Special Needs Plan (SNP) Provider Education

Reviewed 01/2023,
Approved 02/2023 IDCT

FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

Learning Goals

- What is a Special Needs Plan (SNP)?
- What differentiates a SNP from other Medicare Advantage (MA) Plans?
- What SNPs are offered by Freedom Health and Optimum HealthCare?
- What is the SNP Model of Care (MOC)?

Special Needs Plans (SNPs)

- ***Special Needs Plans*** were created by Congress in the ***Medicare Modernization Act (MMA) of 2003*** as a new type of Medicare Advantage plan focused on certain vulnerable groups of Medicare beneficiaries:

1) **Institutionalized/Institutional Equivalents** residing in the community
2) **Dual-Eligible** members (those eligible for both Medicare and Medicaid)
3) Beneficiaries with severe or disabling **Chronic Conditions**

Vulnerable Groups

- Vulnerable members are those members who could benefit from additional specialized monitoring.

- For example, members with the following issues or diagnoses would be considered more “vulnerable”:
  - Frail
  - Disabled
  - End-stage renal disease diagnosis after enrollment
  - End-of-life
  - Multiple and complex chronic conditions

Special Needs Plans Characteristics

- Limited enrollment. Qualifying condition or Medicaid status.
- Beneficiaries are typically older, with multiple comorbid conditions and are more challenging to treat.
- SNP benefit plans are custom designed to meet the needs of the designated population.
- SNP members normally have additional election periods to change their Medicare coverage.
- Plan must have a comprehensive SNP Model of Care (MOC) based on evidence-based guidelines.

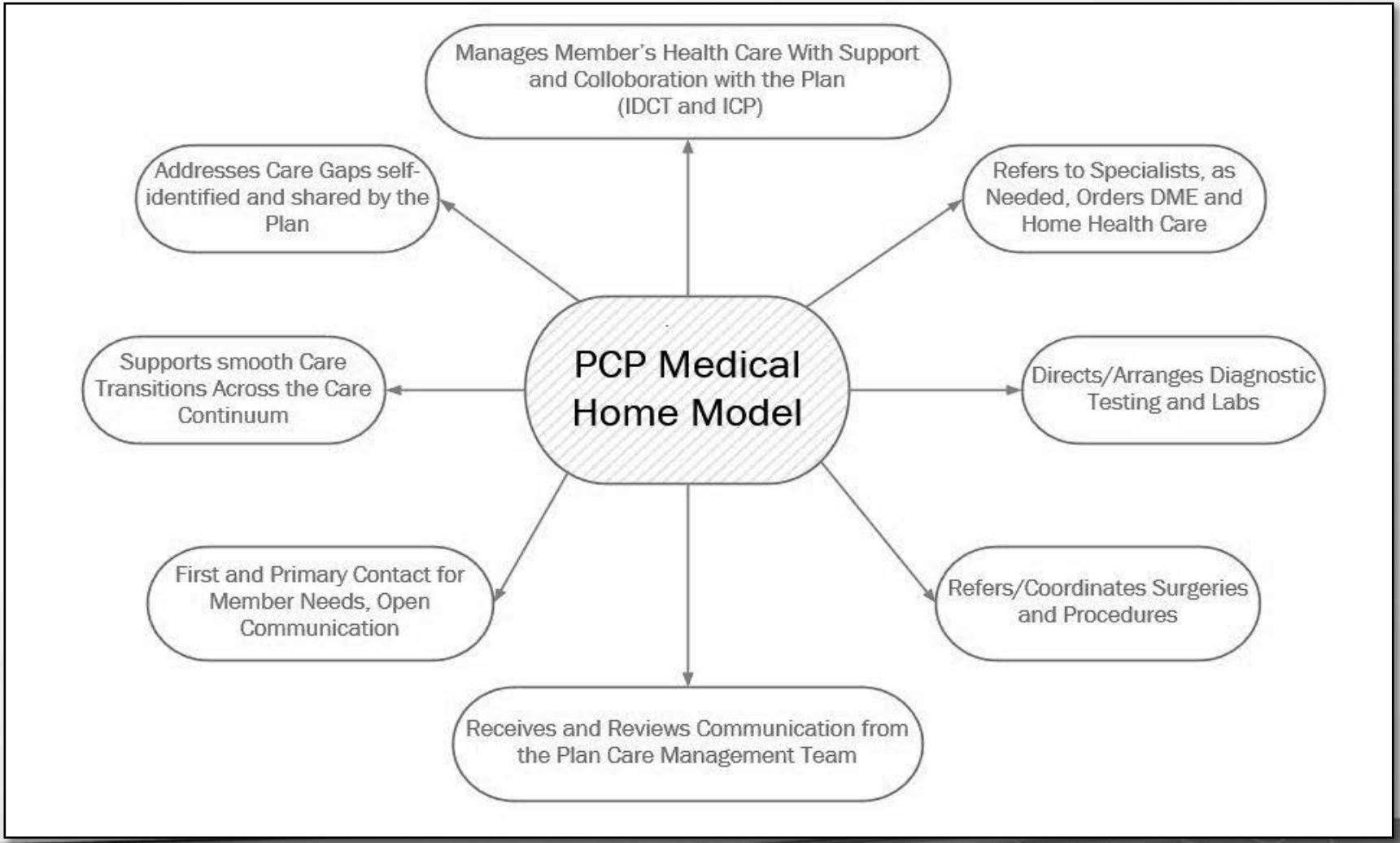
Sample SNP Benefits

- No or low co-pays to encourage use of preventive and ambulatory services (e.g., $0 PCP co-pay)
- Transportation services to increase access to care
- Post-hospitalization meal benefit to support frail member needs
- Over-the-counter (OTC) benefit
- Grocery Cards to improve nutritious food access
- Free health club membership and 24/7 Nurse Advice Line

Our SNP Model of Care Philosophy

- Primary Care Physician (PCP) is medical home
- Tiered Care Plans representing hierarchy of disease severity
- Chronic condition management through integrated benefits, network, and care management activities
- Facilitates access to necessary care especially for Dual Eligibles

PCP Medical Home Model



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SNP Model of Care (MOC)

- The Affordable Care Act (ACA) requires that all SNPs, new, existing, or those seeking to expand service areas, be approved by NCQA effective beginning January 1, 2012.
- The SNP MOC approval process focuses solely on the SNP MOC element requirements.
- The SNP MOC includes evaluation of clinical and non-clinical elements by NCQA as shown in the next slide.

SNP MOC Addresses the Following:

- SNP target population
- Care coordination including care transition protocols
- Staff structure and care management roles
- Interdisciplinary care team
- Provider network having specialized expertise and use of clinical practice guidelines
- Model of Care training – Employee and Provider
- Health risk assessments
- Face-to-Face encounters
- Individualized care plan
- Communication network
- Care management for the most vulnerable subpopulation
- Measurable goals and health outcomes
- Quality measurement & performance improvement

Specific Target Population

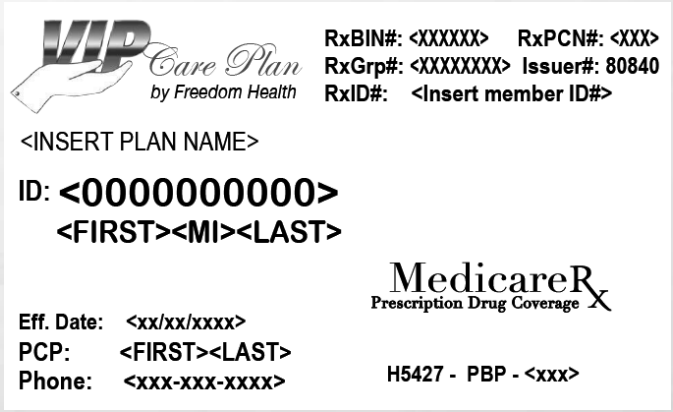
Medicare Eligible members with the following **chronic conditions**:

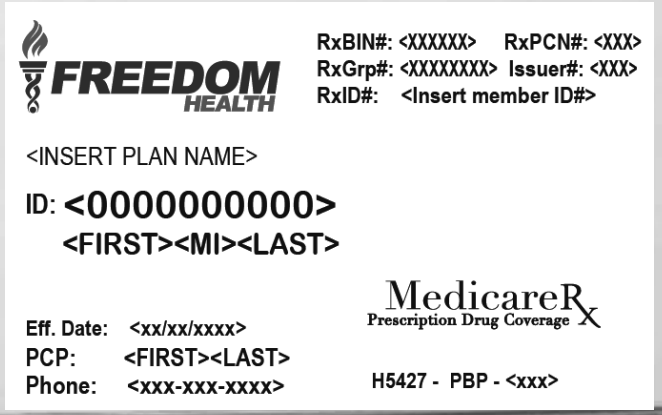
- Congestive Heart Failure
- Cardiovascular Disease
- Pulmonary/Chronic Obstructive Pulmonary Disease/Asthma
- Diabetes

Medicare and Medicaid Dual Eligible members.

Identifying SNP Members- Freedom Health ID Cards and Products

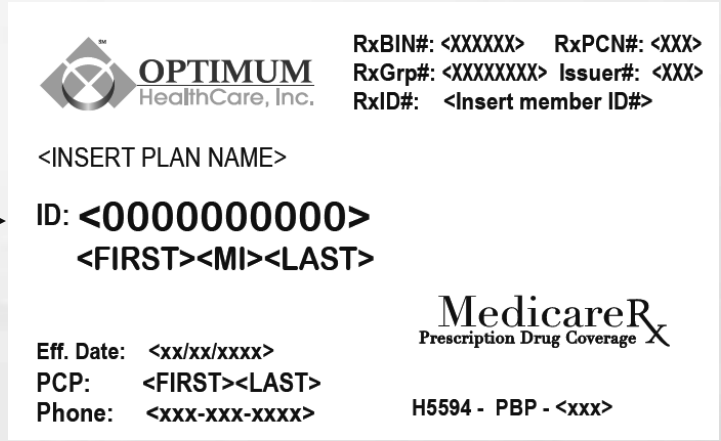
VIP Care	Chronic	CHF, CVD, Diabetes
VIP Savings	Chronic	CHF, CVD, Diabetes
VIP Rewards	Chronic	CHF, CVD, Diabetes
VIP Savings COPD	Chronic	COPD, Chronic Lung Disorders, Asthma, Chronic Bronchitis, Emphysema, Pulmonary Fibrosis
Medi Medi - Full	Dual	$0 Cost Share Medicare/Medicaid Duals
Medi Medi - Partial	Dual	Non $0 Cost Share Medicare/Medicaid Duals





Identifying SNP Members - Optimum HealthCare ID Cards and Products

Diamond Rewards	Chronic	CHF, CVD, and Diabetes
Diamond Rewards COPD	Chronic	COPD, Chronic Lung Disorders, Asthma, Chronic Bronchitis, Emphysema, Pulmonary Fibrosis
Emerald - Full	Dual	$0 Cost Share Medicare/Medicaid Duals
Emerald - Partial	Dual	Non - $0 Cost Share Medicare/Medicaid Duals



Enrollment Process for SNPs

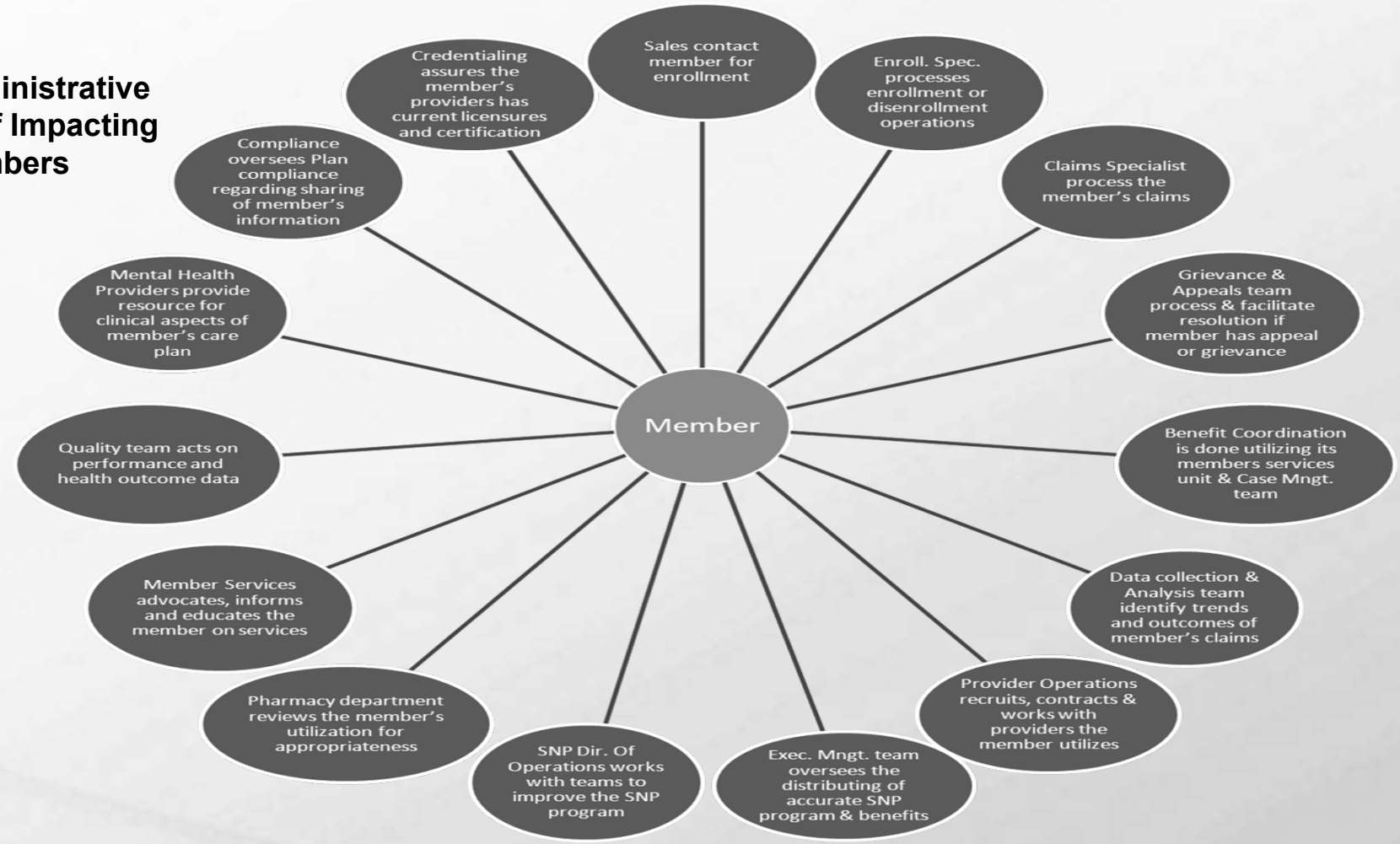
- **Chronic/Pulmonary Enrollees**
  - Member elects Plan by stating they have the disease required to qualify
  - Member will be required to have a physician complete a disease verification form and submit to Plan
  - Members not verified by their Primary Care Physician (PCP) within 60 days of enrollment must be disenrolled
- **Dual-Eligible Enrollees**
  - Member qualifies by receiving both Medicare and Medicaid benefits
  - Member must retain Medicaid eligibility in order to remain in SNP

SNP Measurable Goals

- Improving access to essential services such as medical, mental health, and social services
- Improving access to preventive health services & affordable care
- Improving coordination of care through an identified point of contact (partnership & collaboration with PCPs)
- Improving seamless transitions of care across healthcare settings, providers, and health services
- Enhance quality of care and quality of life including promotion of health equity through the removal of barriers from negative social determinants of health
- Ensuring appropriate utilization of services (reducing hospitalization & readmission rates)

Staff Structure & Care Management Roles

Administrative Staff Impacting Members



All Health Plan staff members interact with SNP beneficiaries to facilitate and provide coordinated care.

SNP Provider Care Management

Patient Centered Medical Home Model

PCP

- Face-to-Face Encounters
- Delivers clinical care and implements care plan
- Coordinates care across continuum (specialist and facility) using referrals and authorization requests
- Utilizes evidence-based care plans

Plan

- Develops care plans, PCP, and member education materials and guidelines
- Drives multidisciplinary team
- Comprehensive disease and case management
- Social services support
- Utilization management support
- Implements quality management program

Coordination of Benefits

- **Chronic, Pulmonary & Dual Eligible SNPs**
  - Member receives all services from the Plan utilizing Plan providers
  - Explanation of Coverage and Summary of Benefits are provided to member and available on Plan website

- **Dual Eligible SNP**
  - While enrolled in SNP Plan, there is no coordination of services through Medicaid and no billing of any services to Medicaid
  - Plan provides all services and adjudicates all claims

Care Coordination

- Ensure that SNP beneficiaries' healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met.

- Maximize the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network.

Case Management

Coordination of Care

- Resource for member to coordinate with PCP
- Counsels members
  - Disease stages
  - Health status change
  - Care plan details
  - Discharge plans and needs for service
  - Transitions of care
  - Coordination of care

Documentation

- All contacts
- Actions taken
- Utilize electronic care management system

Reports

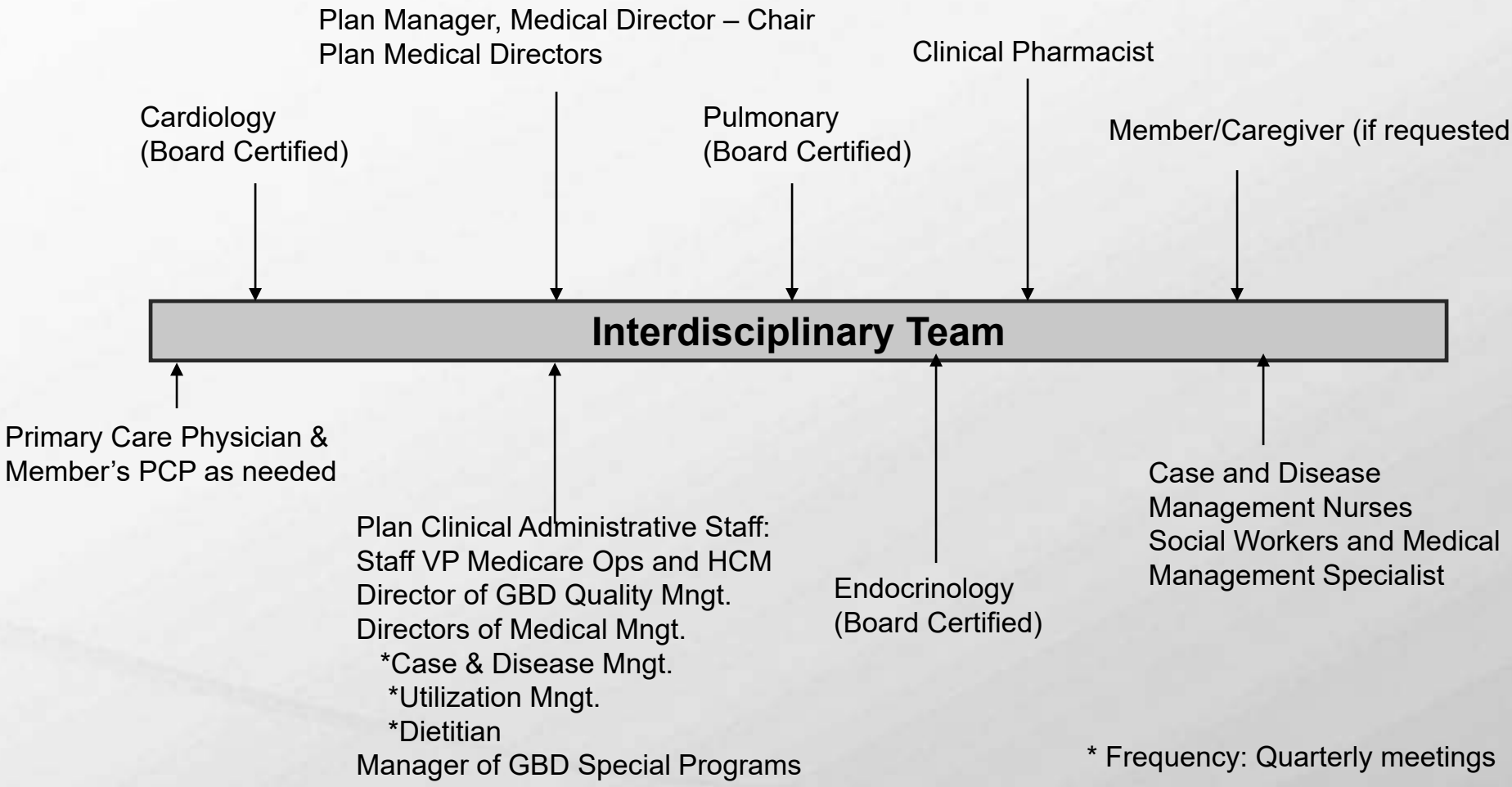
- Review of ongoing reports and communicate with members
- Identify members with planned and unplanned transitions of care
- Identify members who are at high risk

Interdisciplinary Care Team (ICT or IDCT)

Purpose

- Reviews and approves Care Plan models (problems, interventions, goals)
- Reviews and approves care management policies for SNP plans
- Forum to discuss and receive input on cases (PCPs/Members may be invited to attend case discussions) to determine needed changes or re-direction
- Periodic review, update and approval of Clinical Practice Guidelines adopted to promote use of evidence-based guidelines

Interdisciplinary Team Members



* Frequency: Quarterly meetings

Provider Network

- Health Plan Provider Network has specialized clinical expertise pertinent to the SNP Population.

- Credentialing is the process used to ensure facilities are accredited, and specialists have the required experience and training.

Clinical Practice Guidelines

Our Plans have adopted the following nationally-accepted evidence based guidelines:

Evidence-Based Clinical Practice Guidelines | 2023

	Guidelines
Asthma	CDC's National Asthma Control Program 12/12/2022. https://www.cdc.gov/asthma/nacp.htm Global Strategy for Asthma Management and Prevention – Global Initiative for Asthma, 2022. https://ginasthma.org/reports/
Behavioral Health	Delegated MBHO continually reviews and adopts guidelines that meet the new standards for guideline rigor and transparency. https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/
Cancer	National Comprehensive Cancer Network: Breast 06/21/2022; Prostate 09/16/2022; Colon 10/27/0222; Rectal10/27/2022 https://www.nccn.org/professionals/physician_gls/default.aspx American Cancer Society, Guidelines for the Early Detection of Cancer (Last Revised 3/14/2022). https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
Cardiovascular Disease	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019. http://www.onlinejacc.org/content/74/10/e177 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, November 2018. https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol
Chronic Obstructive Pulmonary Disease	Global Initiative for Chronic Obstructive Lung Disease (GOLD);2023 GOLD Reports - 2023 *Global Strategy for Prevention, Diagnosis and Management of COPD*. https://goldcopd.org/2023-gold-report-2/
Congestive Heart Failure	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation. April 2017. https://www.ahajournals.org/doi/abs/10.1161/CIR.0000000000000509 2021 Update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction: A Report of the American College of Cardiology Solution Set Oversight Committee. February 2021. https://www.jacc.org/doi/10.1016/j.jacc.2020.11.022
Diabetes	Standards of Medical Care in Diabetes – American Diabetes Association, January 2023. http://professional.diabetes.org/content/clinical-practice-recommendations
HIV – Adult	Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, July 2016; Last Reviewed & Updated 9/21/2022. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines

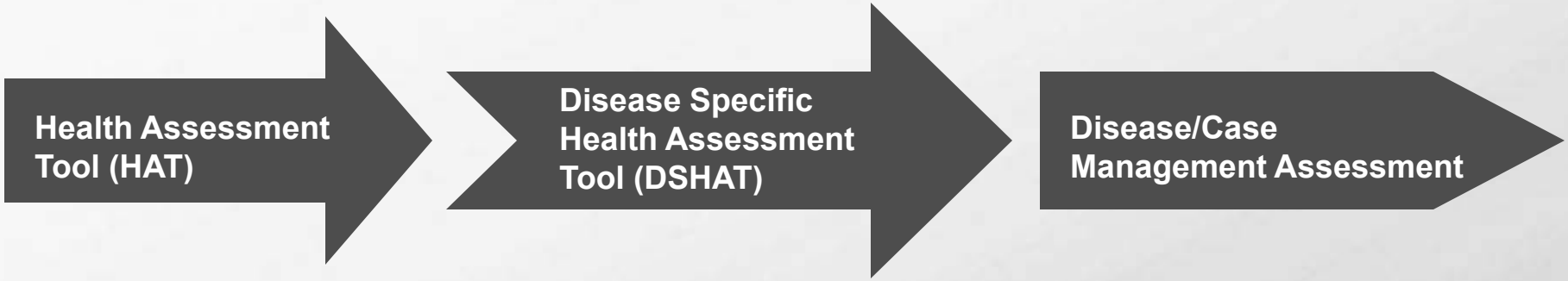
Clinical Practice Guidelines continued

Our Plans have adopted the following nationally-accepted evidence based guidelines:

Evidence-Based Clinical Practice Guidelines	2023
Hypertension	2020 International Society of Hypertension Global Hypertension Practice Guidelines, May 6, 2020. https://www.ahajournals.org/doi/10.1161/HYPERTENSIONAHA.120.15026 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, updated 5/2018. http://www.onlinejacc.org/content/early/2017/11/04/j.jacc.2017.11.006
Preventive Health	Recommendations of the U.S. Preventive Services Task Force. https://uspreventiveservicestaskforce.org/uspstf/

Health Risk Assessment

Annual Health Assessment for all SNP members:



- By mail upon enrollment
- Annually to all SNP members

- Mailed based on HAT responses
- Or disease specified for chronic SNP enrollment
- DSHAT scored with most severe referred to Disease/Case Management

- Nurse/Social Services interview & care planning

Health Assessment Tools

HAT

FREEDOM HEALTH
PO Box 15804, Tampa, FL 33684-9846
Health & Wellness Material

Health Assessment Tool (HAT)

Please complete this annual survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-800-401-2740. TTY: 711

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Gender: ____

Phone number: _____

Member ID: _____

A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. What is your height? (whole numbers) _____ Feet _____Inches 3. What is your weight? (whole numbers) _____lbs.

B. Activities of Daily Living

4. How much help do you need with the following? (check one box for each activity)

Activity	No Help Needed	Some Help Needed	Complete Help Needed
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Eating	❑	❑	❑
Getting out of Bed or Chair	❑	❑	❑
Preparing Meals	❑	❑	❑
Taking your Medicine	❑	❑	❑
Using the Bathroom	❑	❑	❑
Walking	❑	❑	❑
Remembering & Decision Making	❑	❑	❑

5. If you need help, do you have someone close by or a [illegible] you? ❑ Yes ❑ No ❑ Hospice ❑ N/A

C. Health History & Treatment

6. When did you last see your Primary Care Physician?
(check one) ❑ Less than 6 months ❑ More than 6 months ❑ 12 months ago or greater
If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.

7. Do you currently use any medical equipment such as oxygen, electric bed or wheelchair in your home? ❑ Yes ❑ No

8. Are you receiving any nursing, therapy or home health care in your home? ❑ Yes ❑ No

9. Do you have blindness or trouble seeing even when wearing glasses? ❑ Yes ❑ No

10. Do you have deafness or trouble hearing even when wearing a hearing aid? ❑ Yes ❑ No

11. Have you received: (check all that apply) ❑ Flu shot in the past year ❑ Pneumonia shot in the past 5 years ❑ Unsure

12. Have you had a Pap test in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

13. Have you had a mammogram in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

14. Have you had a colon cancer check in the last 10 years? ❑ Yes ❑ No ❑ Unsure

DS HAT

OPTIMUM HealthCare, Inc.
P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

Diabetes Health Assessment Form

Date: _____ Date of Birth: _____

Member Name: _____ Phone#: _____

Member Address: _____

City State Zip: _____ ID#: _____

Ple[illegible] complete the fo[illegible]g assess[illegible]t and return to us in the supplied envelope. These answers will help us det[illegible]e your health st[illegible]tus and [illegible]ou are properly managing your health.

Have [illegible] been admi[illegible]d to [illegible]en to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

If you [illegible]form in error and don't have this health, check the box and return the form to us in the supplie[illegible]elope without answering any of the questions below. ❑ No, I don't have Diabetes.

1. **Which type of medication do you take for your Diabetes?**
(check one) ❑ Pills only ❑ Insulin only ❑ Both pills and insulin ❑ Other medicine by shot ❑ None

2. **If you take insulin, how often do you take it:**
(check one) ❑ 1 time a day ❑ 2-3 times a day ❑ More than 3 times a day ❑ On an insulin pump

3. **How many times in the past year have you had to go to the hospital due to your Diabetes?**
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 4 times

4. **How often do you see your doctor about your Diabetes?**
(check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ 3 times a year or greater

5. **How often do you have your blood HbA1c checked?**
(check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ Never ❑ Don't know what this is?

6. **What was your last HbA1c result?**
(check one) ❑ 6.5 or less ❑ Between 6.6 and 7.5 ❑ 7.6 to 9.0 ❑ More than 9.0 ❑ Don't know

7. **Do you use a glucometer (blood sugar testing device)?** ❑ Yes ❑ No

8. **On a daily basis, how often do you check your blood sugar?**
(check one) ❑ 1 time ❑ 2 times ❑ 3 times ❑ 4 times ❑ 5 times or more ❑ Never

9. **What does your fasting (first one in the morning) blood sugar usually run?**
(check one) ❑ 110 or less ❑ 111-120 ❑ 121-140 ❑ More than 140 ❑ Don't know

10. **What does your blood sugar usually run if taken 2 hours after eating?**
(check one) ❑ 110 -120 ❑ 121-140 ❑ 141-180 ❑ More than 180 ❑ Don't know

Individual Care Plans

All Care Plans use a problem, intervention, goal format. Clinical Practice Guidelines are cited in the Care Plans.

Tier 1

- Applicable to all members in the SNP population
- Health Plan provides to PCP
- Based on general disease information or dual eligible status
- Supplemental English or Spanish Health Appraisal Profile provided to member based on HAT responses/preferred language for self-management & health tracking

Tier 2

- Developed from DSHAT responses specific to member (claims and pharmacy data included)
- Health Plan provides to PCP
- More specific with member response

Tier 3

- Results from extensive Nurse and/or Social Service/Nutritionist Case/Disease Management assessment
- Generates member-specific care plan
- Health Plan provides to PCP
- Jointly developed and updated throughout the Case and Disease Management process

Management of Individual Care Plans

- Participating PCPs serve as the “Medical Home” and receive Care Plans via Health Plan’s HEDIS® MRA Portal or via fax depending on Care Plan Tier to assist in this process and to optimize the health status of Special Needs Plan members. The PCP is responsible for overall management of the member (in coordination with specialty providers and the Health Plan) taking into account the provided Care Plan.

- The Health Plan mails a Care Plan Manual to all PCPs in the Spring of each year which includes examples of individual care plans, instruction on how to access them via the HEDIS® MRA Portal, and the most recently approved Clinical Practice Guidelines.

Tier 1 Care Plans

2023 DIABETES CARE PLAN

Problems

Patient has diabetes identified by HbA1c value.

Interventions, Goals and Legend

HP = High Priority	ST = Short Term
MP = Medium Priority	LT = Long Term
LP = Low Priority	Goal Measurement Frequency: Semi-Annual

PCP MEDICAL HOME

1. Member/Patient will understand their medical home as evidenced by at least two PCP visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will obtain two HbA1c tests during the calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

Prioritized Interventions:

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicating knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

MEMBER/PATIENT ENGAGEMENT:

1. Member will complete at least one health assessment tool (HA[illegible] and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

Prioritized Interventions:

1. *The Plan will mail a HAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

DISEASE EDUCATION:

1. Member will receive initial diabetes education packet from plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST/LT)**
2. Member will receive routine (assuming full quarter eligibility) diabetes education quarterly throughout the calendar year. **(LP, LT)**

Intervention:

- *The plan will mail diabetes educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of adhering to medication regimen, Importance of an annual eye exam, foot care, blood glucose, and blood pressure control, Importance of smoking cessation, Importance of dietary compliance, and information of use of Medical Home.*

QMSC Approved: 3/2023

Evidence Based Guidelines and Other Plan Recommendations

Physician monitoring of outcomes for compliance with regimen goals following guidelines:

- Standards of Medical Care in Diabetes – American Diabetes Association, January 2023. http://professional.diabetes.org/content/clinical-practice-recommendations
- Monitor timely and appropriate laboratory data for compliance and recommended testing of HbA1c, LDL-C level, and other profiles as needed
- Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions
- Monitor progress to determine if further interventions need to be developed and addressed

Ensure your patient is seen within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually address the following with your patients and document in patients' records:

- Advance Care Planning
- Medication Review
- Functional Status Assessment
- Comprehensive Pain Screening
- Behavioral Health, Substance Abuse and Mood Disorders

Care Plan Assistance/Feedback

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

QMSC Approved: 3/2023

Tier 1 Care Plans continued

2023 CONGESTIVE HEART FAILURE CARE PLAN

Problems

Patient has Congestive Heart Failure.

Interventions, Goals and Legend

HP = High Priority	ST = Short Term
MP = Medium Priority	LT = Long Term
LP = Low Priority	Goal Measurement Frequency: Semi-Annual

PCP MEDICAL HOME

1. Member/Patient will understand their medical home as evidenced by at least two PCP visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will have no emergency room, observation or hospital stays due to CHF for the calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

Prioritized Interventions:

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicating knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

MEMBER/PATIENT ENGAGEMENT:

1. Member will complete at least one health assessment tool (HAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, LT)**

Prioritized Interventions:

- *The Plan will mail a HAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HAT (one per subsequent month) for non-response.*
- *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

DISEASE EDUCATION:

1. Member will receive initial congestive heart failure disease education packet from plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST)**
2. Member will receive routine (assuming full quarter eligibility) congestive heart failure disease education quarterly throughout the calendar year. **(LP, LT)**

Intervention:

- *The plan will mail congestive heart failure disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved: 3/2023

Evidence Based Guidelines and Other Plan Recommendations

Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation. April 2017. https://www.ahajournals.org/doi/abs/10.1161/CIR.0000000000000509
- 2021 Update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction: A Report of the American College of Cardiology Solution Set Oversight Committee. February 2021. https://www.jacc.org/doi/10.1016/j.jacc.2020.11.022
- Monitor timely and appropriate medication refills
- Monitor emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions
- Monitor progress to determine if further interventions need to be developed and addressed

Ensure your patient is seen within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually, address the following with your patients and document in patients' records:

- Advance Care Planning
- Behavioral Health, Substance Abuse and Mood Disorders

Care Plan Assistance/Feedback

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

QMSC Approved: 3/2023

Tier 1 Care Plans continued

2023 PULMONARY CARE PLAN

Problems

Patient has poor, intermediate, or at-risk pulmonary health.

Interventions, Goals and Legend

HP = High Priority	ST = Short Term
MP = Medium Priority	LT = Long Term
LP = Low Priority	Goal Measurement Frequency: Semi-Annual

PCP MEDICAL HOME

1. Member/Patient will understand their medical home as evidenced by at least two PCP visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will obtain Flu Shot within calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

Prioritized Interventions:

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicating knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Hom*

MEMBER/PATIENT ENGAGEMENT:

1. Member will complete at least one health assessment tool (HAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

Prioritized Interventions:

1. *The Plan will mail a HAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

DISEASE EDUCATION:

1. Member will receive initial pulmonary care disease education packet from plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST)**
2. Member will receive routine (assuming full quarter eligibility) pulmonary care disease education quarterly throughout the calendar year. **(LP, LT)**

Intervention:

- *The plan will mail pulmonary care disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved: 3/2023

Evidence Based Guidelines and Other Plan Recommendations

Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- Global Initiative for Chronic Obstructive Lung Disease (GOLD); Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease, 2023 Report. https://goldcopd.org/2023-gold-report-2/
- Monitor timely and appropriate medication refills
- Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions
- Monitor progress to determine if further interventions need to be developed and addressed

Ensure your patient is seen within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually address the following with your patients and document in patients' records:

- Advance Care Planning
- Behavioral Health, Substance Abuse and Mood Disorders

Care Plan Assistance/Feedback

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

QMSC Approved: 3/2023

Tier 1 Care Plans continued

2023 CARDIOVASCULAR DISEASE CARE PLAN

Problems

Patient has Cardiovascular Disease.

Interventions, Goals and Legend

HP = High Priority	ST = Short Term
MP = Medium Priority	LT = Long Term
LP = Low Priority	Goal Measurement Frequency: Semi-Annual

PCP MEDICAL HOME

1. Member/Patient will understand their medical home as evidenced by at least two PCP visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will obtain annual lipid profile for effective provider monitoring for calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in calendar year. **(LP, LT)**

Prioritized Interventions:

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

MEMBER/PATIENT ENGAGEMENT:

1. Member will complete at least one health assessment tool (HAT) and/or disease specific health assessment tool (DS-HAT) annually. **(HP, ST/LT)**

Prioritized Interventions:

- *The Plan will mail a HAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HAT (one per subsequent month) for non-response.*
- *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

DISEASE EDUCATION:

1. Member will receive initial cardiovascular disease education packet from plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST)**
2. Member will receive routine (assuming full quarter eligibility) cardiovascular disease education quarterly throughout the calendar year. **(LP, LT)**

Intervention:

- *The plan will mail cardiovascular disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved 3/2023

Evidence Based Guidelines and Other Plan Recommendations

Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019 http://www.onlinejacc.org/content/74/10/e177
- 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, November 2018. https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/03/2018-guideline-on-management-of-blood-cholesterol
- Monitor timely and appropriate medication refills
- Monitor laboratory data for with above guidelines as applicable
- Monitor professional determination further interventions need to be developed and addressed
- Monitor emergency department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions

Ensure your patient is seen within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually, address the following with your patients and document in patients' records:

- Advance Care Planning
- Behavioral Health, Substance Abuse and Mood Disorders

Care Plan Assistance/Feedback

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

QMSC Approved 3/2023

Tier 1 Care Plans continued

2023 DUAL ELIGIBLE MEMBER CARE PLAN

Problems

Patient is socioeconomically disadvantaged which may negatively impact patient's ability to access needed and preventative healthcare services.

Interventions, Goals and Legend

HP = High Priority	ST = Short Term
MP = Medium Priority	LT = Long Term
LP = Low Priority	Goal Measurement Frequency: Semi-Annual

PCP MEDICAL HOME

1. Member/Patient will understand their medical home as evidenced by at least two PCP visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

Prioritized Interventions:

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicating knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure exclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least three a year containing information regarding importance of and how to use PCP Medical Home.*

MEMBER/PATIENT ENGAGEMENT:

1. Member will complete at least one health assessment tool (HAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

Prioritized Interventions:

1. *The Plan will mail a HAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

BENEFIT EDUCATION:

1. Member will receive routine (at least 2/year assuming at least 6 months eligibility) benefit education through Plan mailed member newsletters. **(LP, LT)**

Intervention:

- *The plan will mail benefit education packet twice times a year and/or newsletters at least twice a year containing the following information: Education of Plan benefits, Information of use of Medical Home, which includes access and support to Social and Behavioral Services, Importance of smoking cessation, Importance of immunization, Importance of medication adherence, Early signs of exacerbation of condition, and Importance of dietary compliance.*

QMSC Approved: 3/2023

Evidence Based Guidelines and Other Plan Recommendations

Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- Recommendations of the U.S. Preventive Services Task Force https://uspreventiveservicestaskforce.org/uspstf/

Additional considerations:

- Monitor timely and appropriate medication refills
- Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions
- Monitor progress to determine if further interventions need to be developed and addressed

Ensure your patient is seen within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

Unless annually, address the following with your patients and document in patients' records:

- Advance Care Planning
- Medication Review
- Functional Status Assessment
- Comprehensive Pain Screening
- Behavioral Health, Substance Abuse and Mood Disorders

Care Plan Assistance/Feedback

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

QMSC Approved: 3/2023

Tier 2 Care Plan

FREEDOM HEALTH CARE PLAN

Provider:	Mbr Name:		**Run Date:**
			DS-HAT Date:
Provider County:	Home Phone:	Gender:	DOB:
PCP Phone:	Subscriber ID:	Plan:	

CVD

Freedom Health's Medical Advisory Committee has adopted a number of nationally accepted care guidelines, which define normal or optimal targets referenced in the below care plan. For CVD, we reference the following:

2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019 http://www.onlinejacc.org/content/74/10/e177

2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, November 2018. https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol

All problems listed below are self-reported by member on a CVD Health Assessment Tool and should be validated by PCP

HAT #	Problem	Interventions	Goals
1A	Frequent Symptom: shortness of breath.	Assess etiology of symptom and treat as necessary.	Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST)
6	History: Heart Surgeries.	Minimize cardiac risk factors and ensure appropriate post-operative therapy. Educate member with information regarding health maintenance after incident.	Member will receive routine (at least 1/ quarter assuming full quarter eligibility) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT)
9	Diet Regimen: Low Salt.	Evaluate diet regimen used by member and modify as necessary.	Member will receive routine (at least 1/ quarter assuming full quarter eligibility) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT)
9	Diet Regimen: Heart Healthy.	Evaluate diet regimen used by member and modify as necessary.	Member will receive routine (at least 1/ quarter assuming full quarter eligibility) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT)
13	Significant Impact by Condition on Quality of Life.	Assess Member's daily activities impacted by CVD	Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST)
14	Non-compliance with PCP treatment plan.	Schedule at least 2 appointments / year for treatment planning	Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST)
15	Cardiology Consults: 4+ times/year.	Coordinate care management with Cardiology	Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST)
19	Concerns noted RE: Ability to self-manage.	Assess self-management concerns	Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST)

GOAL LEGEND

HP = High Priority
MP - Medium Priority
LP = Low Priority

ST = Short Term
LT = Long Term
Goal Measurement Frequency: Semi-Annual

Tier 2 Care Plan continued

FREEDOM HEALTH CARE PLAN UPDATE

Provider:
Provider County:
PCP Phone:

Mbr Name:
Home Phone:
Subscriber ID:

Gender:
Plan:

Run Date: 1/20/2023
DS-HAT Date: 01/01/2023
DOB: MM/DD/YYYY

Self Reported Health Assessment **Confidential and Proprietary**

CVD

1. Member has experienced shortness of breath.
2. Member very often experiences shortness of breath.
3. Member does not experience chest pain.
4. Member had a heart attack.
5. Member had a heart attack 2 - 3 years ago.
6. Member has had heart surgeries, ex. bypass, stents.
7. Member's blood pressure does not run higher than 140/90.
9. Member is on a low salt diet.
9. Member is on a Heart Healthy diet.
10. Member does not smoke.
11. Member uses oxygen at home.
12. Member exercises 3-4 days per week.
13. Member states that heart condition very often prevents him/her from enjoying life.
14. Member has not seen PCP in the last year for Heart condition.
15. Member has seen Cardiologist more than 4 times in the last year.
16. Member has not been to the Emergency room due to his/her heart condition in the past year.
17. Member has not been hospitalized in the past year due to his/her heart condition.
18. Member thinks his/her heart condition has stayed the same over the past year.
19. Member has a fair ability to take care of themselves.

Tier 2 Care Plan continued

FREEDOM HEALTH CARE PLAN

Run Date: 1/20/2023
DSHAT Date: 01/01/2023

Provider:
Provider County:
PCP Phone:

Mbr Name:
Home Phone:
Subscriber ID:

Gender:
DOB:
Plan:

Member Summary — **Confidential and Proprietary**

CMS HCC History

HCC GROUP	DISEASE TYPE
HCC018	Diabetes with Chronic Complications
HCC040	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
HCC085	Congestive Heart Failure
HCC108	Vascular Disease
HCC111	Chronic Obstructive Pulmonary Disease
HCC138	Chronic Kidney Disease, Moderate (Stage 3)

Eligiblity History

Year	Effective Range
2009	04/01/2009 - 12/31/2009
2010	01/01/2010 - 12/31/2010
2011	01/01/2011 - 12/31/2011
2012	01/01/2012 - 12/31/2012
2013	01/01/2013 - 12/31/2013
2014	01/01/2014 - 12/31/2014
2015	01/01/2015 - 12/31/2015
2016	01/01/2016 - 12/31/2016
2017	01/01/2017 - 12/31/2017
2018	01/01/2018 - 12/31/2018
2019	01/01/2019 - 12/31/2019
2020	01/01/2020 - 12/31/2020
2021	01/01/2021 - 12/31/2021
2022	01/01/2022 - 12/31/2022
2023	01/01/2023 - CURRENT

Tier 2 Care Plan continued

Information and data included in claims based records relating to sensitive health conditions including, drug, alcohol or substance abuse, mental health, sexually transmitted diseases, HIV/AIDS have been suppressed. There may, however, be the inclusion of some information regarding sensitive conditions. Also, please refer to the HEDIS/MRA Portal for complete HCC member specific data.

Claim Activity - PCP/Specialty

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
1/5/2023	M54.16	Radiculopathy lumbar regi		1125F	PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
1/5/2023	M54.16	Radiculopathy lumbar regi		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
1/5/2023	M54.16	Radiculopathy lumbar regi		1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
1/5/2023	M54.16	Radiculopathy lumbar regi		99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
1/5/2023	M54.16	Radiculopathy lumbar regi		G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	1125F	PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 90 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
12/8/2022	C84.1	Malignant neoplasm of rig	11	99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		1125F	PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		3044F	MOST RECENT HEMOGLOBIN A1C (HBA1C) LEVEL LESS THAN 7.0% (DM)	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 90 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
11/3/2022	M54.16	Radiculopathy lumbar regi		G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
10/11/2022	C84.1	Malignant neoplasm of rig	11	1125F	PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
10/11/2022	C84.1	Malignant neoplasm of rig	11	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
10/11/2022	C84.1	Malignant neoplasm of rig	11	1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE

Tier 2 Can Plan continued

10/11/2022	C64.1	Malignant neoplasm of rig	11	3044F	MOST RECENT HEMOGLOBIN A1C (HBA1C) LEVEL LESS THAN 7.0% (DM)	FAMILY MEDICINE
10/11/2022	C64.1	Malignant neoplasm of rig	11	3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
10/11/2022	C64.1	Malignant neoplasm of rig	11	3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 80 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
10/11/2022	C64.1	Malignant neoplasm of rig	11	99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
10/11/2022	C64.1	Malignant neoplasm of rig	11	G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		1125F	PAIN SEVERITY QUANTIFIED; PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		3044F	MOST RECENT HEMOGLOBIN A1C (HBA1C) LEVEL LESS THAN 7.0% (DM)	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 80 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
10/6/2022	R19.00	Intra-abdominal and pelvi		G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	3044F	MOST RECENT HEMOGLOBIN A1C (HBA1C) LEVEL LESS THAN 7.0% (DM)	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	3075F	MOST RECENT SYSTOLIC BLOOD PRESSURE 130-139 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 90 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	36410	VENIPUNCTURE AGE 3 YEARS OR OLDER NECESSITATING THE SKILL OF A PHYSICIAN OR OTHER QUALIFIED HEALTH C	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
9/21/2022	E11.69	Type 2 diabetes mellitus	18	G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
9/6/2022	I11.0	Hypertensive heart diseas	85	1125F	PAIN SEVERITY QUANTIFIED; PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
9/6/2022	I11.0	Hypertensive heart diseas	85	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
9/6/2022	I11.0	Hypertensive heart diseas	85	1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
9/6/2022	I11.0	Hypertensive heart diseas	85	99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
9/6/2022	I11.0	Hypertensive heart diseas	85	G8417	Bmi is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE

Tier 2 Care Plan continued

8/1/2022	Z03.818	Encounter for observation		87426	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY TECHNIQUE (EG ENZYME IMMUNOASSAY [EIA] ENZYME-LINK	FAMILY MEDICINE
8/1/2022	Z03.818	Encounter for observation		99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
7/29/2022	F32.0	Major depressive disorder	59	99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		1125F	PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC)	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		3044F	MOST RECENT HEMOGLOBIN A1C (HBA1C) LEVEL LESS THAN 7.0% (DM)	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		3075F	MOST RECENT SYSTOLIC BLOOD PRESSURE 130-139 MM HG (DM) (HTN CKD CAD)	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 90 MM HG (HTN CKD CAD) (DM)	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT WHICH R	FAMILY MEDICINE
7/29/2022	M54.16	Radiculopathy lumbar regi		G8417	BMI is documented above normal parameters and a follow-up plan is documented	FAMILY MEDICINE
7/29/2022	Z01.89	Encounter for other speci		4[illegible]0F	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY PRESCRIB	FAMILY MEDICINE

Claim Activity - Other Health Care Provider

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
10/20/2022	N28.89	Other specified disorders		74178	COMPUTED TOMOGRAPHY ABDOMEN AND PELVIS WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS FOLLOWE	Dietitian, Registered - Nutrition, Gerontological
10/20/2022	N28.89	Other specified disorders		74178	COMPUTED TOMOGRAPHY ABDOMEN AND PELVIS WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS FOLLOWE	Dietitian, Registered - Nutrition, Pediatric
10/20/2022	N28.89	Other specified disorders		74178	COMPUTED TOMOGRAPHY ABDOMEN AND PELVIS WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS FOLLOWE	Dietitian, Registered - Nutrition, Renal
10/20/2022	N28.89	Other specified disorders		Q9967	Low osmolar contrast material 300-399 mg ml iodine concentration per ml	Dietitian, Registered - Nutrition, Gerontological
10/20/2022	N28.89	Other specified disorders		Q9967	Low osmolar contrast material 300-399 mg ml iodine concentration per ml	Dietitian, Registered - Nutrition, Pediatric
10/20/2022	N28.89	Other specified disorders		Q9967	Low osmolar contrast material 300-399 mg ml iodine concentration per ml	Dietitian, Registered - Nutrition, Renal
10/6/2022	N28.1	Cyst of kidney acquired		76700	ULTRASOUND ABDOMINAL REAL TIME WITH IMAGE DOCUMENTATION COMPLETE	Dietitian, Registered - Nutrition, Gerontological
10/6/2022	N28.1	Cyst of kidney acquired		76700	ULTRASOUND ABDOMINAL REAL TIME WITH IMAGE DOCUMENTATION COMPLETE	Dietitian, Registered - Nutrition, Pediatric
10/6/2022	N28.1	Cyst of kidney acquired		76700	ULTRASOUND ABDOMINAL REAL TIME WITH IMAGE DOCUMENTATION COMPLETE	Dietitian, Registered - Nutrition, Renal

Claim Activity - Hospital

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty

Tier 2 Care Plan continued

Claim Activity - Skilled Nursing Facility (SNF)

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty

Claim Activity - Pharmacy

DOS	Supply	Drug Name	Prescriber	Generic
01/05/2023	90	ENTRESTO TAB 97-103MG	PCP	SACUBITRIL-VALSARTAN TAB 97-10
12/12/2022	30	ENTRESTO TAB 97-103MG	PCP	SACUBITRIL-VALSARTAN TAB 97-10
10/03/2022	60	ENTRESTO TAB 97-103MG	PCP	SACUBITRIL-VALSARTAN TAB 97-10

Claim Activity - Lab

DOS	Vendor	Result Name	LOINC	Result
10/11/2022	LABCORP		14957-5	17.7000
10/11/2022	LABCORP		2161-8	177.0000
10/11/2022	LABCORP		2888-6	18.9000
10/11/2022	LABCORP		9318-7	10.0000
09/21/2022	LABCORP		10834-0	2.1000
09/21/2022	LABCORP		11580-8	2.8800
09/21/2022	LABCORP		13457-7	107.0000
09/21/2022	LABCORP		13458-5	26.0000
09/21/2022	LABCORP		1751-7	4.3000
09/21/2022	LABCORP		1759-0	2.0000
09/21/2022	LABCORP		17861-6	9.1000
09/21/2022	LABCORP		1975-2	0.4000
09/21/2022	LABCORP		1968-5	1.0000
09/21/2022	LABCORP		2028-9	26.0000
09/21/2022	LABCORP		2075-0	106.0000
09/21/2022	LABCORP		2085-9	37.0000
09/21/2022	LABCORP		2093-3	170.0000
09/21/2022	LABCORP		2132-9	626.0000
09/21/2022	LABCORP		2160-0	1.0500
09/21/2022	LABCORP		2284-8	>20.0
09/21/2022	LABCORP		2345-7	117.0000
09/21/2022	LABCORP		2571-8	144.0000
09/21/2022	LABCORP		2823-3	3.9000

Tier 2 Care Plan continued

09/21/2022	LABCORP	2885-2	6.4000
09/21/2022	LABCORP	2951-2	142.0000
09/21/2022	LABCORP	3094-0	20.0000
09/21/2022	LABCORP	3097-3	19.0000
09/21/2022	LABCORP	4544-3	40.3000
09/21/2022	LABCORP	4548-4	5.9000
09/21/2022	LABCORP	53115-2	0.0000
09/21/2022	LABCORP	5905-5	14.0000
09/21/2022	LABCORP	6[illegible]2-8	69.7000
09/21/2022	LABCORP	6[illegible]2	4.4000
09/21/2022	LABCORP	704-7	0.0000
09/21/2022	LABCORP	706-2	1.0000
09/21/2022	LABCORP	711-2	0.1000
09/21/2022	LABCORP	713-8	3.0000
09/21/2022	LABCORP	71695-1	1.0000
09/21/2022	LABCORP	718-7	13.5000
09/21/2022	LABCORP	731-0	1.0000
09/21/2022	LABCORP	736-9	23.0000
09/21/2022	LABCORP	742-7	0.6000
09/21/2022	LABCORP	751-8	2.6000
09/21/2022	LABCORP	770-8	58.0000
09/21/2022	LABCORP	777-3	186.0000
09/21/2022	LABCORP	785-6	29.7000
09/21/2022	LABCORP	786-4	33.5000
09/21/2022	LABCORP	787-2	89.0000
09/21/2022	LABCORP	788-0	13.1000
09/21/2022	LABCORP	789-8	4.5500
09/21/2022	LABCORP	98979-8	55.0000
09/21/2022	LABCORP	UNLOINC	PRC
09/21/2022	LABCORP	UNLOINC	SPRCS

Tier 3 Care Plan

TIER 3 CARE PLAN

CREATE DATE: [redacted]
LAST UPDATE DATE: [redacted]
LAST SENT DATE: [redacted]

MEMBER NAME: [redacted] GENDER: [redacted] DOB: [redacted]
ADDRESS: [redacted]

CARE PLAN OVERVIEW

Your patient is actively participating in the Health Plan's Care Management Program. Participation includes the creation of an Individualized Care Plan (ICP) that addresses the patient's health care needs identified through telephonic nursing assessment, clinical variables and claims review. This care plan was developed in collaboration with your patient (our member) and is being sent to you for review and consideration. We welcome your feedback and will routinely share care plan updates with you as a in support in your overall care delivery for this patient.

As noted in our SNP Care Plan Manual and our Provider SNP training, the health plan relies on the member's Primary Care Provider (PCP) for ultimate care planning and service coordination as their medical home. The health plan supports your in this endeavor as an integral part of the patient's care team through our Utilization Management and Care Management Programs inclusive of care gap targeted outreach, periodic assessment and wellness promotion.

If you have any feedback on the care plan provided below, please fax to 1-888-214-0794 or if you would like to speak with someone in the Health Plan's Care Management Department you can call 1-888-211-9911.

CARE TEAM

CASE MANAGER:

(1) [redacted]

INTERDISCIPLINARY CARE TEAM (ICT):

(1) [redacted]

CLINICAL PRACTICE GUIDELINES

The Health Plan recognizes the value of Clinical Practice Guidelines in assisting practitioners, staff and members in consideration of appropriate health care for specific clinical circumstances. Clinical Practice Guidelines are adopted from published, nationally and professionally recognized sources. They are used when developing/conducting assessments and are available to case management staff during other care management activities. Please refer to the Health Plan Care Plan Manual add/or the provider section of the Health Plan website for applicable Clinical Practice Guidelines.

PROBLEMS, INTERVENTIONS & GOALS

Tier 3 Care Plan continued

ENDOCRINE - MEMBER HAS DIABETES

CREATED DATE: [redacted] **CREATED BY:** [redacted]

INTERVENTION(S)

(1) PROVIDE EDUCATION REGARDING IMPORTANCE OF ADEQUATE DIET.

INTERVENTION DATE	NOTES
[redacted]	- Case Review/Conference MET
[redacted]	- Case Review/Conference MET
[redacted]	- Case Review/Conference

(2) PROVIDE MEMBER WITH INFORMATION ON DIABETES DIET AND EXERCISE.

INTERVENTION DATE	NOTES
[redacted]	- Case Review/Conference MET
[redacted]	- Case Review/Conference

SHORT/LONG TERM GOAL(S)

(1) IMPROVED BLOOD SUGAR CONTROL TO REACH TARGET.

EVALUATION DATE	STATUS
[redacted]	Goal Met - Parially

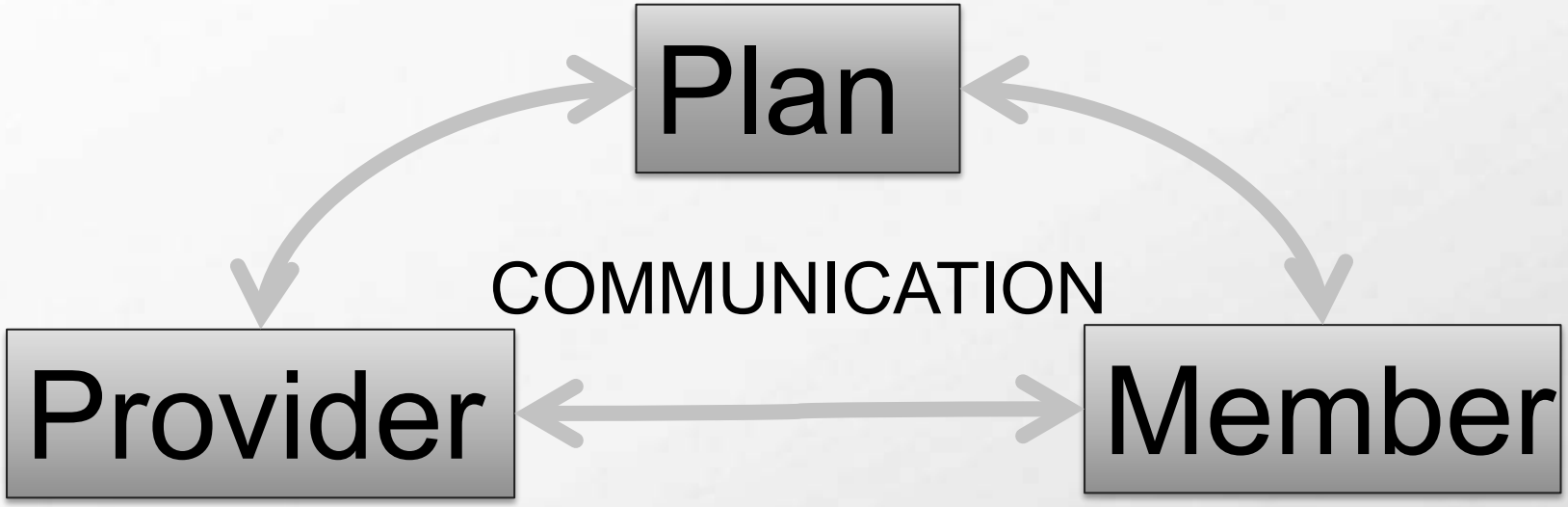
(2) MBR WILL VERBALIZE UNDERSTANDING OF BENEFITS OF REGULAR EXERCISE/ACTITVITY

EVALUATION DATE	STATUS
[redacted]	Goal Met - Parially

(3) MEMBER UNDERSTANDS HEALTH BENEFIT OF DIET ADHERENCE.

EVALUATION DATE	STATUS
[redacted]	Goal Met - Parially

Communication Network



Communication Avenues:
- Health Plan web-based Provider Portal
- Provider Manual
- Member-specific written Care Plans
- Faxes and email communication from the Plan
- Face to Face utilizing Provider Relations Reps.
- Provider phone line
- Web-based meetings and conference calls
- Call in line for provider inquiries
- Participation in standing/ad hoc committee meetings

Communication Avenues:
- Health Plan website
- Health Plan Member Portal
- Educational information and SNP Member newsletters
- Member services phone lines
- Emails and calls with Care team members
- Written Care Plans
- Call in line for Member inquiries, complaints & grievances
- Access to toll-free communication
- Direct access to SNP Case/Disease Management through a toll-free phone number with TTY/TDD
- Conference call communication

Additional Communication Avenues/Health Plan Services: Regulatory Agencies, CMS, Community based services, IDCT

Examples of SNP Newsletters Sent Twice Per Year

Quarterly SNP Education Material

FREEDOM HEALTH

What Your Heart Tells You...

A Short Guide to Heart Failure

"Only do what your heart tells you." – Princess Diana

Heart failure can slowly sneak up on you or it can happen quickly. In either case, your heart will tell you something is wrong, speaking through symptoms such as tiredness, weakness or dizziness. Your heart may be sending you a message if you must use extra pillows to help you breathe at night or you wake up gasping for breath. Swollen legs and feet or a dry cough are other signals from your heart that you need to seek help.

What's Going On?

The heart is a pump, sending oxygen-rich blood out to the rest of the body. When the pump isn't working well, blood can congest your lungs, making breathing difficult, or blood may back up in your veins, causing your feet and legs to swell. Do you have coronary artery disease, an enlarged heart, heart valve problems, high blood pressure or lung disease? Any of these can make you more likely to develop heart failure.

LIVING WITH DIABETES

Eating Healthy

Medication Management

Staying Active

Eating Healthy

What You Eat Matters

- Eat more whole grains, fruits, vegetables and lean protein.
- Eliminate trans fats and added sugar.
- Monitor your blood glucose regularly.
- Eat smaller portions, spread throughout the day.
- Limit alcohol consumption.
- Be mindful of your carbohydrates

We all need food for energy. But it's not always easy choosing healthy options. If you have type 2 diabetes, your food choices are especially important. Your body needs insulin to turn food into energy. With type 2 diabetes, that can be a challenge with certain foods.

What You Eat Matters

It's important for your blood glucose to stay in a healthy range. Most doctors agree that your blood glucose range should be 80–130 mg/dl before a meal and less than 180 mg/dl one to two hours after a meal.

Some Helpful Tips on Staying Focused on Your Health

1. Talk To Your Doctor.

A dietician consultant is a great source of information about healthy eating for individuals diagnosed with diabetes. Speak to your doctor about a referral.

2. Plan Your Meals.

Making food choices when you're already hungry can lead to unhealthy choices. Try to plan ahead to make a healthy meal.

3. Monitor Your Blood Glucose.

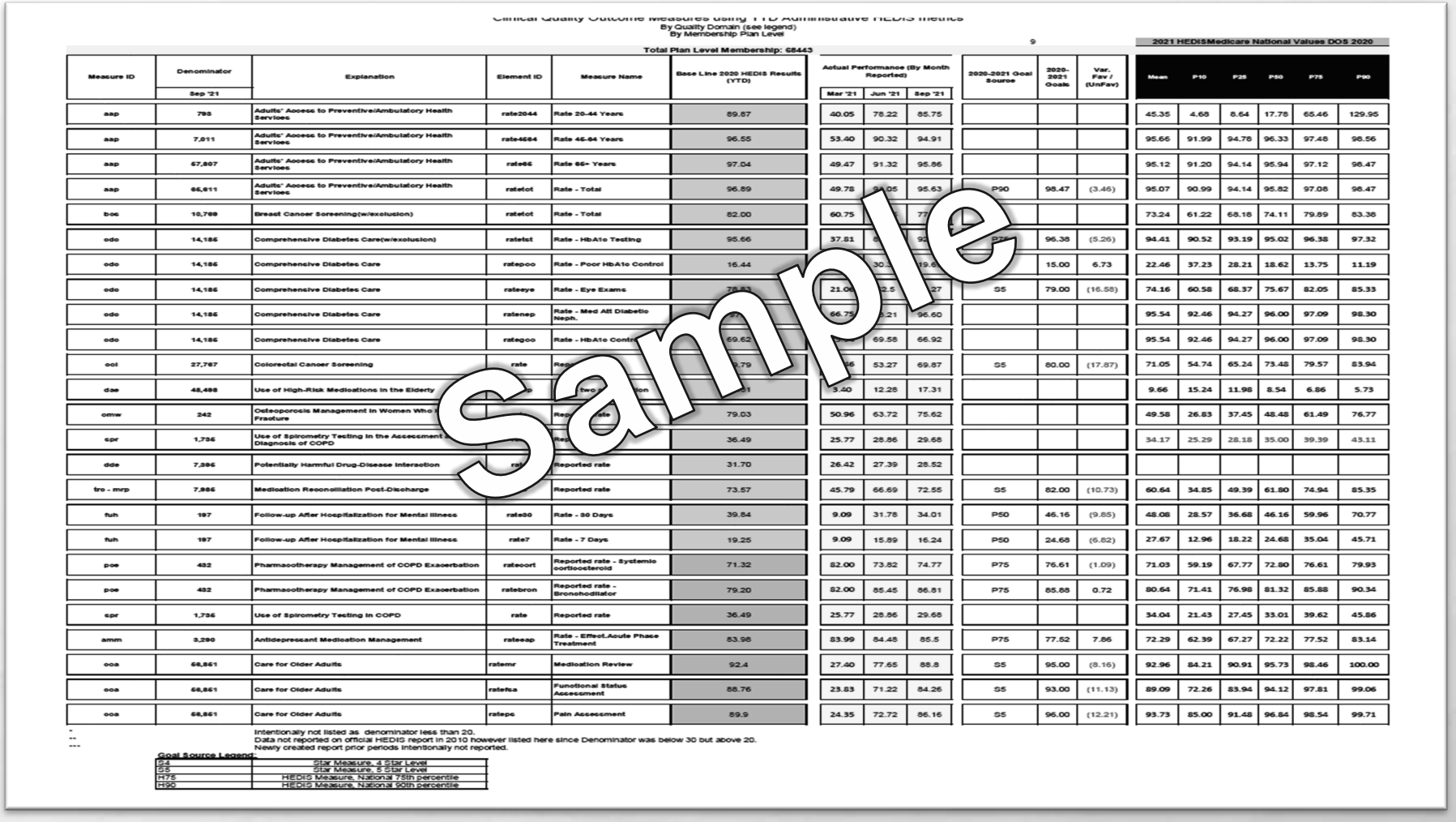
Our bodies are unique and that means everyone responds in a unique way to different foods – even healthy foods. Monitoring your glucose as suggested by your doctor can help you learn how your body responds to different foods.

1

Performance & Health Outcomes Management

- Goals are established according to either internal and/or external benchmarks (for example Medicare or Medicaid national percentiles, NCQA, HEDIS or other accrediting organization/best practice etc.).
- Results of the SNP Member Satisfaction Survey are integrated into the overall performance improvement plan to address issues identified in response to survey.
- Each Special Needs Plan has specific goals relevant to membership.
- The Plan reviews and reports performance on an ongoing basis (Sample on next slide).

Performance & Health Outcomes Management



Clinical Quality Outcome Measures using YTD Administrative HEDIS metrics
By Quality Domain (see legend)
By Membership Plan Level

Total Plan Level Membership: 68443

Measure ID	Denominator Sep '21	Explanation	Element ID	Measure Name	Base Line 2020 HEDIS Results (YTD)	Actual Performance (By Month Reported) Mar '21	Jun '21	Sep '21	2020-2021 Goal Source	2020-2021 Goals	Var. Fav / (UnFav)	2021 HEDIS Medicare National Values DOS 2020 Mean	P10	P25	P50	P75	P90
aap	793	Adults' Access to Preventive/Ambulatory Health Services	rate2044	Rate 20-44 Years	89.87	40.05	78.22	85.75				45.35	4.68	8.64	17.78	65.46	129.95
aap	7,011	Adults' Access to Preventive/Ambulatory Health Services	rate4564	Rate 45-64 Years	96.55	53.40	90.32	94.91				95.66	91.99	94.78	96.33	97.48	98.56
aap	57,807	Adults' Access to Preventive/Ambulatory Health Services	rate65	Rate 65+ Years	97.04	49.47	91.32	95.86				95.12	91.20	94.14	95.94	97.12	98.47
aap	65,611	Adults' Access to Preventive/Ambulatory Health Services	ratetot	Rate - Total	96.89	49.78	91.05	95.63	P90	98.47	(3.46)	95.07	90.99	94.14	95.82	97.08	98.47
bcs	10,788	Breast Cancer Screening(w/exclusion)	ratetot	Rate - Total	82.00	60.75		77				73.24	61.22	68.18	74.11	79.89	83.38
odo	14,186	Comprehensive Diabetes Care(w/exclusion)	ratetst	Rate - HbA1c Testing	95.66	37.81	8	9	P25	96.38	(5.26)	94.41	90.52	93.19	95.02	96.38	97.32
odo	14,186	Comprehensive Diabetes Care	ratepoo	Rate - Poor HbA1c Control	16.44		30.	19.6		15.00	6.73	22.46	37.23	28.21	18.62	13.75	11.19
odo	14,186	Comprehensive Diabetes Care	rateeye	Rate - Eye Exams	76.83	21.06	52.5	27	S5	79.00	(16.58)	74.16	60.58	68.37	75.67	82.05	85.33
odo	14,186	Comprehensive Diabetes Care	ratenep	Rate - Med Att Diabetic Neph.	96.75	66.75	0.21	96.60				95.54	92.46	94.27	96.00	97.09	98.30
odo	14,186	Comprehensive Diabetes Care	rategoo	Rate - HbA1c Contro	69.62		69.58	66.92				95.54	92.46	94.27	96.00	97.09	98.30
col	27,787	Colorectal Cancer Screening	rate	Rep	79	46	53.27	69.87	S5	80.00	(17.87)	71.05	54.74	65.24	73.48	79.57	83.94
dae	48,488	Use of High-Risk Medications in the Elderly		two	31	3.40	12.28	17.31				9.66	15.24	11.98	8.54	6.86	5.73
omw	242	Osteoporosis Management in Women Who Fracture		Rep	79.03	50.96	63.72	75.62				49.58	26.83	37.45	48.48	61.49	76.77
spr	1,736	Use of Spirometry Testing in the Assessment Diagnosis of COPD		Rep	36.49	25.77	28.86	29.68				34.17	25.29	28.18	35.00	39.39	43.11
dde	7,986	Potentially Harmful Drug-Disease Interaction	rate	Reported rate	31.70	26.42	27.39	28.52									
tro - mrp	7,986	Medication Reconciliation Post-Discharge		Reported rate	73.57	45.79	66.69	72.55	S5	82.00	(10.73)	60.64	34.85	49.39	61.80	74.94	85.35
fuh	197	Follow-up After Hospitalization for Mental Illness	rate30	Rate - 30 Days	39.84	9.09	31.78	34.01	P50	46.16	(9.85)	48.08	28.57	36.68	46.16	59.96	70.77
fuh	197	Follow-up After Hospitalization for Mental Illness	rate7	Rate - 7 Days	19.25	9.09	15.89	16.24	P50	24.68	(6.82)	27.67	12.96	18.22	24.68	35.04	45.71
poe	432	Pharmacotherapy Management of COPD Exacerbation	rateoort	Reported rate - Systemic corticosteroid	71.32	82.00	73.82	74.77	P75	76.61	(1.09)	71.03	59.19	67.77	72.80	76.61	79.93
poe	432	Pharmacotherapy Management of COPD Exacerbation	ratebron	Reported rate - Bronchodilator	79.20	82.00	85.45	86.81	P75	85.88	0.72	80.64	71.41	76.98	81.32	85.88	90.34
spr	1,736	Use of Spirometry Testing in COPD	rate	Reported rate	36.49	25.77	28.86	29.68				34.04	21.43	27.45	33.01	39.62	45.86
amm	3,290	Antidepressant Medication Management	rateeap	Rate - Effect.Acute Phase Treatment	83.98	83.99	84.48	85.5	P75	77.52	7.86	72.29	62.39	67.27	72.22	77.52	83.14
ooa	66,861	Care for Older Adults	ratemr	Medication Review	92.4	27.40	77.65	88.8	S5	95.00	(8.16)	92.96	84.21	90.91	95.73	98.46	100.00
ooa	66,861	Care for Older Adults	ratefsa	Functional Status Assessment	88.76	23.83	71.22	84.26	S5	93.00	(11.13)	89.09	72.26	83.94	94.12	97.81	99.06
ooa	66,861	Care for Older Adults	ratepc	Pain Assessment	89.9	24.35	72.72	86.16	S5	96.00	(12.21)	93.73	85.00	91.48	96.84	98.54	99.71

Sample

* Intentionally not listed as denominator less than 20.
** Data not reported on official HEDIS report in 2010 however listed here since Denominator was below 30 but above 20.
*** Newly created report prior periods intentionally not reported.

Goal Source Legend:

S4	Star Measure, 4 Star Level
S5	Star Measure, 5 Star Level
H75	HEDIS Measure, National 75th percentile
H90	HEDIS Measure, National 90th percentile

References

- Clinical Practice Guidelines
- Care Plan Manual
- Resources on Plan websites:
  - ✓ Provider and Member Newsletters
  - ✓ Provider Manual
  - ✓ Educational Material

Training Documentation

Reminder To Complete Training Attestation

Please remember to complete the training attestation after reviewing this document.

You will either have been provided a hard copy form to sign **or** a link to access to complete the attestation.

ATTESTATION OF COMPLETION OF TRAINING
Regarding Special Needs Plans

Question #	Question	Correct Answer
1.	The Primary Care Physician (PCP) is the Medical Home for Members in a SNP plan. True or False	**True**
2.	Beneficiaries who qualify for both Medicare and Medicaid are called: A. SNP Members B. Dual Eligible C. Age-Ins D. None of the above	**B. Dual Eligible**
3.	Dual eligible members must retain Medicaid eligibility in order to remain in the SNP. True or False	**True**
4.	The Health Plan offers Dual & Chronic SNPs to eligible members. True or False	**True**
5.	_____ are goals of our SNP Program. A. Enhance quality of care and quality of life. B. Partnership and collaboration with PCP's. C. Reduce hospital admission rate. D. All of the above.	**D. All of the above**

I have reviewed and completed the required education regarding the Health Plans Special Needs Programs.

Please check the appropriate type of education (initial or annual re-education):

[ ] Initial Education [ ] Annual Education

Please check the appropriate person receiving the education

[ ] Health Plan/Beacon Employee [ ] Primary Care Physician

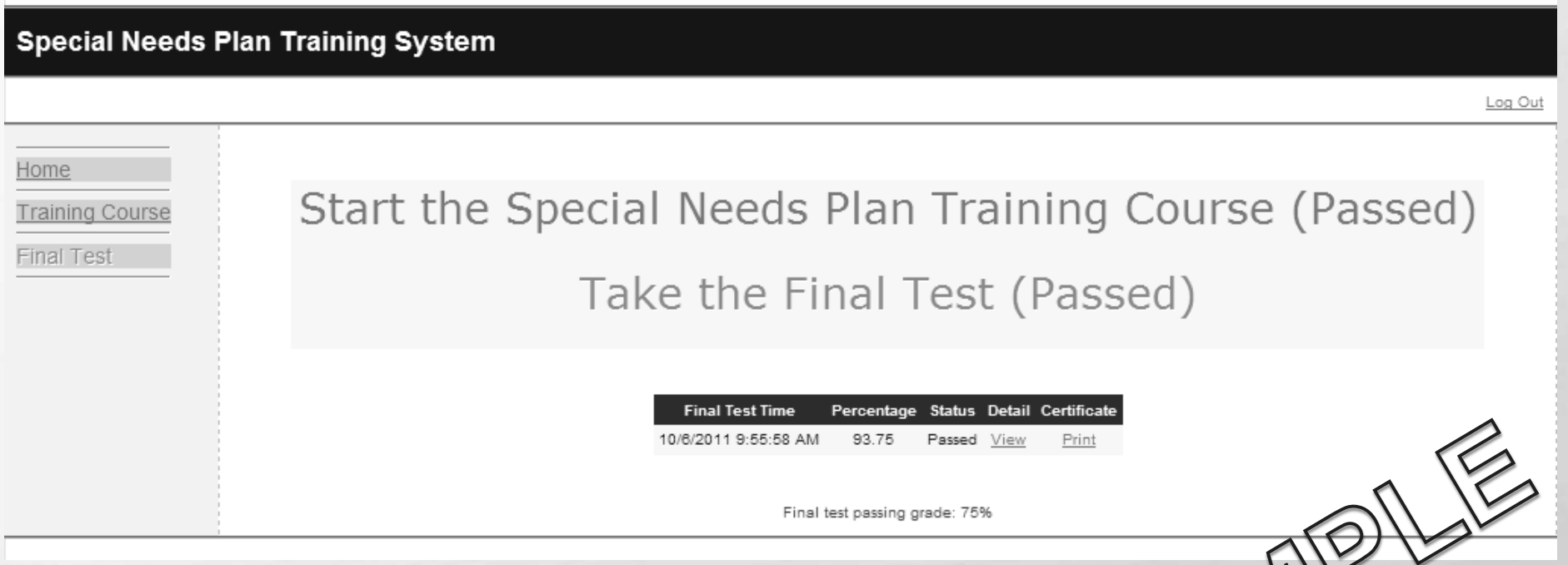
_____
Department

_____
Print Name

_____ _____
Signature Date of Completion

☐ For each Physician who has received education, attach a completed attestation to the Primary Care Physicians list.

SNP Model of Care Training



SAMPLE