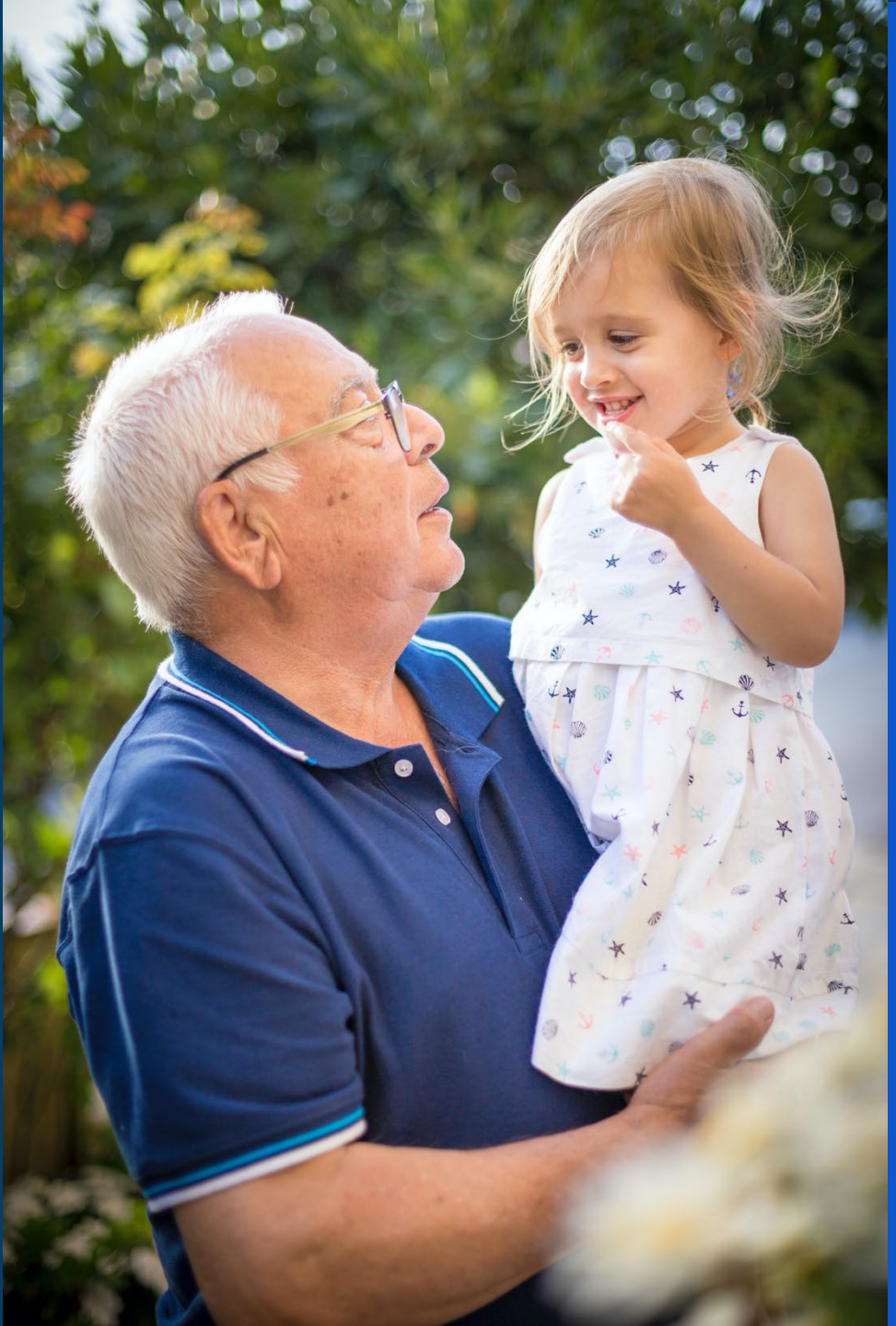


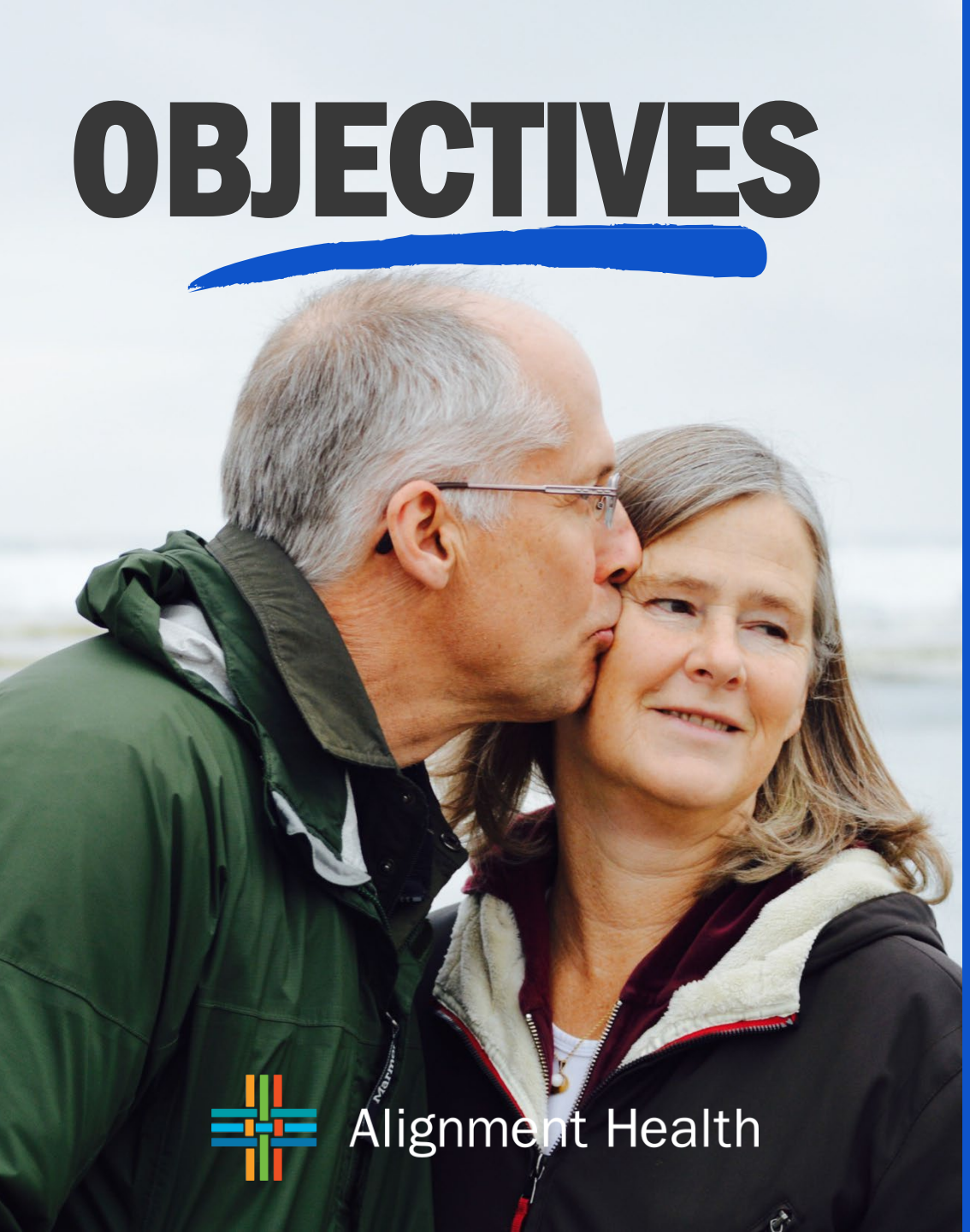
Alignment Health

A NEW ERA OF AGING

SPECIAL NEEDS PLAN (SNP) MODEL OF CARE

PROVIDER TRAINING 2022/2023

OBJECTIVES



The 2022/2023 SNP MOC Training will cover the following:

1. Overview of Special Needs Plans (SNPs)
    - SNP Types
    - Eligibility Criteria
2. SNP Model of Care Requirements
    - MOC Requirements
    - MOC Goals
    - MOC Structure
        - SNP MOC Population Description
        - Care Coordination
        - Provider Network
        - MOC Performance and Quality Outcomes
3. Alignment C-SNP Programs by State
4. Alignment D-SNP Programs by State
5. Provider Responsibilities

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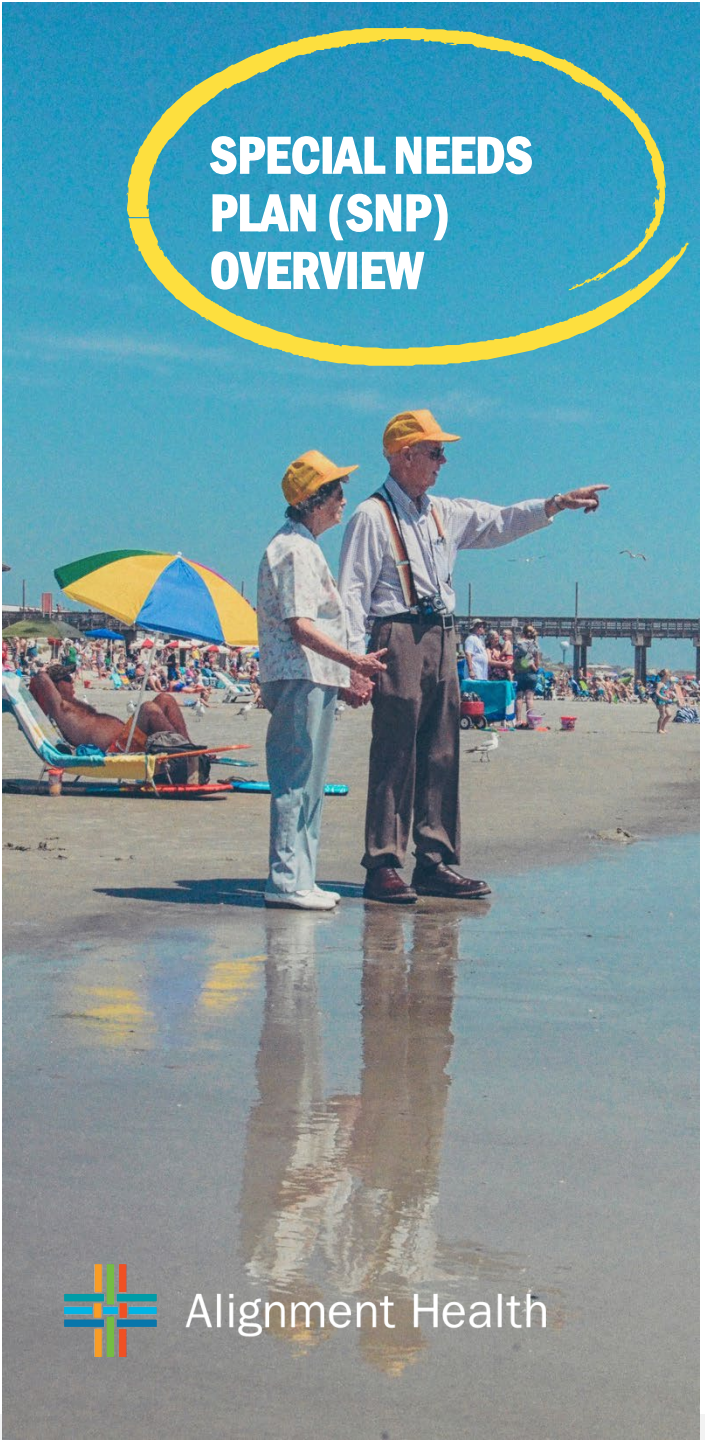
SPECIAL NEEDS PLAN OVERVIEW



SPECIAL NEEDS PLAN OVERVIEW

- The Medicare Act of 2003 established a Medicare Advantage coordinated care plan (CCP) that is designed to provide targeted care to individuals with special needs and certain vulnerable groups of Medicare beneficiaries
- Special Needs Plans (SNPs) are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage
- A SNP can be any type of MA CCP including a health maintenance organization (HMO) plan, an HMO point of service (HMO-POS) plan or a local or regional preferred Provider organization (i.e., LPPO or RPPO).
- SNP Plans provide coverage for at risk populations who have multiple conditions and barriers to participating in self-care management
- SNP Plans provide Members with guidance and resources that help provide access to benefits and information
- Medicare Mandates that the health plan provides initial and annual training to Providers and employees who deliver care to Alignment SNP Members

SPECIAL NEEDS PLAN (SNP) TYPES

CMS OFFERS THREE TYPES OF SNP PLANS:

Dually Eligible (D-SNP or DE-SNP)

- Members who qualify for both Medicare and Medicaid coverage.

Chronic Condition (C-SNP)

- Members with specific severe or disabling chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AIDS

Institutional (I-SNP)

- Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long-term care facility – defined as skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long-term care facility.

ALIGNMENT'S HEART & DIABETES C-SNP PLAN ELIGIBILITY

CHRONIC SPECIAL NEEDS PLAN HEART & DIABETES PROGRAMS

C-SNP programs are available to eligible Members who meet the qualifying conditions below-

1. Reside within the program's identified service areas
2. Have a **qualifying chronic condition** confirmed by their Provider within 60 days of enrollment
3. Qualifying conditions for this C-SNP plan must include at least one following confirmed conditions:
   - ❑ Diabetes Mellitus
   - ❑ Chronic Heart Failure
   - ❑ Cardiovascular Diagnoses
     - Cardiac Arrhythmias
     - Coronary Artery Disease
     - Peripheral Vascular Disease
     - Chronic Venous Thromboembolic Disorder

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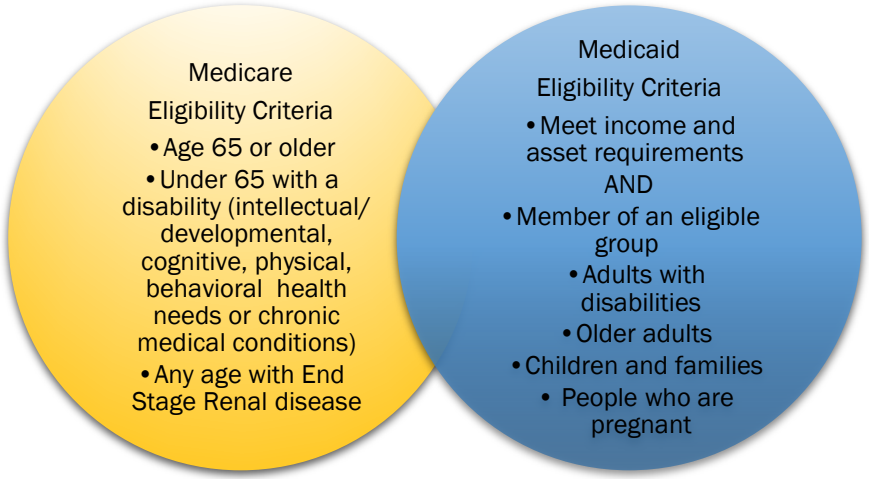
DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) ELIGIBILITY

DUAL ELIGIBLE SPECIAL NEEDS PROGRAMS

A Dual Eligible Special Needs Plan (D-SNP) is available **to qualified seniors and individuals with disabilities** who meet the qualifying criteria listed below:

1. **Meet dual eligibility** status requirements
   - ❑ enrollment in a federally administered Medicare program based on age and/or disability status
   - ❑ The state-administered Medicaid program based on low income and assets
2. Reside within the program's identified service areas
3. Qualify for **BOTH** Medicare **and** Medicaid Benefits
4. Must verify Medicaid eligibility on a monthly basis after enrollment



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DUAL ELIGIBLE SNP PLANS (CONT.)

DUAL ELIGIBLE SPECIAL NEEDS PROGRAMS

- Medicare coverage is primary; Medicaid coverage supplements Medicare coverage
- D-SNP Members are "cost-share protected" meaning the state Medicaid program pays the Member's Medicare (Parts A and B) cost share (copayments, deductibles, coinsurance).
- A D-SNP Member is not responsible for any costs and the Provider cannot balance bill the Member.
- Some D-SNPs are "integrated," meaning the Health Plan administers both Medicare and Medicaid benefits
- D-SNPs must have a State Medicaid Agency Contract (SMAC) that lists all the requirements imposed by the state including at least certain federal minimum requirements
- All D-SNPs must assist Members with Care Coordination and accessing both Medicare and Medicaid benefits, even if the DSNP does not administer the Medicaid benefit

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ALIGNMENT SUMMARY OF SNP PLANS 2022/2023

IN 2022, ALIGNMENT CURRENTLY OFFERS BOTH CHRONIC AND DUAL SNPS

Existing SNP Plans

- **Dual Eligible SNPs (D-SNPs)-**
  - California
  - North Carolina
  - Nevada
- **Chronic Condition SNP (C-SNP) for** Diabetes, Congestive Heart Failure & Cardiovascular Disease
  - California
  - Nevada
  - Arizona
- **Chronic Condition SNP (C-SNP) for** End Stage Renal Disease
  - California

New in 2023 SNP Plans

- **Dual Eligible SNPs (D-SNPs)-**
  - Nevada (PPO)
  - Florida (HIDE)
- **Chronic Condition SNPs (C-SNPs)-Diabetes,** Congestive Heart Failure & Cardiovascular Disease C-SNP
  - North Carolina
  - Texas
  - Florida

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SNP MODEL OF CARE (MOC) REQUIREMENTS

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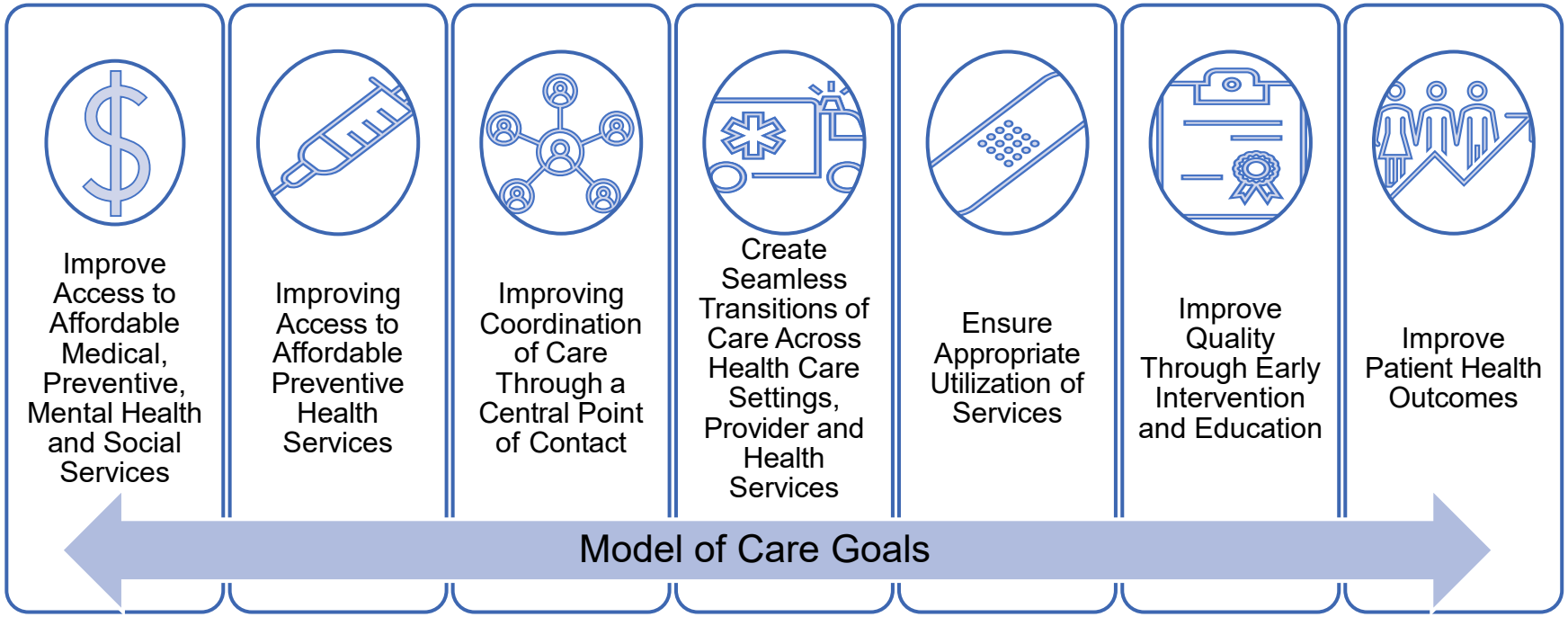
SNP MODEL OF CARE REQUIREMENTS

SNP MODEL OF CARE REQUIREMENTS

- The Model of Care (MOC) is a document that Alignment submits to Medicare to describe how Alignment works to successfully deliver care and services to the SNP Members
- The MOC is a fundamental component of SNP Quality Improvement, so CMS requires the National Committee for Quality Assurance (NCQA®) to review and approve all SNP MOCs based on standards and scoring criteria established by CMS.
- The Model of Care outlines extra, and unique services offered to the Special Needs population
- A Model of Care is required for each SNP type
- The Model of Care includes how Alignment measures the effectiveness of the MOC and the care provided to the SNP Members

OVERALL MODEL OF CARE GOALS



SNP MOC STRUCTURE

THE SNP MOC REQUIREMENTS BY NCQA® AND CMS COMPRISE THE FOLLOWING CLINICAL AND NON-CLINICAL STANDARDS:

SNP Population

- Documentation of how the health plan will determine, verify and track eligibility
- Detailed profile of medical, social, cognitive, environmental conditions, etc. associated with SNP population
- Health conditions impacting beneficiaries & plan for especially vulnerable beneficiaries

Care Coordination

- SNP staff structure, roles and training defined
- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Face-to-Face Visit (F2F)
- Interdisciplinary Care Team (ICT)
- Care Transitions (CT)

Provider Network

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network
- Use of clinical practice guidelines & care transition protocols by Providers
- MOC training for Provider network

Quality Measurement & Performance

- Quality Measure Monitoring
- Measurable goals & health outcomes for the MOC
- Measure patient experience of care surveys and analyze integrated results
- SNP Model of Care Program Evaluation (annual)
- Quality Improvement Plan


SNP POPULATION
DESCRIPTION
Alignment Health

DESCRIPTION OF THE ALIGNMENT'S C-SNP POPULATION

DESCRIPTION OF THE ALIGNMENT'S C-SNP POPULATION

Most Vulnerable Members

- Alignment SNP focuses on the vulnerable sub-population of Members who are at highest risk of poor outcomes
- The Members are identified using Alignment Health Plan's proprietary software that is algorithm based and identifies census information, gaps in care, pharmacy information, HEDIS® information, and predicts risk scores for Alignment Members

Overall SNP Population

- A Population Assessment was conducted to build a Model of Care that will properly serve Alignment Members' needs. Factors we identified include but are not limited to:
    - Age of current Alignment C-SNP Members range from 18-99 years old
    - There are slightly more males than females enrolled in the Alignment C-SNP plan
    - Caucasian, Hispanic and Asian are top 3 ethnicities within the Alignment C-SNP plan
    - Spanish is the preferred language followed by English

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DESCRIPTION OF THE ALIGNMENT D-SNP POPULATION

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of-life – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

CARE COORDINATION

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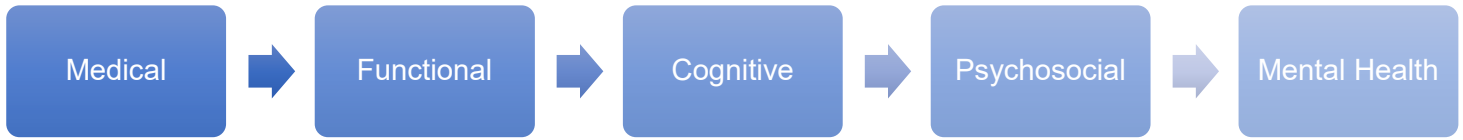
THE HEALTH RISK ASSESSMENT (HRA)

THE HEALTH RISK ASSESSMENT (HRA)

- A Health Risk Assessment (HRA) is required for **all** Members enrolled in a SNP Plan
- The HRA is a tool used to identify Member risk levels including but not limited to Health, Functional, Cognitive, Psychosocial / Mental Health
- Alignment uses HRA risk leveling to identify Member needs to provide better coordination of care and to improve health outcomes while reducing overall cost.
- Alignment attempts to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the Member and Member's Provider (ICT)
- Patients have the right to refuse to complete the HRA
- HRA completion rates (initial and reassessments) are CMS STAR Measures!
- HRAs can be completed via telephone, e-mail, paper, virtually or in-person
- An HRA Assesses needs related to:



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SAMPLE HEALTH RISK ASSESSMENT TOOL (HRAT)

ALIGNMENT HEALTH PLAN

Annual Health and Wellness Assessment
Health and Wellness or Prevention Information

Member Name: _____ **DOB:** _____

Date Completed: _____ **Phone #:** _____

Instructions: Please read each question and mark the box like this ☒ for your answer. Thank you.

1. **In general, how would you describe your health?**
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. **With whom do you live?** *(Select all that apply)*
   ☐ Spouse ☐ Child(ren) ☐ Alone ☐ Other
3. **Are you currently or have you ever been homeless?**
   ☐ No ☐ Currently homeless ☐ Previously homeless
4. **Do you have a caregiver or other support?** *(Someone who does things for you like drivi… cooking or shopping because you are unable to do them on your own.)*
   ☐ No ☐ Yes
5. **Do you smoke/use tobacco products?**
   ☐ No ☐ Yes
6. **How many times in the past year have you used a recreational drug or prescription medication for non-medical reasons?** *(For example, because of the way it made you feel)*
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
7. **How often do you drink alcohol?**
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
8. **Have you had any falls this year?**
   ☐ No ☐ Yes
9. **With "1" being no pain and "10" being the worst pain, how do you rate your pain?**
   ☐ 1 (no pain) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
10. **Is it hard for you to concentrate, remember things or make decisions?**
    ☐ No ☐ Yes
11. **During the past month, have you often been bothered by feeling down, depressed, or hopeless?**
    ☐ No ☐ Yes
12. **During the past month, have you been bothered by little interest or pleasure in doing things?**
    ☐ No ☐ Yes

ALIGNMENT HEALTH PLAN

Member Name:_____

13. **Do you need help with any of the following activities?** *(Select all that apply)*
    ☐ No help needed ☐ Bathing ☐ Mobility (walking) on level surfaces
    ☐ Feeding ☐ Grooming ☐ Stairs
    ☐ Toilet Use ☐ Dressing ☐ Transfers (bed to chair and back)
14. **What types of medical equipment do you use?** *(Select all that apply)*
    ☐ None ☐ CPAP Machine ☐ Cane ☐ Ostomy Supplies
    ☐ Blood pressure ☐ Nebulizer ☐ Walker ☐ Scooter or Power-Operated Vehicle
    ☐ Glucometer ☐ Oxygen ☐ Wheelchair ☐ Hospital Bed
    ☐ Other

Ha… you b… hosp…lized or vi… the Emergency Room in the last 12 months?
☐ … ☐ Y…

Are … being treate… have you been told you have any of the following?
(Sele… l that apply)
☐ Kidney Dialysis
☐ Lung Disease *(COPD/Emphysema)*
☐ Diabetes *(sugar diabetes or too much sugar in your blood)*
☐ High Blood Pressure
☐ Mental Health Need *(Anxiety, Depression, Schizophrenia, or Bipolar Disorder)*
☐ Stroke/TIA
☐ Heart Failure or Enlarged Heart
☐ Heart problems *(irregular heartbeat, heart attack or heart surgery)*
☐ Cancer
☐ None of the above

17. **Are you on five (5) or more medications?**
    ☐ No ☐ Yes
18. **Do you have an Advance Directive for healthcare?** *(A written statement of your wishes regarding medical treatment)*
    ☐ No ☐ Yes
19. **Do you receive Medicaid benefits?**
    ☐ No ☐ Yes

Thank you for completing your Annual Health Assessment.

Please return to Alignment Health Plan in the envelope provided. A nurse will call you to learn more about your health care needs.

HRAT RISK LEVELING

HRAT RISK LEVELING

Alignment uses HRA risk leveling to identify Member needs to provide better coordination of care and to improve health outcomes while reducing overall cost.

Using the HRA assessment results, the Member at-risk score, and the available information obtained from claims, authorizations, AVA™ and/or the Comprehensive Nursing Assessment, a stratification/acuity score and Intensity score is assigned

STRATIFICATION LEVEL EXAMPLE

Stratification Level	Score	Risk Level Identification
High risk	>30	• Member's self-reported health status is poor • May have multiple high risk or co-morbid chronic conditions • Limited or no support and resources • Daily alcohol/drug use • Environment with high-risk safety or accessibility issues • Multiple hospitalizations/ readmissions • New hospital discharge • Homelessness • Kidney Dialysis
At risk	15-30	• Member's self-reported health status is good or fair • May have one or more physical or behavioral conditions • Limited support and resources • Current smoker • Moderate alcohol or drug use • Environment with safety or accessibility issues
Low Risk	<15	• Member's self-reported health status is excellent or very good • May have minimal physical or behavioral conditions • Engaged support and resources • Safe and accessible environment
Unknown-Member's acuity cannot be assessed	0	• Members who did not complete the HRA after multiple attempts, who are Unable to Contact (UTC) after completing the paper HRA or who decline to participate in the HRA or CM process

CARE PLAN DEVELOPMENT

CARE PLAN DEVELOPMENT

- The HRA is the tool used for evaluating the Member's current health status. The Care Plan documents ongoing plan of action to address the Member's care needs with the Member and the ICT
- An initial care plan is developed from the HRA results within 30 CD of completion of the HRA and updated when a Member's health care needs change
- The HRA results are used to develop or update a Member's Basic (BCP) or Individualized Care Plan (ICP) and to stratify the Member into risk categories for Care Management and Coordination
- BCPs are created based on the practice guidelines for the Member's qualifying condition and other conditions identified through the HRA completion or information available at the time of care plan creation
- ICP is developed and maintained for each engaged/participating SNP Member and is created from the HRA and the comprehensive assessment to develop personalized interventions and goals

Interdisciplinary Care Team (ICT)

Interdisciplinary Care Team (ICT)

- The Interdisciplinary Care Team (ICT) is Member-centric and based on a collaborative approach.
- The ICTs overall care management role includes Member and caregiver evaluation, re-evaluation, care planning and plan implementation, Member advocacy, health support, health education, support of the Member's self-care management and ICP evaluation and modification as appropriate.
- Both C-SNP and D-SNP Members must have an Interdisciplinary Care Team that is based on the Member's medical and psychosocial needs as determined by the HRA and Care Plan
- The Member, the Care Manager and the PCP, at a minimum, make up the ICT, but might also include Social Workers, Pharmacists, Medical Director, Specialists or other treating Physicians
- ICT information is communicated through various methods including:
    - The CM system documentation
    - Telephonic communication with Member/caregiver and Provider
    - Written ICT meeting minutes
    - Documentation within the Member's ICP

INTERDISCIPLINARY CARE TEAM- ICT

The Interdisciplinary Care Team is developed based on patient needs/requests and facilitates:

- Access to appropriate and person- centered care
- Multidisciplinary approach to support Integrated Care Management
- Development of a comprehensive plan of care
- Communication regarding individualized care plan

The Care Manager(CM)* leads and determines ICT Membership with the patient and can include :

- Patient/caregiver*
- Medical Expertise*
- Social Services Expertise
- Behavioral Health as indicated
- Pharmacist
- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

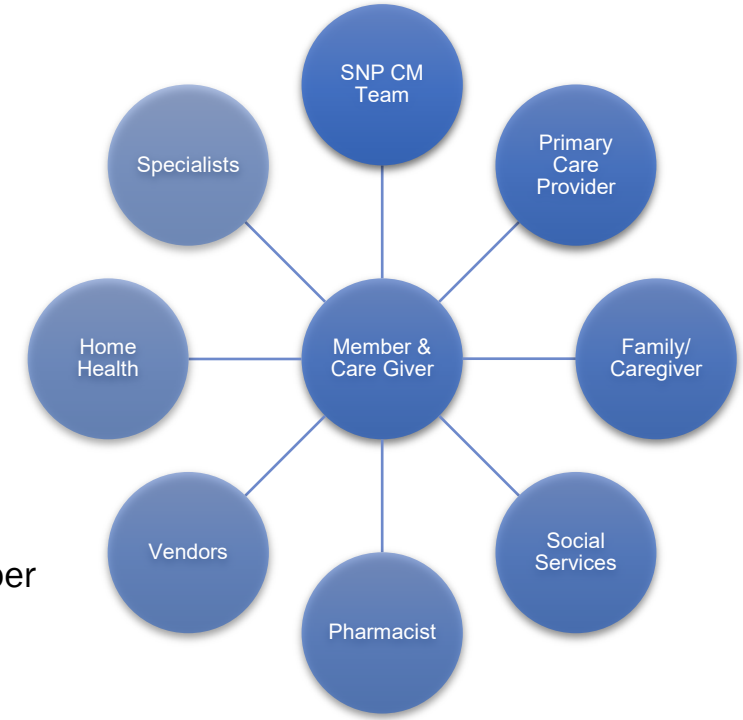
ICT MEETINGS

ICT Members participate based on the Member's needs

CMs keep the team updated with information involving the Member's care plan

ICT meetings are formally conducted at least annually and more frequently based on the patient's needs.

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference
- Exchange of care plan via fax/mail when Member is non-participatory



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FACE-TO-FACE ENCOUNTERS

NEW FOR 2023

FACE-TO-FACE ENCOUNTERS

- Face-to-Face (F2F) Encounters are required on at least an annual basis beginning within the first 12 months of enrollment.
- 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.
- The F2F encounter must be with a Member of the ICT or CM team
- Beginning in 2023, during outreach to the Member, Alignment will offer a virtual visit with a CM to conduct CM assessments or will assist with scheduling a F2F wellness visit with the PCP.
- Alignment's Care Anywhere Practitioners may provide medical or social support through face-to-face visits in the Member's home or through virtual visits when a Member is identified as high-risk and collaborate with the Member's PCP as needed

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CARE TRANSITION

The post-discharge program for C-SNP and D-SNP Members, includes phone calls or visits after being discharged home from the hospital. Members receive a post-hospital call within 10 business days of discharge. During these calls, the CM or Provider:

- Helps the Member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Assists with needed home health and equipment
- Resolves barriers to obtaining medications
- Educates the Member on new or continuing medical conditions

PROVIDER NETWORK

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ALIGNMENT PROVIDER NETWORK

ALIGNMENT PROVIDER PARTNERS RESPOND TO MEMBER'S NEEDS BY:

- Communicating With Care Coordination and Others in The Member's Care Team
- Attending ICT Meetings
- Supporting Care Transitions
- Assisting With Development and Updates to the ICP
- Reviewing and Responding to Patient Specific Information
- Completing Annual Wellness Exams
- Encouraging Medication Adherence
- Promoting Quality Improvement
- Understanding The MOC By Completing The Training

CARE ANYWHERE/ALIGNMENT PRACTITIONERS

- In addition to the Alignment contracted Provider network, Alignment supports the Member and the Primary Care Provider through the Alignment Care Anywhere Program
- The Alignment's Care Anywhere program is a physician led, Advance Practice Clinician (APC) driven model of care designed to support SNP Members who have been identified as benefiting from a comprehensive in-home assessment to address immediate, chronic, and social health care needs
- The CareAnywhere program delivers an extra layer of care services for targeted Members to not only reduce the unnecessary utilization of ER and inpatient services, but also to improve health outcomes and restore humanity in advanced care planning
- All Alignment Contracted Providers, Facilities and Ancillary Providers, undergo a Credentialing process to ensure they meet all Federal And State Credentialing Requirements
- All licensed Practitioners and Providers who have an independent relationship with Alignment Health Plan require credentialing
- Verification of credentialing information is performed by Alignment or its delegate initially prior to contracting and every 3 years after or sooner based on state requirements


Alignment Health
PLAN PERFORMANCE
AND QUALITY OUTCOMES

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QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

- Alignment has a Quality Improvement Plan (QIP) that is specific to the C-SNP or D-SNP MOCs and designed to measure the effectiveness of each MOC
- Data is collected, analyzed and evaluated in order to report on the MOC quality performance improvement
- Specific HEDIS® health outcomes measures are identified in order to measure the impact the MOC has on all SNP Members
- All SNP Program Member satisfaction surveys are utilized to assess overall satisfaction with the MOC
- The results of surveys are used to modify the MOC QIP on an annual basis
- Each year, an annual evaluation of the MOC is performed and the results shared with the stakeholders through the Quality Improvement Committee (QIC)

PROCESS MEASURE SAMPLE

Measure*	Description
Initial HRA Completed Timely (Initial HRA and Annual HRA)	Initial HRA Must be completed within +/- 90 days of effective enrollment
Annual HRA Completed Timely	Annual HRA completed within 365 days of previous HRA
HRA Completed Timely (Initial HRA and Annual HRA)	Combined total of Initial and Annual HRA rates above
Individualized Care Plan Completion	Percent of Members with ICPs created within 30 days post HRA or UTC call cycle or Refusal or within 365
Interdisciplinary Care Team Participation	Engaged Members will be managed by an Interdisciplinary Care Team
Face to Face Visits	Completion of at least one Face to Face encounter annually
Member Engagement	Engaged Members participating in a Care Management Program
Member Experience	Members overall satisfaction with Care Management based on annual Member Satisfaction Survey Results
Member Access to Care	Members overall satisfaction with access to care
Member Complaints	Percent of complaints related to Provider network are less than 20%
Social Services Referrals	D-SNP Engaged Members participating with Social Services or accessing Community Resources

**Measures may not be applicable to all SNP types*

HEALTH OUTCOMES MEASURE SAMPLES

Measure*	Description
Diabetics with controlled HbA1c	Diabetic Members who had evidence of controlled blood sugar (Hba1c ≤ 9)
Medication Adherence for Cholesterol (Statin)	Eligible Members who are adherent to statin therapy
Care of Older Adult (66+): Pain Assessment	Members with documented evidence of being evaluated by the Provider with a Pain Assessment
Care of Older Adult (66+): Medication Review	Members with documented review by prescribing Provider or clinical pharmacist of ALL Member's medications, prescription, OTC and herbal therapies.
Transition of Care follow-up after hospitalization	Members discharged from the hospital will have a telephonic, virtual or in person follow up visit within 30 days
Follow-up after hospitalization for Mental Illness	Members discharged from the BH hospital will have a telephonic, virtual or in person follow up visit within 45 days
Hospitalizations/1000 Members per year	Number of Inpatient hospitalizations per Member month (annualized)
Inpatient Readmission Rate	Reduce the rate of readmissions within 30-days post discharge
Emergency Room Rate/1000 Members per year	Number of ED visits per Member month (annualized)
Transplant Rate	Number of ESRD Member receiving a Transplant
Follow-up after ED visit for people with high-risk Chronic Conditions	Percent of ED visits for Members with multiple high-risk chronic conditions who received a follow-up service within 7 days of the visit
Beta Blocker treatment after Heart Attack (PBH)	Eligible Members who received BB tx for 6 months post dc for Acute MI
Statin therapy for Patients with DM (SPD)	Eligible Members with DM and do not have ASCVD who received and adhered to statin therapy
Statin therapy for patients with CVD (SPC)	Eligible Members with CV disease who received statin therapy
Colorectal cancer Screening (COL)	Eligible Members who receive a colon cancer screening
Osteoporosis Testing (OMW)	Eligible women who have received a bone density test or medication within 6 months of fracture

**Measures may not be applicable to all SNP types*

ALIGNMENT HEALTH PLAN CHRONICSPECIAL NEEDS PLANS

(C-SNP)

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ALIGNMENT HEALTH PLAN-

C-SNP CALIFORNIA

PLAN NAME: HEART & DIABETES HMO

- Existing C-SNP Counties in 2022 include Los Angeles, Orange, San Diego, San Bernardino, San Francisco and Stanislaus Counties
- NEW C-SNP Counties for 2023 include Alameda, Fresno, Madera, Marin, Riverside, San Joaquin, San Luis Obispo, Santa Clara, and Ventura Counties

Counties in Orange are existing 2022 Counties
Counties in Blue are new as of 2023

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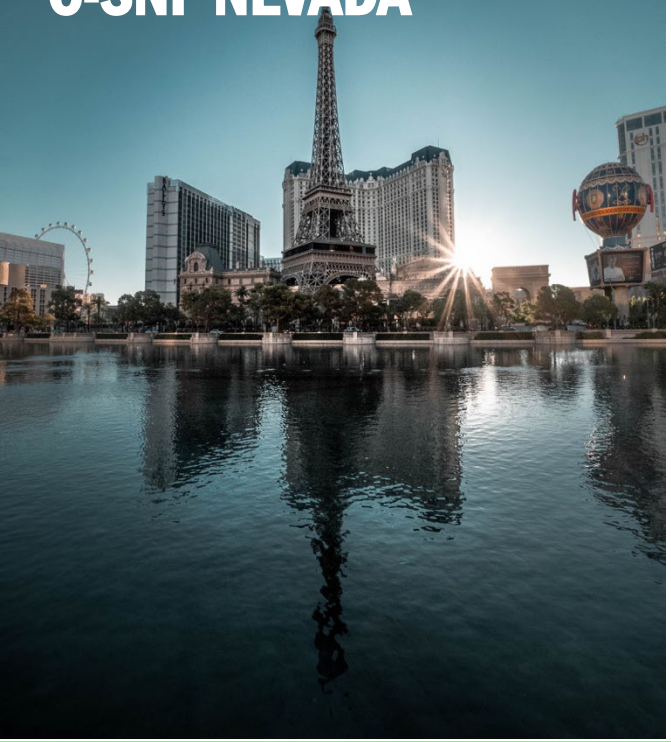
ALIGNMENT HEALTH PLAN- C-SNP NEVADA



PLAN NAME:

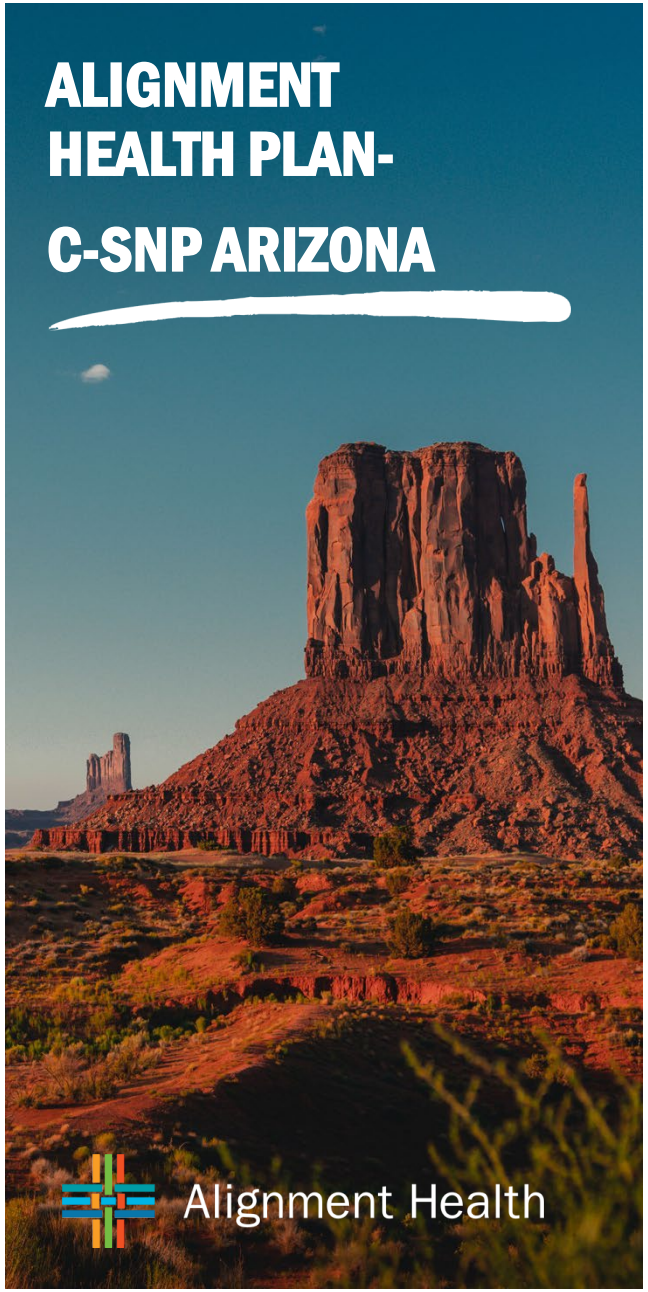
ALIGNMENT HEALTH PLAN HEART & DIABETES

- Existing C-SNP Counties in 2022 Clark, Nye and Washoe Counties
- NEW C-SNP Counties for 2023 include Carson City, Storey and Douglas Counties

Counties in Orange are existing 2022 Counties
Counties in Blue are new as of 2023

ALIGNMENT HEALTH PLAN-

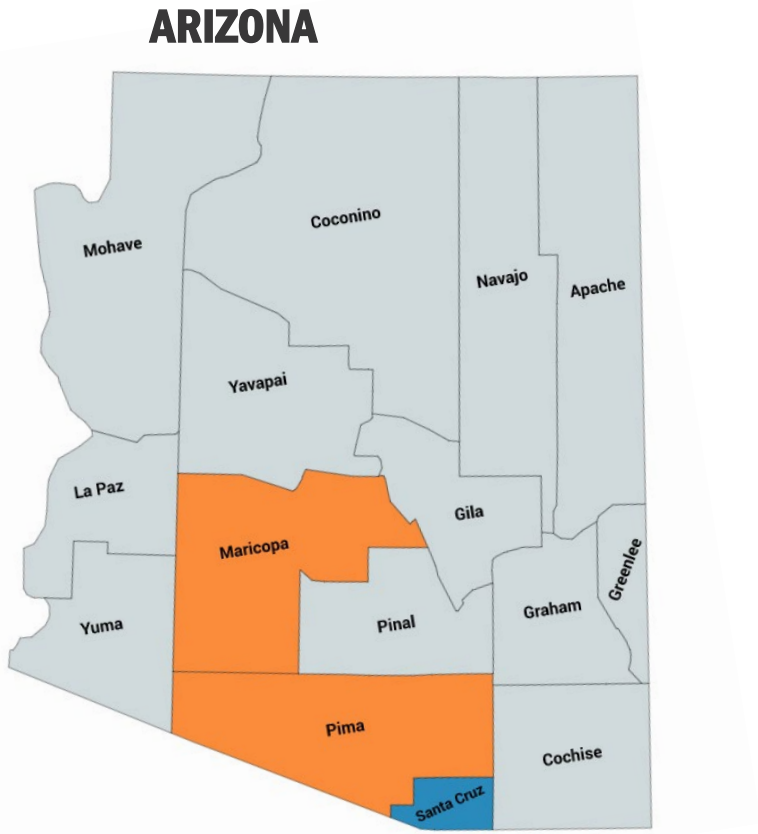
C-SNP ARIZONA



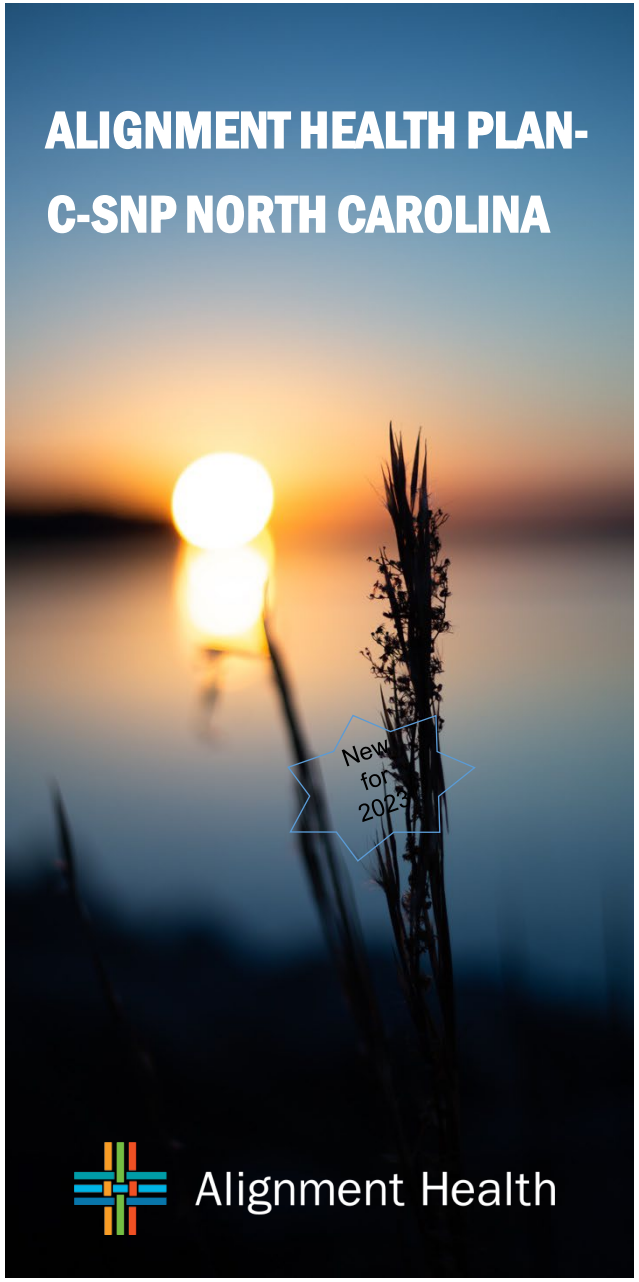
PLAN NAME: ALIGNMENT HEALTH PLAN HEART & DIABETES

- Existing C-SNP Counties in 2022 include Maricopa and Pima Counties
- NEW C-SNP for 2023 is Santa Cruz County

Counties in Orange are existing 2022 Counties
Counties in Blue are new as of 2023

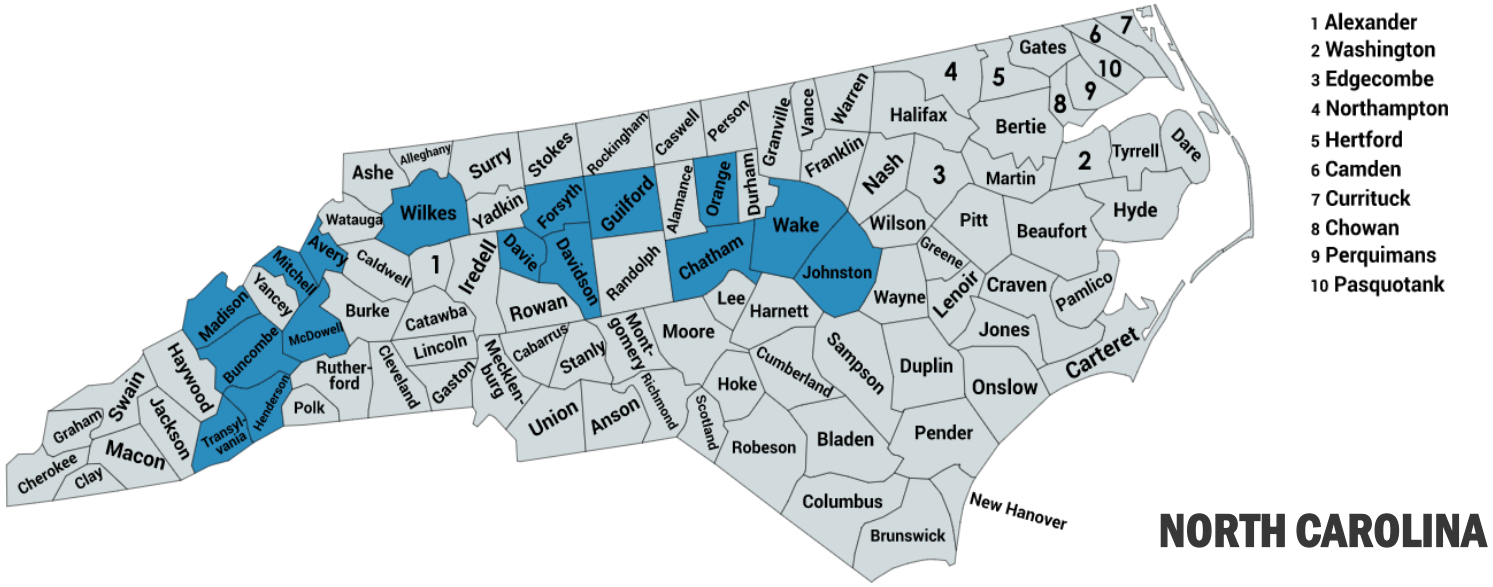


ALIGNMENT HEALTH PLAN- C-SNP NORTH CAROLINA



PLAN NAME: ALIGNMENT HEALTH HEART & DIABETES

- NEW C-SNP Counties for 2023 include Wake, Chatham, Johnston, Guilford, Forsyth, Davidson, Wilkes, Davie, Buncombe, Henderson, McDowell, Transylvania, Madison, Mitchell, Avery, and Orange Counties



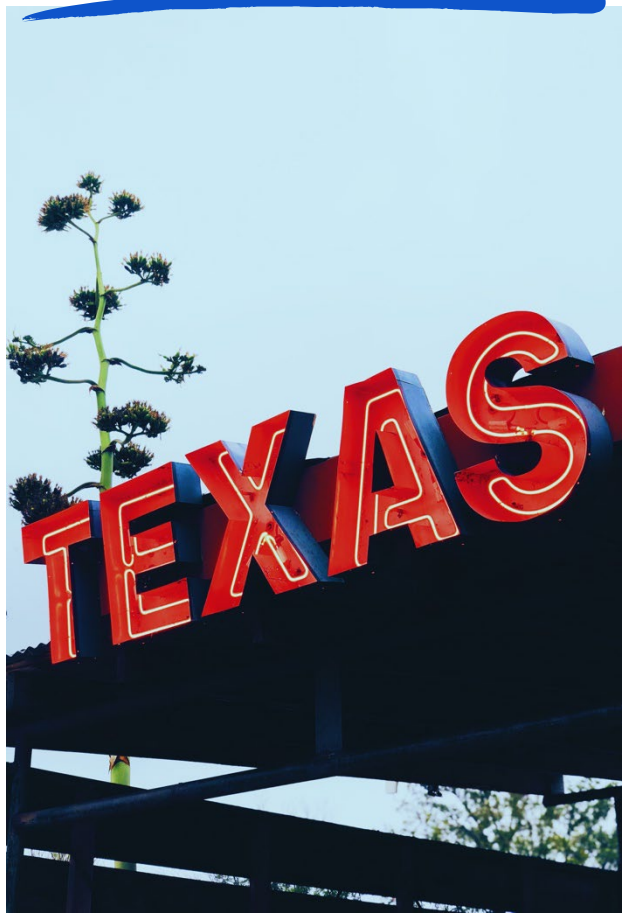
Counties in Blue are new as of 2023

PLAN NAME- ALIGNMENT HEALTH HEART & DIABETES

- NEW C-SNP Counties for 2023 include Duval, Clay, Manatee and Sarasota Counties

Alignment Health

ALIGNMENT HEALTH PLAN- C-SNP TEXAS



PLAN NAME- ALIGNMENT HEALTH HEART & DIABETES

- NEW C-SNP Counties for 2023 include El Paso and Hudspeth Counties

ALIGNMENT HEALTH PLAN C-SNP ESRD ELIGIBILITY

Alignment Health

ALIGNMENT CHRONIC SPECIAL NEEDS END STAGE RENAL DISEASE(ESRD) PROGRAM

The ESRD C-SNP program is available to eligible Members who:

1. Reside within the **Los Angeles County or Orange County** service area
2. Have a **qualifying chronic condition** (ESRD) confirmed by their Provider
3. Qualifying conditions for this ESRD C-SNP plan must include at least one following confirmed conditions:
    - ❑ Kidneys cease functioning
        - Regular course for long-term dialysis
    - ❑ Kidney transplant to maintain life

Alignment Health

ALIGNMENT HEALTH PLAN- C-SNP ESRD PLAN

PLAN NAME: ALIGNMENT HEALTH PLAN ESRD BALANCE

- Existing C-SNP Counties in 2022 include Los Angeles and Orange Counties

CALIFORNIA

Counties in Orange are existing 2022 Counties

ADDITIONAL BENEFITS FOR C-SNP PLANS MAY INCLUDE:

ALIGNMENT C-SNP BENEFIT SUMMARY

- Care Anywhere Evaluations- Annual Wellness Examination
- Preventive and Comprehensive Dental Services
- Routine vision exams and glasses or contact coverage
- Routine preventive screening
- Hearing exams
- Transportation
- Social Needs Benefits-
  - Companion Care- 48 hours per year
  - Monthly Grocery Allowance for food and produce purchase
  - Pet Service- 7 boarding days or 14 walks per year
- Home Delivery Chronic Meal Benefit for up to 14 days (28 meals)
- Over the Counter Medication Benefit- Monthly allowance
- Personal Emergency Response System (PERS)
- Fitness Benefit
- 24/7 ACCESS On-Demand Concierge team helps Members navigate the services and benefits available
- ACCESS On-Demand Concierge Black Card- gives access to concierge service 24 hours a day, 7 days a week and works like a debit card to pay for items, including over the counter (OTC), grocery and Alignment Health Plan healthy rewards

ALIGNMENT HEALTH PLAN

DUAL ELIGIBLE SPECIAL NEEDS PLANS

(D-SNP)

Alignment Health

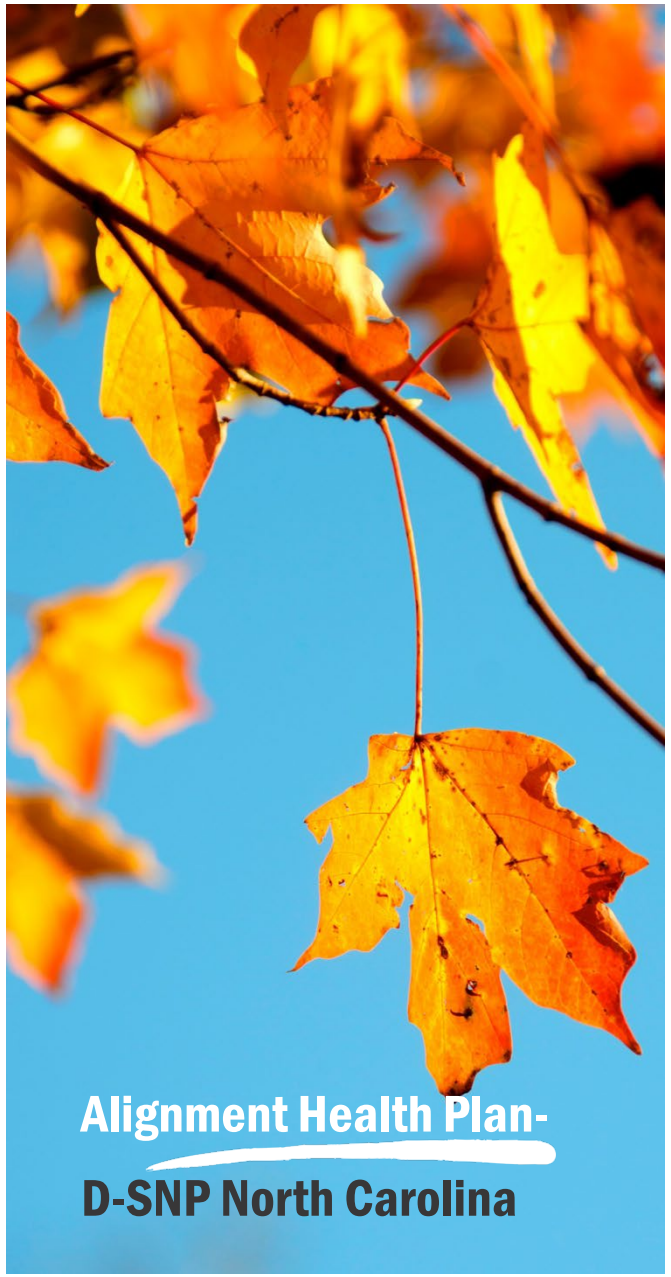
Alignment Health

ALIGNMENT HEALTH PLAN-

D-SNP CALIFORNIA

PLAN NAME: ALIGNMENT CAL PLUS DUALS

- Existing D-SNP Counties in 2022/23 include Marin, San Joaquin, Stanislaus, San Francisco, San Luis Obispo and Ventura Counties



PLAN NAME: ALIGNMENT HEALTH PLAN NC DUALS

- **Existing Counties in 2022 include Chatham, Johnston, Wake, Avery, Buncombe, Davidson, Davie, Forsyth, Guilford, Henderson, Madison, McDowell, Mitchell, Transylvania, and Wilkes Counties**
- **NEW for 2023 is Orange County**

NORTH CAROLINA

1 Alexander
2 Washington
3 Edgecombe
4 Northampton
5 Hertford
6 Camden
7 Currituck
8 Chowan
9 Perquimans
10 Pasquotank

HMO D-SNP

- **PLAN NAME: ALIGNMENT HEALTH PLAN THE ONE**
- Existing D-SNP HMO Counties in 2022 include Clark, Washoe and Nye Counties
- NEW D-SNP Counties for 2023 include Carson City, Storey and Douglas Counties

Counties in Orange are existing 2022 Counties
Counties in Blue are new as of 2023

PPO D-SNP

NEVADA

PLAN NAME: ALIGNMENT HEALTH DUALS

- NEW in 2023, Alignment will offer a D-SNP PPO plan in Clark, Washoe, Nye, Carson City, Storey and Douglas Counties

ALIGNMENT HEALTH PLAN- FLORIDA

New for 2023

Alignment Health

PLAN NAME: ALIGNMENT HEALTH THE ONE (HMO D-SNP)

ALIGNMENT HEALTH EL UNICO (HMO D-SNP)

- NEW D-SNP for 2023 includes Clay, Duval, Manatee, and Sarasota Counties
- The D-SNP Plan will be a Fully Integrated D-SNP (FIDE) Plan which manages both Medicare and some Medicaid benefits
- Alignment will coordinate Medicaid benefits for Members and provide coverage of Medicaid services, including behavioral health services, for eligible Members
- The Alignment D-SNP will cover the following Medicaid Services in addition to Medicare benefits:
  - Behavioral health services
  - DME and other Medical Supplies
  - Therapy Services
  - Nursing Facility Services
  - Transportation Services

Counties in Blue are new as of 2023

ADDITIONAL BENEFITS FOR D-SNP PLANS MAY INCLUDE

ALIGNMENT D-SNP BENEFIT SUMMARY

- Care Anywhere Evaluations- Annual Wellness Examination
- Preventive and Comprehensive Dental Services
- Routine vision exams and glasses or contact coverage
- Routine preventive screening
- Hearing exams
- Transportation
- Social Needs Benefits-
  - Companion Care- 48 hours per year
  - Monthly Grocery Allowance for food and produce purchase
  - Pet Service- 7 boarding days or 14 walks per year
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Alignment Health
WORKING WITH OUR PROVIDERS

- Collaborate with the Alignment Care Management and Care Anywhere Teams, the ICT, Members and Caregivers
- Review and Respond to Care Plan Development and Invitations to Attend the Interdisciplinary Care Team Meetings
- Encourage the Member to Participate in Completing Health Risk Assessments, Work with the ICT, Keep Appointments and Comply with Treatment Plans
- Participate in Alignment's Quality Improvement Initiatives and Satisfaction Surveys
- Promptly Respond to Alignment's Request for Information Related to Member Complaints, Quality Concerns and Medical Record Review Requests
- Complete Credentialing and Re-Credentialing Processes
- Complete This Annual SNP MOC Provider Training and Attestation of Completion


Alignment Health
THANK YOU!