guideline/protocol is vetted by the plan's HIV Specialists PCP's, its Medical Director, Quality, Care Management, Pharmacy, if applicable, the Infection Control and Prevention Committee Chair and any other staff required depending on the topic. A physician is assigned to write the modification in cases of clinical practice guidelines. In cases of protocols, a physician may be assigned and/or a director-level plan staff. The final draft is vetted through the plan's committee structure which is also the communication mechanism. The Utilization Management Committee is the main committee that would approve modifications that affect enrollees. The National Director of Care Coordination is responsible for implementation with the Care Coordination team to incorporate any modifications into the patient's ICP. As noted in MOC Element 2D, this would then be communicated during the weekly (or if appropriate, sooner) ICT and acted on by the enrollee's ICT Team and/or other appropriate providers.

Factor 4: Care Transition Protocols

As outlined in MOC Element 2F, the goal of PHP's care transition protocol is to reduce fragmented and unsafe care, complications, and readmissions. An inpatient care episode of any kind for a patient with HIV can result in a significant decline in the enrollee's overall well-being. By sharing all relevant information as outlined in MOC Element 2F, PHP providers are well-informed so that continuity of care remains successful. For example, the ICT may delay routine cancer screening in the ICP of an enrollee who is facing issues of homelessness and depression until his/her immediate psychosocial needs are stabilized.

PHP maintains a robust Transition of Care program, as part of the overall Model of Care. Because of this, PHP providers are aware of the enrollee issues and concerns that impact the coordination and continuity of care between care settings such as the hospital to home or skilled nursing facility, from the skilled nursing facility to home or assisted living, or from home to an institutional setting (hospital/long term care/assisted living). The ICT works together with the PHP provider/vendor to coordinate planned and unplanned care transitions.

Improving quality and safety during transition of care handoffs is fundamentally different from improving quality and safety in a single setting. Transition of care quality aims to facilitate the bringing together two or more disparate organizations who are culturally, linguistically, and socially accepting of persons with HIV/AIDS, the medical provider, the enrollee and family and the Health Plan to provide a match between an

individual's care needs and his or her care setting. The PHP RNCTM collaborates with the attending facility physician and/or the HIV PCP, the facility discharge planning staff, the accepting facility admission staff when admitting to a second facility, the enrollee, the enrollee family/significant other, and the Interdisciplinary Care Team (ICT).

Delivery of Necessary Specialized Care

PHP's RN Care Team Managers (RNCTMs) work with the enrollee and medical provider to assure the medical care and services ordered for a patient meet evidence-based criteria and patients linked to the appropriate provider to obtain the needed services. The RNCTM is the navigator through the health system and assures that needed care, services and transitions are effectuated in an effective and timely manner. The standard operating procedure (SOP) for determining services and connecting patients to care is described below.

The standard operating procedure (SOP) for determining services and connecting patients to care is described below.

- PHP publishes in its enrollees Evidence of Coverage (EOC) and provider manuals, the plan benefits and those services that require prior authorization.
 - The enrollees' Primary Care Provider orders care or services for the patient.
 - All appointments with procedures require prior authorization.
 - Patients may request RNCTM assistance in making appointments or other care coordination services at any time. The RNCTM works in collaboration with the Utilization Management Registered Nurse (UMRN).
 - The request is reviewed by the UMRN against InterQual, clinical UM guidelines, and Medicare National and/or Local Clinical Coverage guidelines.
 - Services and specialty referrals that meet criteria are authorized by clinical staff. The UMRN can approve the request in consultation with the Plan Medical Director and/or the National Director of Care Coordination.
 - Service and specialty referrals that do not meet criteria are reviewed by the Medical Director who may approve, modify, or deny the request after review. Only the Medical Director can issue a modification or denial.

Referral and Authorization Process

Self-referred covered services do not require a provider referral or prior authorization from the Utilization Management Department. Services include:

1. Primary care provider (PCP) visits
2. Preventative Care Services
3. Urgent or emergency care services, including behavioral health services and substance use disorder services.

4. Confidential HIV testing and counseling services
5. Treatment of sexually transmitted infections
6. Family planning services
7. Obstetrics/gynecology care
8. Therapeutic and elective pregnancy termination
9. Initial mental health assessment
10. Sensitive and confidential services (e.g., sexually transmitted disease services, services related to sexual assault, drug and alcohol abuse for children aged twelve (12) and over.
11. Immunizations
12. Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs and IHCPs)
13. Non-medical transportation (NMT)
14. Dialysis Care out of area.
15. Podiatry

MOC 3 Element C: MOC Training for the Provider Network

Regulations at 42 CFR § 422.101(f)(2)(ii) require that SNPs conduct MOC training for their network of providers. Here PHP demonstrates oversight of provider network training.

PHP's Model of Care training is designed to reflect the educational commitment to enrollees, staff, and network providers. The National Director of Care Coordination in concert with the Utilization Management Committee consisting of the Plan Medical Director, the Chief of Care Management, the Vice President of Care Management, AHF medical providers, and others, develops and approves the Plan Model of Care. AHF is fully accredited by the [Accreditation Council for CME \(AACME\)](#) and maintains strict adherence to the Essentials and Standards for granting *AMA PRA Category 1 Credit(s)*™ for physicians who attend.

Factor 1: Implement MOC provider training.

The National Director of Provider Relations is responsible and accountable for oversight of the Model of Care training for network providers. Initial MOC training for staff model and network providers is provided within 90 days of employment for staff model providers by the RNCTMs or Provider Relations staff. Network providers receive training within 90 days of Board approval of their credentialed application by either the Provider Relations Representative or the RNCTM. Different strategies and training venues are varied to encourage attendance by the contracted network providers. The training approach varies and includes but is not limited to:

- Onsite individual office training

- Plan sponsored lunch/dinner at local restaurant for multiple providers and their staff.
- Web-based training modules accessed electronically.
- Printed information supplied via electronic distribution such as Fax Blast
- Printed information supplied in a new provider “Welcome” packet.

Training Materials

The training materials consist of targeted handouts and PowerPoint interactive presentations of program modules. An example of the PowerPoint presentation and the course in education vendor AHF University/HealthStream follows:



What's this Model of Care (MOC) all about?

Why do we have to have one?



1. Medicare Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focus on certain vulnerable groups of Medicare beneficiaries which includes care for seniors and persons with disabilities (SPD).
2. **AHF PHP is a C-SNP (the "C" is for "chronic" condition) that focuses on the vulnerable group with HIV/AIDS.**
3. The Social Security Act requires that every Special Needs Plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).
4. **Therefore AHF PHP has a MOC!**

What is a MOC?



- The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- The MOC is a written document. It must ensure the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

What must be in the written MOC?

- NCQA assesses MOCs from SNPs according to detailed scoring guidelines published by CMS.
- The MOC requirements comprise the following standards:
 - MOC 1 - Description of the SNP Population.
 - MOC 2 - Care Coordination.
 - MOC 3 - SNP Provider Network.
 - MOC 4 - Quality Measurement & Performance Improvement.
- AHF PHP received a score of 97.5% on its written SNP Model of Care Program from NCQA/CMS for 2023.



AHF's MOC – What You Need to Know

- Every member in our Plans has at least one chronic condition HIV/AIDS.
- Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
- The model of health service delivery is a one which combines Chronic Care Disease Management and Population Health.
- QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.
- It's teamwork by all staff at every level.



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- Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
- The model of health service delivery is a one which combines Chronic Care Disease Management and Population Health.
- QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.
- It's teamwork by all staff at every level.



MOC 1 - Description of the SNP Population

Every member in our Plans has at least one chronic condition - HIV/AIDS. Examples of some of the other co-morbidities of this population are in the table below based on 2022 data.

PLAN	Positive Depression Screen	Diabetes DX	Hypertension DX	Coronary Artery Disease	Multiple ADL Impairments	Multiple chronic conditions	Spent a night in the Hospital
MAO H5852	16.7%	35.7%	70.1%	10.3%	13.3%	83.3%	14.2%

Cultural, linguistic and special needs sensitivity training is conducted annually with monthly reminds via our CHORD publication to all who encounter or may encounter interaction with members.

MOC 2 - Care Coordination Overview

- Starts with identifying chronic disease status by using the Health Risk Assessment (HRA) by the RN Care Team Manager (RNCTM)
- Severity Level (SL) is calculated from HRA results (SL 1, 2 or 3 or Low, Medium, High)
 - Members assigned SL 3 (High) are placed under **Complex Care** Management
 - Members assigned SL 2 (Medium) are placed under **Chronic Disease** Management
 - Members assigned SL1 (Low) are placed in **Population Health** Management
- A Care Plan, which includes member goals, is established and shared
- Interdisciplinary Care Team Meetings are held to coordinate care & discuss best options for care and its delivery
- Ongoing support – working the care plan – teaching self management to member
- Annual re-evaluation of member

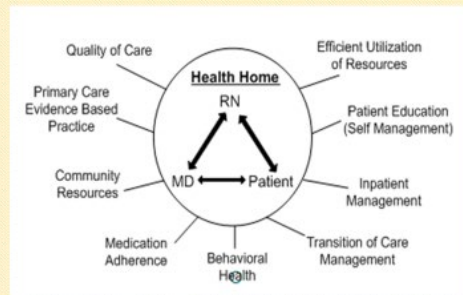
MOC 2 - Care Coordination Severity Level Definitions

- **Population Health Management (Low - SL 1)** Addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. (NCQA Resource Guide)
- **Chronic Disease Management (Medium - SL 2)** Ongoing care and support to assist individuals impacted by a **chronic** health condition with the medical care, knowledge, skills and resources they need to better manage on a day to day basis.
- **Complex Care Management (High - SL 3)** Designed for care of individuals with multiple chronic conditions, limited functioning and behavioral and social needs. Complex case management is a subset of case management aimed at members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.

MOC 2 - Care Coordination Severity Determination Guidelines

ACTIVITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria [Severity Level]	Low	Moderate	High/Complex
	Population Health Management	Disease Management	Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse within last 3 months	Active substance use/addiction disorder
Depression Screening PHQ-9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach Annual Reassessment	Bi-Monthly (08 weeks) telephonic outreach Annual Reassessment	Monthly telephonic outreach Annual Reassessment

MOC 2 - Care Coordination Patient-centered Medical Health Home



A valuable concept that facilitates the achievement of Care Coordination and Population Health Management goals is the **patient-centered medical health home (PCMH)**. The PCMH is a model of care that builds relationships between members and their care teams and streamlines care coordination.

MOC 2 – Care Coordination SNP Administrative Staffing

- Chief of Managed Care
- VP of Care Management
- Plan Medical Director
- Health Plan Administrator
 - National Director, Contracting and Provider Relations
 - Associate Director, Contracting and Provider Relations
 - Director of Medical Staff Office and Credentialing
 - Director Member Services + Call Center Operations
 - Member Service Enrollment & Eligibility Analyst
 - Health Equity and Education Program Manager
- Compliance Officer
- National Quality Director
 - Associate Director of Quality
 - Quality Data Analyst QI
 - Quality Project Managers
- Director, Risk Adjustment
- National Director, Managed Care Operations + Program Development
 - Associate Director of Claims Operations
- Associate Director of Data and Information Architecture
- Senior Director, Finance and Claims Operations

MOC 2 – Care Coordination SNP Clinical + Provider Staffing

- Primary Care Providers
- National Director, Care Coordination and Clinical Risk Manager
- Registered Nurse Care Team Manager
- Manager of Care Coordination
- Medical Social Workers
- Community Health Workers
- Behavioral Health Professionals
- Care Partners/Care Coordinators
- Director of Pharmacy
- Utilization Management RN
- Authorization Coordinators

MOC 3 - Provider Network Adequate + Specialized

The organization must have an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population.

- AHF Primary Care Physicians
- Network Primary Care Physicians
- Specialists
- Provider Contracts
 - Vision
 - Skilled Nursing Homes
 - Home Health
 - DME
 - Dental
 - Hospitals
 - Lab
 - Radiology
 - PT, OT & ST
 - Hospice



MOC 3 - Provider Network MOC Training

Code of Federal Regulations (42CFR §422.101(f)(2)(ii)) require SNPs to conduct MOC training for their network of providers.

- Training is provided initially and on an annual basis.
- Attendance at training must be documented.
- PHP uses a multidisciplinary team to implement the comprehensive training program.

MOC 4 - Quality Measurement & Performance Improvement Overview

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC. The AHF QI Plan outlines a coordinated and integrated system for organization-wide assessment and improvement. This is accomplished by:

- Using comparative data to focus on areas of greatest opportunity for improvement to establish goals, measures and benchmarks.
- Working collaboratively to develop or enhance mechanisms for patient safety, infection control and oversight.
- Evaluate and assess effectiveness of QI Plan via measurement outcomes and accomplishment of goals
- Create interdisciplinary performance improvement initiatives based on gaps in data; unmet benchmarks.
- Dissemination of results and performance improvement initiatives across the organization.

MOC 4 - Quality Measurement & Performance Improvement Model of Care Dashboard

For the SNP members, their unique needs are considered as evidenced by the MOC Dashboard of measures

For the SNP members, their unique needs are considered as evidenced by the MOC Dashboard of measures

PHP Model of Care Dashboard – 2023 Based on 2022 Data (Selected Sample)				
Measure	Data Source	2022 Result 2021 Data collection	2023 Result 2022 Data Collection	Change
% enrollees with Viral Load Suppression <200 copies/ml each year	Data Warehouse	88.35%	88.00%	-0.35%
% enrollees with at least three visits each year	Data Warehouse	79.10%	93.00%	+13.90
% enrollees who received appropriate lab test for kidney disease in the measurement year	STAR Ratings HEDIS	98%	99.00% (measure changed)	+1.00%
% Enrollees with diabetes who received a retinal eye exam with result in the measurement year	STAR Ratings HEDIS	57.00%	69.00%	+12.00%
% Enrollees with diabetes whose HgA1c level was <9 in the measurement year	STAR Ratings HEDIS	80%	75%	-5.00%

MOC 4 - Quality Measurement & Performance Improvement Data Used to Evaluate if MOC Goals Met

PHP participates in both CMS required activities and internally developed activities that monitor quality of care and service. These measures are regularly reported out at least annually to the QMC, EOC, the Provider Meetings, ICT Meetings, and All Staff Meetings.

The following outline summarizes the key components:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcome Survey (HOS)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- Quality Improvement Project (QIP)
- Performance Improvement Project (PIP)
- Chronic Care Improvement Project (CCIP)
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and Reporting of Part D Medication Therapy Management Data
- Grievance Aggregation and Category Stratification
- Initial Assessment and Reassessment Timeliness
- Star Ratings
- Internal Initiatives and Key Indicators

Questions?

An electronic copy of the Model of Care is available to all every year.

Contact your Director/Associate Director of Care Coordination (staff) or Provider Relations Representative (providers) for more information.

An example of the enhanced training for providers is PHP's ACCME Accredited continuing medical education program which presents HIV education to the staff providers and network providers in a live presentation which is also webcasted via the internet and phone twice a month. The medical, nursing, pharmacy staff, as well as social workers and other allied health providers are provided direct MOC training by the RNCTMs and encouraged to take advantage of the accredited CME HIV education that supports the Model of Care goals of cutting-edge medicine and patient advocacy. CME/CEU credits are provided at no cost to the attendees.

The CME program provides physicians, nurses and technical support personnel employed or affiliated within the delivery system, the medical knowledge base for delivering that health care. Through regularly scheduled medical conferences and seminars, practicing physicians, including Internists, Family Physicians, Infectious Disease specialists and their associates, are kept informed of demographic trends, diagnostic tools, current therapies, and social services designed to address the health needs of PLWHA of all ages. Training topics include but are not limited to:

- PHP special needs population, meeting needs and providing care to persons with HIV.
- Issues and Barriers to Care Encountered by Persons Who are HIV Positive
- Adherence to Plan of Care and Medication Management in the World of an HIV Positive Patient
- Review of HIV/AIDS specific MOC Program purpose and measurable goals
- Interdisciplinary Team purpose and structure.

- Grievance and appeals
- Utilization Management
- Population Care Management
- Community Collaboration
- Health Risk Assessments: The Foundation of the Care Plan and Interdisciplinary Care Team
- Care Plan Development: Provide training in the and creating care plans.
- Clinical Practice Guidelines

Training Resources

Trainings are provided in multiple formats, such as face to face presentations, telephonic presentations, and web-enabled presentations. Plan RN Care Team Management staff and Provider Relations staff are trained and upon successful completion of the training, conduct MOC training sessions for Plan, staff model and network providers. The National Director of Care Coordination monitors the trainings, maintains the documentation of same and provides periodic reports to the Quality Management Committee on the performance and training compliance of program participants.

Factor 2: Document and maintain evidence of training.

Evidence of Provider MOC Training sessions are maintained in several different formats depending on the venue used for the training. Training performed electronically using mail, email or fax are tracked as is receipt of information (such as Fax Blast confirmation log). In person training will have documented attendance. An electronic log in for web-based presentations is maintained. Group participants joining via web conference must email or fax a sign-in sheet after the training. The Director/Associate Director Provider Relations has access to the electronic attestation log shown below.

The screenshot displays the user interface for the 'AHF Models of Care' course. At the top, there is a navigation bar with links for 'Connections', 'My Team', 'To Do', 'Completed', 'Profile', 'Catalog', 'Event Calendar', and 'Help'. Below this, a blue header bar contains the course title 'AHF Models of Care' and a 'Certificate >' button. The course status is shown as 'Completed' with an estimated time of '11m'. Underneath, there are tabs for 'Learning Activities' and 'Overview'. The 'Learning Activities' section lists 'AHF Models of Care' with a green checkmark and 'Attestation' with a green checkmark and a score of 100%.

Factor 3: Address training completion challenges

PHP has an extensive network of PCP and Specialist across multiple regions including hospital systems and large group practices. Coordinating training for such a large volume of providers presents as a significant challenge. Providers may be reticent to complete, miss training sessions, or experience time constraints due to patient loads and care needs.

To best address these challenges, PHP uses a multi-venue approach and multidisciplinary team to implement the comprehensive training program.

- The Chief of Care Management, as a Senior Management Leader communicates the MOC protocols in Provider Leadership meetings/conferences and venues.
- The National Director of Care Management, Utilization and Risk Management routinely communicates MOC information in Provider Leadership meetings, ICT meetings, staff meetings and through email communications.
- The Clinical Operations Manager is the day-to-day operational clinical resource and oversees the HRA process and Individual Care Plan Development and speaks to providers on MOC protocols on a regular basis in the ICT, Case Conferencing, provider calls/meetings.
- National Director of Care Coordination/Clinical Risk Manager oversees Complaints and Grievances process and meets weekly with Providers named in any complaint or grievance.
- Medical Director – oversees Care Coordination and Appropriate Utilization
- Provider Relations staff meets with providers regularly to teach and close gaps in knowledge.

Out-of-network (OON) providers will receive periodic training, via printed information or Fax Blast information, with confirmation of the distribution recorded and tracked. Any OON provider who requests on-site training will be scheduled and coordinated with Population/Care Management and Provider Relations.

The National Director of Provider Relations manages the implementation and logistics of the in-person training program. The Vice President of Care Management and the National Quality Director oversees the Training Program. The Medical Director consults on the training materials, as needed, and reviews the post-test analysis to identify opportunities for improving the training materials and delivery.

Factor 4: Address incomplete or deficient training.

When the required MOC training is deficient, the following processes are in place.

AHF Employed Providers

Providers who fail to attend scheduled trainings are sent reminder notices and offered make up schedule sessions. Providers who do not complete their MOC training are given additional scheduling choices/venues. If training is not completed within the additional allotted time, the provider's noncompliance is reported to their supervisor. The Provider is subject to the full AHF employee progressive discipline process and may also include a note to their credential file for consideration during re-privileging and/or referral for peer review by the provider's supervising provider.

Contracted Network Providers

Network providers who do not complete their initial training are given additional opportunities but those who do not complete their training are addressed by the Plan Medical Director for action, with notation in their credentialing file for consideration upon reappointment. Network providers who consistently fail to meet requirements and/or compliance will be considered for potential progressive action, including a note to their credential file for consideration during re-privileging and termination from the network in egregious cases.

MOC 4: MOC Quality Measurement and Performance Improvement

The Quality Improvement (QI) Plan includes performance improvement and is designed to optimize the delivery of clinical treatment and services to improve physical and mental health outcomes for HIV/AIDS SNP enrollees as required by Regulations at 42 CFR § 422.152(g).

MOC 4 Element A: MOC Quality Performance Improvement Plan

Factor 1: Detail quality improvement (QI) process.

The Quality Improvement (QI) Plan is based on a comprehensive approach to identifying and systematically measuring, assessing, and improving processes within the organization which can lead to greater effectiveness and efficiency. The QI Plan outlines a coordinated and integrated system for organization-wide assessment and improvement of inter-related safety, support and clinical care processes that affects outcomes. This is accomplished by:

- Using comparative data to focus on areas of greatest opportunity for improvement.
- Work collaboratively to develop or enhance mechanisms for patient safety oversight.
- Work collaboratively to enhance the adverse events and peer review processes.

- Evaluate and assess QI Plan's effectiveness to include but not limited to the Model of Care, committees reporting to QI, Programs, goals, outcomes, and overall performance to learn and make course corrections.
- Dissemination of results across the organization.

For the SNP enrollees, their unique needs are considered as evidenced by the MOC Dashboard of measures which includes Health Resources and Services Administration (HRSA) HIV-AIDS Bureau (HAB) derived measures for HIV outcome measurement. The unique needs of the PHP plan enrollee are compliance with medication adherence obtained through the primary care provider office visit as evidence by viral load suppression lab results. Other process and outcome measures that are deemed appropriate based on our SNP population comorbidities or results of regulatory program participation were selected for the MOC Dashboard with input from QMC, leadership and the Interdisciplinary Care Team (ICT) to advance the health and care of the SNP enrollee. These measures are listed below under Factor 2: Describe QI data collection.

The QI Plan utilizes the Plan-Do-Study-Act (PDSA) model of performance improvement, which is the formal performance improvement methodology adopted by PHP and emphasizes the improvement of systems and processes, retrospectively and proactively, in a reporting, just (non-punitive and accountable), flexible, and learning work environment using techniques such as root cause analysis, failure mode and effects analysis, evidence-based methods, and the monitoring of measurements over time. This same cycle is used for re-measurement if a measurement indicator is not met. Rapid cycle improvement may be employed to determine the correct intervention to achieve the best outcome both clinical health and for rate reporting.

The AIDS Healthcare Foundation Board of Directors delegates to the Executive Oversight Committee (EOC) to conduct oversight of quality, safety, and service. The EOC approves the QI Plan, MOC Plan, the UM Plan, the comprehensive QI Work Plan and the UM Work Plan. It is now the Quality Improvement / Health Equity Committee (QIHEC), (formerly the Quality Management Committee) monitors the QI Plan execution and performs an annually assessment and evaluation of QI Plan accomplishments, barriers, and goal setting for the upcoming year. In addition, the Health Equity Officer is now an active enrollee of the committee. This role has oversight to ensure care is being managed in an inclusive manner for all enrollees. Data is compiled and reviewed to identify disparities and make corrections in care delivery.

All appropriate services to SNP enrollees are provided and delivered unless enrollees refuse (which is documented and discussed in MOC 2). PHP adheres to the prioritization technique of looking at high risk, high volume and high cost of which all SNP enrollees qualify. Furthermore, with the risk stratification of enrollees, those that are at highest risk receive additional attention from RN Care Team Managers. Enrollees and their allies/families/support system are involved in these performance improvement activities, as appropriate.

Factor 2: Describe QI data collection.

The specific data collection sources used to evaluate and report MOC quality performance include:

- Claims data from the current claim software system (HealthSuite) a product of the vendor RAM Technologies.
- AHF Data Warehouse includes any provider data not paid through the Health Suite claims adjudication system, e.g., Med Impact PBM paid claim data, encounter data, delegated vision provider, delegated behavioral health provider, etc.
- Laboratory results data from preferred lab vendor, LabCorp, and any other lab. Integrated Medical Record data from 2 software systems:
 - AthenaOne (EMR)
 - eQHealth (Case Management/Authorization software)
- HIE vendors (Health Information Exchange) incorporated into integrated medical record:
 - Lanes
 - The Collective
 - Point, Click Care

Additional System Information:

- **RAM HEALTHsuite** is the claims processing system/vendor.
- **AHF Data Warehouse** is a data repository for all AHF data and is utilized for measures and reports requiring data not found in other systems. The data warehouse contains the data from LabCorp and Med Impact and specific delegated vendors for vision and behavioral health.
- **AthenaOne** is the electronic medical record (EMR) system that ambulatory care physicians and clinical staff use to document patient encounters, streamline clinical workflow, and securely exchange clinical data with other providers, patients, and information systems such as the case management system. The EMR transitioned to AthenaOne in February 2023. The previous system (CPS - Centricity Product Solutions) holds archived records.

- **The case management software system (eQHealth)** is CMS Certified and the medical record module for RN Care Team Managers to document initial Health Risk Assessment, reassessment, medication management, transition of care and other documentation pertinent to care management. This is the system that generates the ICP and is sent to the patient and providers.
- **Health Information Exchange (HIE)** have been implemented to obtain medical information from hospitals and other medical entities on the exchange in almost real-time and for compliance with regulatory statues. Currently, there is no HIE that houses all this information via one vendor which is why PHP contracts with several covering all areas of the plan. Records obtained from an HIE are stored in the care management software and electronically shared with providers in the EMR.

These data sources are used to process measures using well-established, valid and reliable measurement sets through certified vendors for HEDIS, CAHPS and HOS. Data is sent through secure FTP sites. Internal data is pulled directly from software systems for internal measures.

Performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance include, but are not limited to, the following list of examples:

To continuously analyze, evaluate and report quality performance, numerous reports are produced weekly, monthly, and quarterly to improve performance prior to the final, annual measure data reports. For example, weekly reports are created from enrollee surveys to address any issue reported after a provider visit and delivered via automated email to Care Management so that the patient can be contacted and matter resolved. Two examples of monthly reports include: 1.) Measurement gap list for providers and care managers emailed to each provider and care manager; and 2.) enrollee satisfaction rates via automated emailed to Managed Care Directors and Managed Care Leadership. Quarterly reports include HRA completion rates and viral load suppression presented at UMC and QIHEC, respectively.

Factor 3: Detail QI staff and oversight

Leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process via attendance and participation in the quarterly Quality improvement and Health Equity Committee and its 6 subcommittees. The Quality Improvement/Health Equity Committee (QIHEC) is chaired by the Medical Director or designee.

The Quality Improvement/Health Equity Committee (QIHEC) establishes direction, recommends changes, and evaluates results of ongoing clinical and service improvement activities. The QIHEC:

- Approves the scope of improvement activities as documented in the MOC program description annually.
- Reviews the progress as documented in the work plan and makes recommendations as needed every quarter.
- Ensures adequate practitioner participation in planning, implementing, and evaluating the MOC program.
- Communicates the results of the MOC program at least annually to the Executive Oversight Committee.

The QMC is a multi-disciplinary committee and includes the following enrollees:

Chief of Managed Care	National Director of Care Management, Utilization and Risk Management
Medical Director, Managed Care	Health Plan Administrator or Designee
National Director of Quality	Deputy General Counsel
Director of Pharmacy	Director of Credentialing or Designee
National Director of Infectious Disease or Designee	Los Angeles CA Community Provider(s)
Behavioral Health Representative	

Other departments and/or personnel are invited as required.

Assisted by the expert work of the committees reporting up to QIHEC, measurement indicators are reported and reviewed for performance improvement and safety efforts, barriers and opportunities for improvement are identified and recommendations are made to continue, change, or complete initiatives based on established goals. The QIHEC reports results of quality and safety monitoring and improvement activities to the Executive Oversight Committee (EOC) of the Board. The Committee also provides oversight of the activities of committees reported up to QIHEC; each of which meet on an at least quarterly basis. Findings are also shared with senior management, medical leadership, health care center leadership, nurse managers and other groups as appropriate. The following are the Committees that report up the QIHEC:

- Utilization Management Committee
- Pharmacy & Therapeutics Committee
- Risk Management Committee
- Credentialing and Peer Review Committee
- Infection Control and Prevention Committee
- Ryan White Quality Committee

In addition, the Compliance Committee and the Client Advisory Committee have a consultative relationship to the QIHEC.

Key personnel involved in internal quality improvement processes are as follows.

Associate Director of Risk Management (employed) tracks and trends grievances, handles all potential quality issue investigations, - and contributes to the QIP's, PIP's and CCIP's. Risk Management Reports are reviewed quarterly at QIHEC and EOC with feedback provided if trending requires additional investigations or improvement processes.

QI Project Managers (employed) ensure the completion of the HEDIS Survey from start to finish. This includes the quantitative and qualitative analysis for each measure and preparing the reporting rates for presentation, report cards and gap lists. The entire QI Staff participates in data validation of HEDIS measures. In addition, the QI Project Managers are responsible for the analysis and presentation of all process, performance and outcome measures based on AHF goals which include but are not limited to the MOC Dashboards, the QIP's, PIP's and CCIP's, internal PDSA cycles, CAHPS and HOS. Presentations are done at QMC, EOC, Provider Meetings, and various other meetings as needed, based on results requiring communication.

Health Education Program Manager (contracted) is responsible for the, in person and online enrollee health education classes, enrollee and provider newsletters and patient incentive programs.

Health Equity Officer (HEO)(employed) is responsible for developing, supporting and implementing health equity policies and practices. The HEO is also responsible for building a diverse program ensuring inclusiveness and equity in healthcare. This person also works to advance racial equality and promotes programs that have a focus on eliminating healthcare inequities and promotes wellbeing and healthcare success for all enrollees.

National Director of Quality (employed) has the primary role in analyzing quality performance information and oversight of all analysis and presentations and can initiate focus review if measurement data or outcomes are questionable. Collaborative decision-making authority lies with the National Quality Director, the Medical Director and the Chief of Managed Care.

Factor 4: Determine whether goals met/not met.

PHP demonstrates that the SNP-specific measurable goals and health outcome objectives are integrated in the overall quality performance improvement plan, the QI Work Plan and the Annual Assessment and Evaluation of the QI Plan is completed via two process measures:

- Engagement and retention in care.
- Medication adherence.

Because PHP is a Special Needs Plan designed for Persons Living with HIV/AIDS, the key health outcome is to keep each enrollee's viral load suppressed. As with all Medicare Advantage Plans, the overall benchmark PHP follows for demonstration of high quality of care and service is CMS' 5 Star Plan Rating. For 2025, PHP's Star Rating was 3.5.

For the Annual Assessment and Evaluation, each committee and program must submit a review and report on their goals set at the beginning of the previous year. Through analysis and review, the Directors/Associate Directors and Committee Chairs determine if goals are met or not met. This is determined by using the specific MOC measurement benchmark. Benchmarks are based on past performance with the exception of the mandated measures: HRA, ICP and ICT that are required to be set at 100%.

Further, the National Quality Director and staff create a MOC Dashboard with the measures and most recent annual results for each measure. Any measure not meeting benchmark will have an intervention designed using the PDSA cycle to improve the measure by a subject matter workgroup facilitated by QI. A measure may be required to undergo corrective action plan (CAP) which includes a root cause analysis if drop exceeds 10% of prior year results. The CAP is completed by the subject matter experts for that measure. In addition, if it is determined that the goals were not met, a review of processes which did not work, reworking the solutions, defining barriers and determining new pathways to success are submitted to QI through a narrative report in the Action Item Log. This process continues for the new year listing accomplishments and the goals set for the upcoming year.

The MOC Dashboard, analysis and correction action plans are presented at QIHEC for implementation of process improvement over the next year with the next annual report determining if improvement was effective. Lessons learned are discussed and any

unique situations, such as the past COVID pandemic, are taken into consideration by QIHEC. Measures are edited, eliminated, or added based on MOC mandates, SNP population data and outcomes, practice guideline changes or other regulatory or contractual stipulations and consistent sustainability of significant improvement in order to focus on measures in greater need of improvement.

The Tables below (Benchmarks/Dashboard) show the measures, benchmarks and timeframes that demonstrate the high level of service and quality care SNP recipients receive and the continually pursuit of improved scores.

2024 Model of Care Benchmarks

Measure	Benchmark	Outcome	Timeframe	Data Source
Appropriate use of Services for Chronic Conditions				
% of enrollees with Viral Load Suppression < 200 copies/ml	88%		Annual	Lab Data Warehouse
% enrollees with at least 3 visits per year	90%		Annual	Claims
CDC - Retinal Eye Exam	60%		Annual	Claims and integrated Medical Record
CDC - HbA1c Blood Sugar Controlled	70%		Annual	Lab Data Warehouse
Improving Coordination of Care				
Functional Status Assessment	85%		Annual	Integrated Medical Record
Medication Review	85%		Annual	Integrated Medical Record
Pain Screening	85%		Annual	Integrated Medical Record
Improving Access to Care				
% enrollees satisfied with access to routine care	80%		Annual	CAHPS Survey
% of enrollees satisfied with access to urgent care	75%		Annual	CAHPS Survey
Improving Affordability				
% of enrollees saying "no" to delay/not filled RX because could not afford RX	85%		Annual	CAHPS Survey
Improving Delivery of Service				
% enrollees said provider had medical/record information during appointment	80%		Annual	CAHPS Survey
% enrollees said received help to manage care from different providers and services	80%		Annual	CAHPS Survey
Enhanced Care Transition				
Advance Care Planning	50%		Annual	Integrated Medical Record
Medication Reconciliation Post Discharge (MRP)	50%		Annual	Integrated Medical Record
Preventative Health				
Colorectal Cancer Screening (COL)	68%		Annual	Claims and integrated Medical Record
Controlling High Blood Pressure (CBP)	70%		Annual	Claims and integrated Medical Record
Breast Cancer Screening	66%		Annual	Claims and integrated Medical Record
% enrollees reporting flu vaccine received	80%		Annual	CAHPS Survey
Compliance with Model of Care Measures				
% of enrollees with timely HRA	100%		Annual	CMS Validation Audit
% enrollees with ICP	100%		Annual	eQHealth
% enrollees with ICT	100%		Annual	eQHealth

Below is the 2024 Model of Care Dashboard detailing timeframe and benchmark and outcome.

2024 PHP Model of Care (MOC) Dashboard Measures

Measure	Measure Definition	Benchmark	Timeframe	Data Source	Goal Met Determinant
Appropriate Use of Services for Chronic Conditions					
% enrollees with Viral Load Suppression < 200mg	The percent of enrollees with a viral load suppression < 200 mg.	88%	Annual	Lab: Data Warehouse	At or above benchmark
% enrollees with at least 3 visits per year	The percent of enrollees with at least 3 provider visits, 90 days apart or more, annually.	90%	Annual	Claims	At or above benchmark
CDC- Retinal Eye Exam	Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: <ul style="list-style-type: none"> A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. 	60%	Annual	Claims & Integrated Medical Record	At or above benchmark
CDC - HbA1c Blood Sugar Controlled	The percentage of diabetic enrollees 18-75 (denominator) whose most recent HbA1c level is less than 9%, or who were tested during the measurement year (numerator).	70%	Annual	Lab: Data Warehouse	At or above benchmark
Improving Coordination of Care					
Functional Status Assessment	Percentage of enrollees with at least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.	85%	Annual	Integrated Medical Record	At or above benchmark
Medication Review	Percentage of enrollees with a review of all medications, including prescription medications, OTC medications and herbal or supplemental therapies.	85%	Annual	Integrated Medical Record	At or above benchmark
Pain Screening	Percentage of enrollees with at least one pain assessment during the measurement year, as documented through either administrative data or medical record review.	85%	Annual	Integrated Medical Record	At or above benchmark
Improving Access to Care:					
% enrollees satisfied with access to routine care	Percentage of enrollees who respond positively to the CAHPS question: "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"	80%	Annual	CAHPS Survey	At or above benchmark
% enrollees satisfied with access to urgent care	Percentage of enrollees who respond positively to the CAHPS question: "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?"	75%	Annual	CAHPS Survey	At or above benchmark
Improving Affordability					
% enrollees saying "No" to delay/not filled RX because could not afford it	Percentage of enrollees who responded "No" to the CAHPS question: "In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?"	85%	Annual	CAHPS Survey	At or above benchmark
Improving Delivery of Service					
% enrollees said provider had medical records/information during appointment	Percentage of enrollees who respond positively to the CAHPS question: "In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?"	80%	Annual	CAHPS Survey	At or above benchmark
% enrollees said received help to manage care from different providers and services	Percentage of enrollees who respond positively to the CAHPS question: "In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?"	80%	Annual	CAHPS Survey	At or above benchmark

PHP also participates in both CMS required activities and internally developed activities that monitor quality of care and service. These measures are regularly reported out at least annually to the QIHEC and EOC Meetings and can be presented at other meetings as requested. The following outline summarizes the key components:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- Health Outcome Survey (HOS)
- Quality Improvement Project (QIP)
- Performance Improvement Project (PIP)
- Chronic Care Improvement Project (CCIP)
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and Reporting of Part D Reporting Elements (HPMS)
- Grievance Aggregation, Category Stratification and Trending
- Initial Assessment and Reassessment Timeliness
- Star Ratings
- Internal Initiatives and Key Indicators

Quality Improvement Project (QIP) and Performance Improvement Projects (PIP).

PHP has focused the following QIPs and PIPs: :

- QIP-Promote Effective Management of Chronic Disease: Management of HIV/AIDS
- PIP-Breast Cancer Screening (BCS) – the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer during the measurement year.
- PHP-Improving the number of existing enrollees with a diagnosis of substance use disorder (SUD) or specialty mental health (SMH) enrolled into case management.

PHP launched a Women’s Health Campaign in 2023 which continued throughout 2024 and into 2025. AHF has chosen Women’s Health as a special focus area as a PIP as Women’s health was identified as a disparity within our membership due to the limited number of women compared to men in our enrollee population. The Women’s Health initiative improves not only rates in women’s’ health prevention but improves the general overall wellbeing of our women enrollees through an evidence-based quality improvement program and recognizes healthcare teams providing initiative excellence.

Mental Health and Substance Use Disorder have a direct correlation to retention in care rates. By linking these enrollees to case and care management programs, it is our hope we can also improve retention in care and viral load suppression rates. Case management plays an important role in this PIP.

MOC Dashboard outcomes analysis and corrective action is reviewed and discussed during the QIHEC, UMC and Enrollee and Provider Committee and ICT Meetings. This information is also shared in enrollee and provider newsletters and any other stakeholder requesting this information.

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

Per 42 CFR 422.101(f)(3)(ii), as part of the evaluation and approval of the SNP model of care, NCQA must evaluate whether goals were fulfilled from the previous model of care. The plan must identify and clearly define measurable goals and health outcomes for the MOC. PHP addresses the following factors in this Element:

Factor 1: Identify Goals:

As noted in MOC The table below identifies and defines the measurable goals and health outcomes used to improve the health care needs of SNP enrollees. The key outcome indicator is viral load suppression maintained below 200 copies/ml since this is considered undetectable. All the other measures contribute below to the key indicator, which for HIV treatment, is the gold standard of success.

As noted in MOC 4 Element A: MOC Quality Performance Improvement Plan, the Benchmark table (shown again below) shows the analysis by which the processes and procedures are determined if goals are met:

2024 PHP Model of Care (MOC) Dashboard Measures

Measure	Measure Definition	Benchmark	Timeframe	Data Source	Goal Met Determinant
Appropriate Use of Services for Chronic Conditions					
% enrollees with Viral Load Suppression < 200mg	The percent of enrollees with a viral load suppression < 200 mg.	88%	Annual	Lab: Data Warehouse	At or above benchmark
% enrollees with at least 3 visits per year	The percent of enrollees with at least 3 provider visits, 90 days apart or more, annually.	90%	Annual	Claims	At or above benchmark
CDC- Retinal Eye Exam	Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. 	60%	Annual	Claims & Integrated Medical Record	At or above benchmark
CDC - HbA1c Blood Sugar Controlled	The percentage of diabetic enrollees 18-75 (denominator) whose most recent HbA1c level is less than 9%, or who were tested during the measurement year (numerator).	70%	Annual	Lab: Data Warehouse	At or above benchmark
Improving Coordination of Care					
Functional Status Assessment	Percentage of enrollees with at least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.	85%	Annual	Integrated Medical Record	At or above benchmark
Medication Review	Percentage of enrollees with a review of all medications, including prescription medications, OTC medications and herbal or supplemental therapies.	85%	Annual	Integrated Medical Record	At or above benchmark
Pain Screening	Percentage of enrollees with at least one pain assessment during the measurement year, as documented through either administrative data or medical record review.	85%	Annual	Integrated Medical Record	At or above benchmark
Improving Access to Care:					
% enrollees satisfied with access to routine care	Percentage of enrollees who respond positively to the CAHPS question: "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"	80%	Annual	CAHPS Survey	At or above benchmark
% enrollees satisfied with access to urgent care	Percentage of enrollees who respond positively to the CAHPS question: "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?"	75%	Annual	CAHPS Survey	At or above benchmark

Improving Affordability					
% enrollees saying "No" to delay/not filled RX because could not afford it	Percentage of enrollees who responded "No" to the CAHPS question: "In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?"	85%	Annual	CAHPS Survey	At or above benchmark
Improving Delivery of Service					
% enrollees said provider had medical records/information during appointment	Percentage of enrollees who respond positively to the CAHPS question: "In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?"	80%	Annual	CAHPS Survey	At or above benchmark
% enrollees said received help to manage care from different providers and services	Percentage of enrollees who respond positively to the CAHPS question: "In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?"	80%	Annual	CAHPS Survey	At or above benchmark

To help ensure availability of preventative services, all the PHP primary care providers (PCPs) have an expectation to follow the United States Preventative Services Task Force (USPSTF) guidelines that have an "A" recommendation. An "A" means the USPSTF recommends the service. There is high certainty that the net benefit is substantial. PCPs have the latitude to determine if the preventative service is clinically appropriate. Many of the USPSTF recommendations are HEDIS measures.

For these measures, the providers receive a monthly gap list from the plan as well as the RNCTM. The gap list is worked from both the enrollee and Care Coordination Team side in an effort to motivate the enrollee to complete preventative health care, and from the provider side to help the providers determine what preventative service is not documented. Selected USPSTF recommendations in the form of a measure are on the MOC Dashboard: i.e., Colon Cancer Screening.

The plan also offers in home preventative healthcare screenings such as ColoGuard for Colon Cancer Screening and in-home Nurse Practitioner visits can be arranged for other tests, screenings and or annual wellness visits. To help enrollees so that they do not have to schedule an ophthalmology appointment. Provider offices have been provided with retinal eye exam cameras and trained on how to take the retinal eye picture. The picture is electronically sent to be read by an Ophthalmologist and the report returned to the primary care provider via the electronic health record.

These processes also help insure the management of chronic conditions. Providers are requested to complete the enrollee Annual Wellness Visit early in the year to capture all the patient's chronic conditions, so they can be confirmed, monitored, and treated. RNCTM's annually (and initially upon enrollment) complete the HRA to complement this and these assessments are compared and discussed during the ICT.

Factor 2: Identify health outcome measures.

Overall, PHP key health outcome measure is to keep each enrollee's viral load suppressed. This is completed via two process measures: engagement in care (which includes attending appointments) and medication adherence. There is no measure more vital to the HIV enrollee than ensuring that the enrollee's viral load of HIV is suppressed for the enrollee's quality of life and longevity. Viral load suppression, medication adherence and office visits are addressed during every HRA, on every ICP if there is any issue and presented during all ICT's. Enrollees are educated on each of these measures to insure their own good self-management. ICT members, particularly the RNCTM and providers oversight the viral load closely and carefully to maintain the highest levels of compliance.

PHP also participates in the Medicare Health Outcome Survey (HOS), a patient-reported outcomes measurement survey. A random sample of Medicare Plan enrollees is drawn and surveyed. Two years later, the baseline respondents are surveyed again to establish follow up measurement. The survey consists of the following major components:

- Questions to gather information for case-mix and risk-adjustment.
- Questions to collect results for four HEDIS® Effectiveness of Care measures.
- Updated questions on race, ethnicity, sex, primary language, and disability status
- Health Status (Physical and mental health functioning are the primary outcome measures)

HOS has been under scrutiny during the pandemic and, in fact, had two measures removed from 2022 Star Ratings due to data validity and reliability issue. AHF's QIHEC decided to remove these measures from the MOC Dashboard measurement because of continued validity and reliability issues and small denominators. Another point of concern is that HOS was built using a typical plan with a normal bell-shaped curve distribution of well-enrollees and unhealthy enrollees. C-SNPs by definition have 100% of their membership with a chronic disease so are highly skewed. This, in turn, make HOS results questionable.

Factor 3: Track and assess goals.

Both electronic data and medical record data is used to for internal reports and HEDIS. Electronic data is collected through a SQL program written specifically based on specifications provided by the National Quality Director or designee as dictated by the certified HEDIS vendor, by NCQA, by standard HIV measurement criteria such as HRSA or by a regulatory agency. Medical Record data is obtained through both electronic means, when available, and through medical record review. When medical record review is required, a standardized data capturing template is used online as for our

HEDIS data abstraction. In house templates for various projects are used online, using a spreadsheet software program.

Transition of care measures which are: 1.) completion of an advanced care plan or advanced directive and 2.) Medication reconciliation after discharge from the hospital. Both of these goals are monitored by the RNCTM and completed, if necessary, and shared with the provider or an appointment made with the provider for the enrollees. The completion of the advanced care plan/directive and the medication reconciliation are documented in the integrated medical record. Both measures are on the MOC Dashboard.

MEASURE	2022 MY HEDIS RATES	2023 MY HEDIS RATES
Transition in Care		
Medication Reconciliation Post Discharge	59%	66%
Notification of inpatient Admission	71%	38%
Patient Engagement After Inpatient Discharge	72%	83%
Receipt of Discharge Information	24%	43%
Advance Care Planning (COA/ACP)	97%	97%

Enhanced Care Transition					
Advance Care Planning	Percentage of enrollees with evidence of advance care planning as documented through either administrative data or medical record review.	50%	Annual	Integrated Medical Record	At or above benchmark
Medication Reconciliation Post-Discharge (MRP)	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	50%	Annual	Integrated Medical Record	At or above benchmark
Preventative Health					

The QI interventions that were implemented after the root cause analysis resulted in PHP meeting the benchmarks / goals, in Advance Care Planning (ACP) and in Medication Reconciliation Post Discharge (MRPD). ACP increased slightly by 0.04 percentage points and MRPD increased by 6.87 percentage points.

Factor 4: Determine If goals are met

National and local benchmarks are set for each health outcome goal for the intent to meet or exceed these rates. Each measurement rate is compared to the benchmark and if the benchmark is met or exceeded the MOC determined the goal is met. Meeting regulatory percentile rates is the external determinant in meeting health outcome goals.

Statistically, PHP does utilize a T test to determine if an improvement or a drop in a rate is statistically significant. Use of run charts to display data over time, is the preferred method so as to see trends and determine statistically significant improvements, and sustainability however, both are used, if needed.

PHP performs a complete focus review on each data table used to establish our measurement indicator rates, and a formal data validation process. This has resulted in obtaining standardized data entry and improving documentation. This work continues on, at minimum, an annual basis.

The process for determining whether or not a goal is met is a culmination of Care Coordination and Quality. As noted throughout, PHP uses a multi-step, evidenced based approach to assess whether health outcome goals are being met for each enrollee. Using the Quality Measures as part of the person-centered, coordinated, and focused approach of the following as detailed in MOC 2 Care Coordination, the internal key processes and procedures include:

- Initial and Annual Health Risk Assessment
- Individual Care Plan and Implementation
- Enrollee/Caregiver engagement
- Interdisciplinary Care Team
- Ongoing Monitoring and Tracking
- Performance Metrics and Evaluation
- Continuous Quality Improvement

National and local benchmarks are set for each health outcome goal for the intent to meet or exceed these rates. Each measurement rate is compared to the benchmark and if the benchmark is met or exceeded the MOC determined the goal is met. Meeting regulatory percentile rates is the external determinant in meeting health outcome goals. The MOC Dashboard shows the expectation of each measure. When measures meet or exceed the goals, the indication is that processes in place and the person-centered

approach are working toward better health outcomes. These processes are then used as internal “best practices” and an integral part of the Model of Care.

Factor 5: Steps If Goals Are Not Met

If goals are not met, there are several quality tools that the Plan uses. The National Quality Director or designee leads this effort. A brainstorming session takes place first to determine if there are any data quality issues with the computer technology or a sentinel event causing the unmet goal. This may result in an informal root cause analysis if issues are suspected so they can be fixed immediately.

If there was no sentinel event and data is found to be sound from a technical perspective, it is analyzed for special cause versus common cause variation. This is performed using control charts and/or run charts with a minimum of 18 data points, preferably 36 data points. If common cause variation is determined through using this method of statistical process control, data continues to be tracked using this systematic methodology for a brief period (usually 3 months but the National Quality Director can decide on longer) to determine if goals return to the “met” status.

If special cause variation is proven, a root cause analysis is performed via an ad hoc group of stakeholders and staff familiar with the process and staff involved in the process. The root cause is addressed via an internal quality improvement process which includes the tracking of data as explained above. QI improvement process uses the Plan-Do-Study-Act (PDSA) cycle as indicated in the QI Program Description.

Any urgent needs are addressed immediately, particularly for patient care, while any studies continue their research, findings, recommendations, and implementations. Any of these issues are referred to the Medical Director, RNCTM, Director of Pharmacy, if needed, and provider (s) involved.

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

PHP uses the survey tool known as Consumer Assessment of Healthcare Providers & Systems (CAHPS). The survey is administered by a third-party CMS approved vendor each year using a mixed mode data collection protocol that includes two survey mailings and telephone follow-up of non-respondents to the mailed questionnaire. CAHPS requires a sample size of 800 enrollees with no more than a 20% oversample used randomly for non-respondents. Due to low enrollment for PHP, almost all, if not all, SNP enrollees are surveyed. Questions ask about ease of getting needed care and seeing specialists, getting appointments and care quickly, doctors who communicate well, coordination of enrollees’ health care services, health and/or drug plan provides information or help when enrollees need it, ease of getting prescriptions filled, rating of

health and/or drug plan, rating of health care quality, annual flu vaccine, and pneumonia vaccine. Plan developed questions are also included on this survey specific to SNP concerns.

Factor 1: Describe the survey:

Factor 2: Specify rationale for survey selection.

The rationale for using this tool is because it is a standardized document used by many health plans making comparison of data easier. It has also been tested for validity and reliability with a wide range of questions. Elements of this survey are used in the calculation of the Plan's Star Ratings. A third-party vendor administers the survey to reduce bias. The follow-up methodology provides multiple opportunities to complete the survey and increase return rate. This, in turn, provides results and allows objective and meaningful comparisons among contracts. CAHPS results are presented annually to QMC and EOC as well as other staff and stakeholders. Areas of focus are identified by a CAHPS Work Group and implemented each year prior to next survey to measure effectiveness of interventions via CAHPS results the following year.

Factor 3: Describe process for collecting enrollee feedback.

The patient experience is well integrated into the overall MOC performance improvement plan categories. Selected CAHPS questions are used in the MOC Dashboard because they are highly relevant to the SNP enrollees experience of care in order for the Plan to oversee and meet the goals of patient office visits, where labs are drawn, and medication is prescribed so that key viral load suppression measure for each enrollee can be achieved. It is important to ensure the patient has ease of obtaining appointments and the provider is truly engaged in the interdisciplinary care team with the enrollee and the rest of the ICT. QIHEC selected CAHPS questions that capture concerns requiring focused attention to achieve the health outcomes. CAHPS measures, particularly for the MOC Dashboard, are tracked over time so that a trend can be identified. Recently, a trend was identified via CAHPS regarding answering calls and message return from the healthcare center (HCC). Several adjustments were put into place as a result. The HCCs now have a designated person to monitor and screen messages. Education on the appointment guidelines was also implemented. Analysis revealed lack of understanding of the MOC and contractual guidelines. As a result, MOC training provided includes a test for staff to take after viewing the presentation. The training is also incentivized with a point-system reward program that employees can exchange for gifts. All staff are also given a copy of the MOC with the expectation of reading it. This process is integrated into the MOC Performance Improvement Plan.

Factor 4: Analyze enrollee feedback and address identified issues

To address issues identified in survey responses, data is analyzed and compared to prior year. Significant drops in scoring are discussed in *ad hoc* brainstorming sessions to determine causes, barriers and potential interventions. Prioritization occurs based on items the Plan can more easily control and achieve improvement in a relatively short period of time. Longer term goals may require a focused survey to try to determine more specifics and uncover a root cause. These issues and potential solutions are brought to the Enrollee Provider Committee Meeting for reporting and discussion and then to QIHEC for presentation and recommendations, if any.

Selected survey responses appropriate and relative to Provider Office Staff are presented at luncheon meetings annually by the Health Educator Program Manager. The National Quality Director or designee presents selected measures at Provider Meetings. Interim surveys are conducted after completed appointed to determine if problem areas are improving or to address these areas in earlier than waiting for the results of an annual survey. The results of the interim surveys are emailed to selected Plan staff monthly and weekly reports of any problems are sent to RNCTM's and Enrollee Services weekly.

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

Factor 1: Support ongoing improvement

PHP uses the quality performance indicators and measures listed in **MOC 4 Element B** to support ongoing performance by sharing results and acting when benchmarks are not met. The National Quality Director compares the annual rate with the benchmark. Any rate not meeting or exceeding the benchmark is highlighted for discussion of a quality intervention. This is presented at QIHEC. Following this, a work group convenes to utilize the quality tools and methods discussed in Factor 4A and interventions are decided for deployment to improve. This is also known as a corrective action plan. Formal corrective actions plans are used for measures that have dropped, usually greater than 10 points and are decided on by the National Quality Director. Other measures not meeting benchmark utilize the PDSA concepts.

The interventions are presented at the next QIHEC and also published in the Provider Newsletter. An example of this process was for the measure "HRA completion rate" since it was not at 100%, AHP PHP work team decided to enlist the help of the AHF enrollment agents to provide an abbreviated copy of the HRA with the enrollment application to obtain initial assessment information. Due to the fact PHP is a HIV C-SNP, the mere completion of an application discloses the diagnosis of HIV for the enrollee.

Confidentiality has always been of utmost concern and any enrollment is treated with the respect and privacy the potential enrollee deserves. Enrollees are requested to sign an Authorization for Disclosure of Health Information form during the enrollment process.

To recap, annually, all MOC Dashboard measures are analyzed and presented at QIHEC indicating those measures meeting benchmark and those that did not. An intervention is created by an interdisciplinary team of those who are involved with the measure to improve the measurement rate using the quality improving tools and mentioned stated in Section 4A. This intervention or corrective action is presented along with Dashboard results at QIHEC. Implementation of intervention starts immediately. The National Quality Director or designee facilitates the PDSA cycle of improvement.

The key indicator of VL Suppression demonstrates the efficacy of our health management programs which is why it is presented quarterly at QIHEC. Seeing a dip in the VL Suppression rate during the pandemic resulted in immediate action. We are still addressing Viral Load suppression post pandemic with the following actions:

- RNCTM's were instructed to telephone every patient immediately, provide reassurance, determine any barriers, resolve them, and insure medication adherence and viral load suppression.
- The Plan Pharmacy Director was notified to assist with medication as well as the Plan's Medical Directors, Nurse Practitioners, and network providers.

The Medical Director and the National Quality Director have oversight responsibility for monitoring and evaluating the effectiveness of the MOC. The Quality Improvement / Health Equity Committee (QIHEC) meets quarterly and is chaired by the Medical Director or National Quality Director. The National Quality Director or designated QI Staff presents and reviews performance data and analysis. At these meetings, as well as the ICT Meeting, participants discuss and plan for opportunities to improve the MOC. The Medical Director attends the weekly ICT Meetings and is one of the conduits along with the Director/Associate Director of Care Coordination to the QIHEC. 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 enrollees. The National Quality Director is responsible for follow-up of QIHEC recommendations/action items. The Director/Associate Director of Care Coordination is responsible for the follow-up of ICT Meetings findings/action items. Follow-up may include implementation plans and/or additional analyses that are needed.

Additional staff supporting efforts to improve the MOC:

- Director, Information Systems & Technology

- Director, Provider Relations and Contracting
- Care Coordination Supervisors/Managers and RNCTMs
- Health Plan Administrator
- Health Equity Officer
- Health Education Program Manager

Factor 2: Evaluate results

PHP uses graphic display and dashboard reports focused on specific SNP populations, HEDIS, CAHPS and HOS measures, and those elements of importance to continually assess and evaluate quality and utilization review functions. Our run charts of certain measures help us view data over time, see trends and have a visual confirmation of improvement or notice a drop in a rate early on for us to enact a focus review. Our histograms of certain measures help us view and compare categorical data. This assists in making prioritization decisions. Data are analyzed, including national and local comparisons, with consideration of variations in many factors including demographics of the population, the reasons for grievances and appeals, and the overall effectiveness of the program. RNCTMs and the ICT are provided with reports, such as care gap list, which assist them to addressing the health status of the enrollees. This information is shared at the appropriate committees and ICT meetings and acted upon and reported up to the QIHEC.

Each committee maintains an Action Item Log and minutes. Issues of concern are brought to the QIHEC to review and/or analyze with respect to reaching goals and improving the MOC and making course corrections. QIHEC pays special attention to “lessons learned” and “closing the loop” and informs the organization through the recording of its minutes, communication to the EOC and appropriate committees and as applicable, will communicate with providers through blast fax or Provider Newsletter and communicate with enrollee/caregiver via direct communication from RNCTM, enrollee Newsletter or can present at a Client Advisory Meetings. All those components help us to continually assess and evaluate quality and utilization and identify opportunities for improvement of our MOC.

One of the lessons learned was the duplication of effort in some of the committees reporting up to QIHEC. This was identified by QIHEC via the action item logs and minutes. If an issue needs referral to QIHEC, it is done during the committees reporting out. This is then placed as new agenda item on QIHEC and if action is needed, the issue is placed on the action item log for tracking and completion. This entire process was then reflected in the QI Plan. The QI process continues to be efficient with strong communication both lateral and horizontal with good documentation. Accreditation

organizations and regulatory agencies have commented on the comprehensive minutes and tracking for continuous quality improvement at AHF PHP.

Factor 3: Assess ability to improvement

PHP has established a committee structure and meeting schedule that promotes accountability and appropriate resource allocation, as well as routine data collection, analysis, and timely remediation of variances as well as timely implementation of action items derived from lessons learned during MOC performance evaluation. For example, the ICT meets weekly and amongst other agenda items, provides a focus review for members of the ICT, and discusses both successes and barriers of the enrollees' treatment plan and progress. If trends are noticed, action plans are developed or if deemed an interdisciplinary support is needed, a recommendation for a potential quality issue (PQI) investigation is forwarded to the Quality Department. PQI's are reported and discussed at the Risk Management Meetings and up through QIHEC and EOC which are all held quarterly and provide for the necessary time to aggregate data and information. QIHEC pays special attention to "lessons learned" and "closing the loop" and informs the organization through the recording of its minutes, communication to the EOC and appropriate committees and, as applicable, will communicate with providers through blast fax or Provider Newsletter and communicate with enrollee/caregiver via direct communication from RNCTM, enrollee Newsletter or can present at a Client Advisory Meetings.

PHP continually improves its reporting systems and databases to promote timely and flexible initial as well as follow up data collection to assist with root cause analysis and to improve the evaluation and prioritization of proposed interventions. For example, the QI HEDIS Project Manager is now able to produce reports close to real-time HEDIS data (in consideration of claims lag) instead of having to wait for annual HEDIS data results. This real-time data access has allowed us to respond timely to enrollee health outcomes results, produce gap list of non-compliant enrollees 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 enrollees who are missing preventive screenings, medication refills, and missing PCP visits.

One of the specific reports identifies enrollees who have not seen their PCP in 104 days. This targeted approach improves our ability to ensure that enrollees are receiving the attention necessary to enhance their self- management skills and improve overall care. In 2023 and continuing throughout 24 and 25, there is a strong focus on patient retention in care. PHP focuses on enrollee retention and utilizes the services and resources of the RNCTM and team who coordinate with an AHF program of Community Health Workers who locate patients that have fallen out of care. This has been successful

with many patients being brought back into care into both the Plan and to their providers. To reinforce the person-centered approach, wherever possible a warm hand off to the RNCTM and the Provider/staff occurs.

Finally, a driving force behind timely improvements is the need to improve prior to the next data submission for HEDIS, CAHPS, HOS, Compliance Validation Audit, etc. which is annual. Maintaining a culture to achieve a 5 Star Ratings provides staff motivation and rationale for the sense of urgency to “get things done.”

Factor 4: Document and communicate lessons learned

PHP has a very interactive, cohesive, collaborative, communication dialogue with enrollees, providers, and its staff. Feedback is not only graciously accepted but is sought out. The QI program documentation, including the Model of Care, are maintained per regulatory requirements for ten years, in an electronic format, generated by the plan’s information and care management systems. Documents included, but not limited to are the enrollees’ medical information, QI Plan, QI Work Plan, QI/MOC Annual Evaluation and Assessment, Quality Improvement Projects, QIHEC Minutes, EOC Minutes and other committee meeting minutes.

The QI/MOC Annual Evaluation and Assessment is a very interactive process, as are most our endeavors, with input from PHP committees, providers, and enrollees. The evaluation of the MOC is also documented through the minutes and actions of various committees involved in analyzing and improving the MOC such as Utilization Management Committee, Enrollee Provider Committee, and Pharmacy and Therapeutics Committee. These committees meet on a regular basis to analyze the trends and report up to QIHEC.

Regulatory reports, measurements and reporting are shared as required. PHP makes information about improvements to the MOC available to providers and enrollees on at least annually and more often if needed. QIHEC pays special attention to “lessons learned” and “closing the loop” and documents them in their meetings. The Quality staff informs the organization through the recording of its minutes, communication to the EOC and appropriate committees and as applicable, will communicate with providers through blast fax or Provider Newsletter and communicate with enrollee/caregiver via direct communication from RNCTM, enrollee Newsletter or can present at a Client Advisory Meetings. The Client Advisory Committee (CAC), which is coordinated by Enrollee Services, is one of the venues to obtain feedback from enrollees regarding Plans, program, and customer service. A report to QIHEC is requested from Enrollee Services and is discussed and documented in the QIHEC minutes. This information is also used to help plan and prioritize quality improvement activities. All

those components help us to continually assess and evaluate quality and utilization and identify opportunities for improvement of PHP and the Model of Care.

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

Communication of the Quality and Performance Improvement Program is essential to promote objective and systematic monitoring and evaluation of clinical and administrative services. This includes but is not limited to: enrollees, providers, staff, and other PHP stakeholders. Activities of PHP and the QIHEC are designed to ensure involvement from multiple disciplines and specialties. Feedback is provided regarding performance and results of reviews, studies, and surveys. Health care providers are contractually required to cooperate with and participate in QM activities. PHP makes information about its QPI program available to providers and enrollees annually.

Factor 1: Describe communication of performance results

Many ways are used to communicate information to ensure stakeholders can receive results, benefit from, and participate in improvement processes related to the Model of Care. Following is a list of communication methods:

- Formal Documents (e.g., MOC Program Description, MOC Dashboard, Provider Handbook, Executive Summary and Annual Evaluation)
- Routine reports to the Executive Oversight Committee of the Board of Directors and the Quality Improvement / Health Committee and its subcommittees
- Formal Presentation and Educational Sessions (e.g., MOC, CAHPS, HEDIS, Quality Improvement Projects)
- Quarterly Enrollee Newsletter (*Positive Outlook*)
- Quarterly Provider Newsletter (*Positive Practice*)
- Provider Trainings and luncheons
- Enrollee Education Classes
- Social Marketing: Billboards and Webpage Announcements
- Website

Factor 2: Detail schedule for routine communications

Dissemination of performance results to enrollees occurs through the following:

SNP Plan enrollees and Caregivers

- Interdisciplinary Care Plan – at least Initially and Annually
- Enrollee Newsletters - Quarterly
- Summary of Benefits- Annually

SNP Provider Network

- Provider Newsletters - Quarterly

- SNP Model of Care Training - Annually
- Provider Meetings - Monthly
- Provider Report Cards with Presentation- At least Annually

SNP Board of Directors

- Executive Oversight Committee – Quarterly
- Executive Committee of the Board – Annually

SNP Plan Leadership

- Interdisciplinary Care Team Meetings - Weekly
- Quality Management Committee - Quarterly
- Utilization Management Committee – Quarterly
- Enrollee Provider Committee - Quarterly
- Risk Management Committee – Quarterly
- Pharmacy & Therapeutics Committee – Quarterly
- Credentialing & Peer Review Committee
- Executive Oversight – Quarterly

SNP Management Group

- Interdisciplinary Care Team Meetings – Weekly

SNP Plan Personnel and Staff

- Interdisciplinary Care Team Meetings - Weekly
- Representation at Committee Meetings - Quarterly
- All Staff Meeting – Quarterly
- SNP Model of Care Training - Annually

The General Public

- Plan Website – at minimum Annually.
- Organizational Website – at minimum Annually

Regulatory Agencies

- The Plan submits the MOC Plan annually.
- The QI Plan, Work Plan and QI Plan Evaluation and Assessment are submitted annually.
- HEDIS, CAHPS and HOS are performed annually and submitted.
- Quality Improvement Projects are submitted quarterly and/or annually, as required.
- Chronic Care Improvement Projects are submitted annually.

Factor 3: Detail ad hoc communication process.

Ad hoc communications to stakeholders take place through several methods. SNP MOC improvements or performance reports are communicated as determined by the ICC, QIHEC or other committees with endorsement from or Plan clinical and/or operations

Leadership. Examples of ad hoc communication methods to different stakeholders are included below:

SNP Plan Enrollees and Caregivers

- U.S. Mail
- External Plan Website
- Interactive Voice Response (IVR) calls
- Telephone call
- Virtual calls
- E-Mail/Text
- Face-to-Face communication

SNP Provider Networks

- Fax Blasts
- Meetings: Virtual and In-Person
- Telephone
- E-Mail
- External Plan Website
- Provider Portal
- Patient Reports
- Provider Handbook

SNP Board of Directors

- Telephone call
- E-Mail
- Meetings: Virtual and In-Person

SNP Plan Leadership

- E-Mail
- Weekly Reports
- Telephone
- Meetings: Virtual and In-Person
- Employee Intranet

SNP Management Groups

- E-Mail
- Weekly Reports
- Telephone
- Meetings: Virtual and In-Person
- Employee Intranet

SNP Personnel and Staff

- E-Mail
- Weekly Reports
- Training

- Telephone
- Meetings: Virtual and In-Person
- Employee Intranet

The General Public

- Marketing Campaigns
- Website posting

Regulatory Agencies

- E-Mail
- Telephone
- Health Plan Management System
- Conference Calls and Webinars

Factor 4: Identify staff responsible for communication of performance results.

The Chief of Care Management, the Plan Administrator, the Director of Risk Adjustment, the Senior Director of Care Management Finances, the National Quality Director, the National Director of Care Management, Utilization and Risk Management and the National Director of Provider Relations and Contracting are responsible for communication performance updates in a timely manner. They are assisted by the Health Education Program Manager, in collaboration with Member Services for the member and provider newsletters, enrollee incentives, educational opportunity, client advisory boards, etc. The Compliance Officer assists with regulatory submissions. The Website Administrator is responsible for website posting as directed by SNP Leadership. The National Quality Director and the Quality Department prepare analytics and presentations of the results of the annual Model of Care performance evaluation. Presentations are given at the following meetings and are edited for the audience being served:

- QIHEC
- ICT
- UMC
- Risk Management Meeting
- Compliance Committee
- Executive Oversight Committee
- Executive Committee of the Board
- All Staff Meeting
- Any other requesting department, group, or committee

Dissemination of performance results to providers during Medical Staff meetings provides a forum for eliciting feedback and identifying areas for improvement. Quality improvement clinical and service activity outcomes and survey results are communicated to providers by:

- The National Director of Quality (or designee) is responsible for educational presentations at monthly Medical Director & bimonthly Medical Staff meetings
- The Health Education Program Manager and/or Clinical Quality Team Lead are responsible for the communication of the Quarterly Provider Newsletters (Positive Practice) that include HEDIS, CAHPS, HOS and other quality reports. The National Director of Quality (or designee) is responsible for trainings on quality projects and initiatives. (e.g., Hepatitis C Treatment, Diabetes Care, Substance Abuse Treatment).
- The Plan administrator with the assistance of Provider Relations staff communicates MOC improvements and performance results to providers through educational content on the plan's website.
- RN Care Team Managers and Care Coordination staff will interact with providers to discuss any changes in the MOC and address any impact to enrollees' care plans.
- The National Director of Quality (or designee) is responsible for the Provider Report Cards, Healthcare Center Report Cards, and Gap List to assist providers with their measurement results improvement.
- Provider Relations is responsible for training sessions/visits with providers for education of QI/MOC as well as other issues.
- Provider Relations is responsible for sending information via fax (Blast Fax) to providers on QI/MOC issues as well as other important topics.
- The Plan Administrator in collaboration with the National Director of Provider Relations and Contracting, the National Director of Quality and the National Director of Case Management and Utilization and Risk Management are responsible for the contents of the Provider Handbook.
- The Plan Administration and staff is responsible for maintaining the Provider Website.
- The National Director of Provider Relations and Contracting is responsible for the Inclusion of QI/MOC requirements in provider contracts.

Oversight:

SNP Board of Directors

Executive Oversight Committee - A summary of the annual evaluation including key findings, barriers and opportunities for improvement is presented to the Executive Oversight Committee by the National Quality Director in each year. Prior to the end of each year, Star Ratings Results, HEDIS, CAHPS and HOS are presented by the National Quality Director or Chief of Managed Care to a special group called the Executive Committee of the Board which includes all Senior Leadership of the entire AHF organization. At these times, the Board enrollees provide valuable feedback endorsing

current QI work plans and/or directing priorities and recommending improvement interventions.

SNP Leadership

Quality Improvement / Equity Health Committee - Through the participation of SNP Leadership on the Quality Improvement / Health Equity Committee (QIHEC) and its 6 subcommittees performance results and other pertinent information are shared with multiple stakeholders.

The QIHEC and its subcommittees ensure communication flows up and down and bi-directional as appropriate to use the best expertise on each committee for the best outcomes. The QIHEC establishes direction, recommends changes, and evaluates results of ongoing clinical and service improvement activities. The QIHEC:

- Approves the scope of improvement activities as documented in the MOC program description annually.
- Reviews the progress as documented in the work plan and makes recommendations as needed every quarter.
- Ensures adequate practitioner participation in planning, implementing, and evaluating the MOC program.
- Communicates the results of the MOC program at least annually to the Executive Oversight Committee.

SNP Management Group

Interdisciplinary Care Team - PHP is committed to patient-centered care that includes collaboration between the interdisciplinary care team and patients, families, and their direct caregivers. Enrollees/patients/clients and their allies/families/support system are involved in performance improvement activities as appropriate.

Enrollees of the Interdisciplinary Care Team, (RNCTM, LVN Care Partner, Care Coordinator, and PCP) are responsible for completing many of the tasks that are outlined in the Quality and Performance Improvement Program Description. During orientation they are educated on their role and its impact on quality outcomes for the enrollees and quality measures for the organization. Enrollees of the ICT distribute educational materials related to quality improvement programs to enrollees. They obtain feedback about existing programs from enrollees and share this information with the Quality and Performance Improvement Program.

The QI program incorporates documentation from the following areas including but not limited to enrollee services, utilization management, care management, grievances and appeals, credentialing, provider relations, claims, sales, and marketing.

The Quality Improvement Program components, including policies and procedures, subcommittee documents, and other related documents and activities are housed on a secure site. These documents are readily available to staff and available upon request and during onsite audits.

PHP is constantly striving for innovative ways to communicate so the message “sticks” in unique, educational ways. We continue to utilize the client advisory committee meetings and act on consumer input. To this end we perform provider satisfaction surveys and enrollee focused surveys to try to determine more opportunities for improvement.

This 2026 Model of Care provides the blueprint, processes and rationale for PHP’s Enrollees, Providers and Care Management Division staff.