ATTACHMENT V-A

MEDICARE ADVANTAGE AND PRESCRIPTION DRUG SPECIAL NEEDS PLANS - MODEL OF CARE (SNP-MOC) QUESTIONNAIRE (SNP-Q)

Name of Sponsoring Organization:

Enter your response here

Contract Numbers:

Enter your response here

Name and Title of Person Completing Questionnaire:

Enter your response here

Date Completed:

Select date

This questionnaire is designed to assist CMS in understanding the unique qualities of your organization's SNP program operations.

Please upload the completed form to HPMS within 5 business days of receiving your audit engagement letter. Separate questionnaires may be provided for each entity/operating system showing the CMS contracts that are applicable to each completed questionnaire (*if multiple questionnaires are completed, they must be zipped together and uploaded to HPMS as a single file*).

We recognize that your time is valuable and appreciate your availability to provide responses to our questions regarding the SNP program operations. The responses to these questions may be discussed during the SNP audit.

1. Has your organization experienced any seamless enrollments, PBP mergers, acquisitions, or plan consolidations within the 12 months preceding the date of the engagement letter? If so, please describe the circumstance.

Enter your response here

2. Confirm your organization's SNP plan type offerings (C-SNP, D-SNP or I-SNP) at time of audit engagement letter and provide enrollment statistics for the three largest PBPs of each SNP type offered as of the date of the audit engagement letter. If only 1 or 2 SNP types offered, provide enrollment statistics for those SNP types.

Enter your response here

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1000 (Expires: TBD). The time required to complete this information collection is estimated to average 701 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

3. Describe your organization's internal system utilized for tracking HRAs, ICPs, and ICT decisions and activities.

Enter your response here

4. Does your organization use an acuity scoring system to assess enrollee severity of illness/intensity of service? If yes, please describe your organization's enrollee risk stratification levels and your process for assigning enrollees to a risk stratification level.

Enter your response here

5. Describe the processes when transition of care is documented for a new enrollee or an enrollee who has experienced hospitalization. How do you define transition of care?

Enter your response here

6. Describe the process for tracking MOC training for ICT-implicated staff and FDRs.

Enter your response here

7. Describe the outreach policy pertaining to HRA administration and ICP development. Describe the process for enrollees that cannot or do not want to be contacted.

Enter your response here

8. Please identify FDRs that you contract with that conduct SNP related care coordination activities, such as administering HRAs or outreach.

Enter your response here