

ATTACHMENT B

Model of Care Matrix Document: Off-Cycle Submission

Table 1: Special Needs Plan (SNP) Contract Information

SNP Contract Information	Applicant’s Information Field
Contract Name (as provided in HPMS)	<i>Enter Contract Name here</i>
Contract Number	<i>Enter Contract Number here (Also list other contracts where this MOC is applicable)</i>

Care Management Plan Outlining the Model of Care

In the following tables, list the page number and section of the corresponding description in your Care Management Plan for each Model of Care (MOC) element. Once you have completed this document, upload it into HPMS along with a summary of changes and a redlined version of the revised MOC.

1. Description of the SNP Population

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. The organization must provide an overview that fully addresses the full continuum of care of current and potential SNP enrollees, including end-of-life needs and considerations, if relevant to the target population served by the SNP.

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
<p>Element A: Description of the Overall SNP Population The description of the SNP population must include, but not be limited to, the following:</p> <ul style="list-style-type: none"> ■ Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP enrollees. ■ Detailed profile of the medical, social, cognitive, and environmental aspects, the living conditions, and the co-morbidities associated with the SNP population in the plan’s geographic service area. ■ Identification and description of the health conditions impacting SNP enrollees, including specific information about other characteristics that affect health, such as population demographics (e.g., average age, gender, ethnicity) and potential health disparities associated with specific groups (e.g., language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other). ■ Definition of unique characteristics for the SNP population served: <ul style="list-style-type: none"> ■ C-SNP: What are the unique chronic care needs for C-SNP enrollees? Include limitations and barriers that pose potential 	<p><i>Enter corresponding page number and section here</i></p>

<p style="text-align: center;">Model of Care Elements</p>	<p style="text-align: center;">Corresponding Page #/Section in Care Management Plan</p>
<p>challenges for these C-SNP enrollees.</p> <ul style="list-style-type: none"> ▪ D-SNP: What are the unique health needs for D-SNP enrollees? Include limitations and barriers that pose potential challenges for these D-SNP enrollees. ▪ I-SNP: What are the unique health needs for I-SNP enrollees? Include limitations and barriers that pose potential challenges for these I-SNP enrollees as well as information about the facilities and/or home and community-based services settings in which your enrollees reside. 	
<p>Element B: Sub-Population: Most Vulnerable Enrollees</p> <p>As a SNP, you must include a complete description of the specially-tailored services for enrollees considered especially vulnerable using specific terms and details (e.g., enrollees with multiple hospital admissions within three months, “medication spending above \$4,000”). The description must differentiate between the general SNP population and that of the most vulnerable enrollees, as well as detail additional benefits above and beyond those available to general SNP enrollees. Other information specific to the description of the most vulnerable enrollees must include, but not be limited to, the following:</p> <ul style="list-style-type: none"> ▪ Description of the internal health plan procedures for identifying the most vulnerable enrollees within the SNP. ▪ Description of the relationship between the demographic characteristics of the most vulnerable enrollees and their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, and other factor(s) affect the health outcomes of the most vulnerable enrollees. ▪ Identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable enrollees, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable enrollees and/or their caregiver(s). 	<p><i>Enter corresponding page number and section here</i></p>

2. Care Coordination

Care coordination helps ensure that SNP enrollees’ healthcare needs, preferences for health services, and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes 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 as well as the care coordination roles and responsibilities overseen by the enrollees’ caregiver(s). The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNP’s care coordination activities.

<h2 style="text-align: center;">Model of Care Elements</h2>	Corresponding Page #/Section in Care Management Plan
<p>Element A: SNP Staff Structure</p> <ul style="list-style-type: none"> ■ Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of SNP enrollees. This includes, but is not limited to, identification and detailed explanation of: <ul style="list-style-type: none"> ▪ Employed and/or contracted staff who perform administrative functions, such as: enrollment and eligibility verification, claims verification and processing, etc. ▪ Employed and/or contracted staff who perform clinical functions, such as: direct enrollee care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, etc. ▪ Employed and/or contracted staff who perform administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols. ■ Provide a copy of the SNP’s organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP. ■ Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions. ■ Describe how the SNP conducts initial and annual MOC training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing. ■ Describe how the SNP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records. ■ Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff, and describe what specific actions the SNP will take when the required MOC training has not been completed or has been found to be deficient in some way. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element B: Health Risk Assessment Tool (HRAT)</p> <p>The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP enrollee. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan (ICP) and ongoing coordination of Interdisciplinary Care Team (ICT) activities; therefore, it is imperative that the MOC include the following:</p>	<p><i>Enter corresponding page number and section here</i></p>

<p style="text-align: center;">Model of Care Elements</p>	<p style="text-align: center;">Corresponding Page #/Section in Care Management Plan</p>
<ul style="list-style-type: none"> ■ A clear and detailed description of the policies and procedures for completing the HRAT, including: <ul style="list-style-type: none"> ▪ Description of how the HRAT is used to develop and update, in a timely manner, the ICP (MOC Element 2D) for each enrollee, and how the HRAT information is disseminated to and used by the ICT (MOC Element 2E). ▪ Detailed explanation for how the initial HRAT and annual reassessment are conducted for each enrollee. ▪ Description of how the SNP ensures that the results from the initial HRAT and the annual reassessment HRAT conducted for each individual are addressed in the ICP. ▪ Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the ICT, provider network, enrollees and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP enrollee’s ICP. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process. 	
<p>Element C: Face-to-Face Encounter</p> <p>Regulations at 42 CFR §422.101(f)(1)(iv) require that all SNPs must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual’s consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee’s ICT or the plan’s case management and coordination staff, or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy, and as a result, the MOC must include the following:</p> <ul style="list-style-type: none"> ■ A clear and detailed description of the policies, procedures, purpose, and intended outcomes of the face-to-face encounter. ■ A description of who will conduct the face-to-face encounter, employed and/or contracted staff. ■ A description of the types of clinical functions, assessments, and/or services that may be provided during the face-to-face encounter. ■ A description of how health concerns and/or active or potential health issues will be addressed during the face-to-face encounter. ■ A description of how the SNP will conduct care coordination activities through appropriate follow-up, referrals, and scheduling as necessary. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element D: Individualized Care Plan (ICP)</p>	<p><i>Enter</i></p>

<p style="text-align: center;">Model of Care Elements</p>	<p>Corresponding Page #/Section in Care Management Plan</p>
<ul style="list-style-type: none"> ■ The ICP components must include, but are not limited to: enrollee self- management goals and objectives; the enrollee’s personal healthcare preferences; description of services specifically tailored to the enrollee’s needs; roles of the enrollees’ caregiver(s); and identification of goals met or not met. <ul style="list-style-type: none"> ▪ When the enrollee’s goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions. ■ Explain the process and which SNP personnel are responsible for the development of the ICP, how the enrollee and/or his/her caregiver(s) or representative(s) are involved in its development, and how often the ICP is reviewed and modified as the enrollee’s healthcare needs change. If a stratification model is used for determining SNP enrollees’ healthcare needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each enrollee’s ICP. ■ Describe how the ICP is documented and updated, including updates based on more recent HRAT information and where the documentation is maintained to ensure accessibility to the ICT, provider network, enrollee, and/or caregiver(s). ■ Explain how updates and/or modifications to the ICP are communicated to the enrollee and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel, and other stakeholders as necessary. 	<p><i>corresponding page number and section here</i></p>
<p>Element E: Interdisciplinary Care Team (ICT)</p> <ul style="list-style-type: none"> ■ In the management of care, the SNP must use an ICT that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the SNP. ■ Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise, training, and capabilities of the ICT members align with the identified clinical and social needs of the SNP enrollees, and how the ICT members contribute to improving the health status of SNP enrollees. If a stratification model is used for determining SNP enrollees’ health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT. <ul style="list-style-type: none"> ▪ Explain how the SNP facilitates the participation of enrollees and their caregivers as members of the ICT. ▪ Describe how the enrollee’s HRAT (MOC Element 2B) and ICP (MOC Element 2D) are used to determine the composition of the ICT, including those cases where additional team members are needed to meet the unique needs of the individual enrollee. ▪ Explain how the ICT uses healthcare outcomes to evaluate 	<p><i>Enter corresponding page number and section here</i></p>

<p style="text-align: center;">Model of Care Elements</p>	<p style="text-align: center;">Corresponding Page #/Section in Care Management Plan</p>
<p style="text-align: center;">established processes to manage changes and/or adjustments to the enrollee’s healthcare needs on a continuous basis.</p> <ul style="list-style-type: none"> ■ Identify and explain the use of clinical managers, case managers, or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted. ■ Provide a clear and comprehensive description of the SNP’s communication plan that ensures exchanges of enrollee information is occurring regularly within the ICT, including but not limited to the following: <ul style="list-style-type: none"> ▪ Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, enrollees, caregiver(s), community organizations, and other stakeholders. ▪ The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other. ▪ How communication is conducted with enrollees who have hearing impairments, language barriers, and/or cognitive deficiencies. 	
<p>Element F: Care Transition Protocols</p> <ul style="list-style-type: none"> ■ Explain how care transition protocols are used to maintain continuity of care for SNP enrollees. Provide details and specify the process and rationale for connecting the enrollee to the appropriate provider(s). ■ Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A. ■ Explain how the SNP ensures elements of the enrollee’s ICP are transferred between healthcare settings when the enrollee experiences an applicable transition in care. This must include the steps that need to take place before, during, and after a transition in care has occurred. ■ Describe in detail the process for ensuring the SNP enrollee and/or caregiver(s) have access to and can adequately utilize the enrollees’ personal health information to facilitate communication between the SNP enrollee and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network. ■ Describe how the enrollee and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities. ■ Describe how the enrollee and/or caregiver(s) are informed about who their point of contact is throughout the transition process. 	<p style="text-align: center;"><i>Enter corresponding page number and section here</i></p>

3. SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP enrollees. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized healthcare needs of the target population as identified in MOC Element 1, and provide oversight information for all of its network types. Each SNP is responsible for ensuring their MOC identifies, fully describes, and implements the following sub-elements for its SNP Provider Network.

<p style="text-align: center;">Model of Care Elements</p>	<p style="text-align: center;">Corresponding Page #/Section in Care Management Plan</p>
<p>Element A: Specialized Expertise</p> <ul style="list-style-type: none"> ■ Provide a complete and detailed description of the specialized expertise available to SNP enrollees in the SNP provider network that corresponds to the SNP population identified in MOC Element 1. ■ The description must include evidence that the SNP provides each enrollee with an ICT that includes providers with demonstrated experience and training in the applicable specialty or area of expertise, or, as applicable, training in a defined role appropriate to their licensure in treating individuals that are similar to the target population. ■ Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP enrollees. Specialized expertise may include, but is not limited to: internal medicine physicians, endocrinologists, cardiologists, oncologists, mental health specialists, other. ■ Describe how providers collaborate with the ICT (MOC Element 2E) and the enrollee, contribute to the ICP (MOC Element 2D), and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP enrollees' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP enrollee in a timely and effective way; how reports regarding services rendered are shared with the ICT; and how relevant information is incorporated into the ICP. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element B: Use of Clinical Practice Guidelines & Care Transition Protocols</p> <ul style="list-style-type: none"> ■ Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation. ■ Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP enrollees. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2D), communicated with the ICT (MOC Element 2E), and acted upon. ■ Explain how SNP providers ensure care transition protocols are being used to maintain continuity of care for the SNP enrollee as outlined in MOC Element 2F. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element C: MOC Training for the Provider Network</p> <ul style="list-style-type: none"> ■ Explain in detail how the SNP conducts initial and annual MOC training for network providers and out-of-network providers seen by enrollees on a routine basis. This could include but is not limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via 	<p><i>Enter corresponding page number and section here</i></p>

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
<p>the SNP’s website.</p> <ul style="list-style-type: none"> ■ Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include but is not limited to: copies of dated attendee lists, results of MOC competency testing, web- based attendance confirmation, electronic training records, and physician attestation of MOC training. ■ Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP will take when the required MOC training has not been completed or is found to be deficient in some way. 	

4. MOC Quality Measurement & Performance Improvement

The goals of performance improvement and quality measurement are to improve the SNP’s ability to deliver healthcare services and benefits to its SNP enrollees in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers, and governing body of a SNP must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
<p>Element A: MOC Quality Performance Improvement Plan</p> <ul style="list-style-type: none"> ■ Explain in detail the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP enrollees. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates enrollees’ unique healthcare needs. The description must include, but is not limited to, the following: <ul style="list-style-type: none"> ■ The complete process, by which the SNP continuously collects, analyzes, evaluates, and reports on quality performance based on the MOC by using specified data sources, performance, and outcome measures. The MOC must also describe the frequency of these activities. ■ Details regarding how the SNP leadership, management groups, and other SNP personnel and stakeholders are involved with the internal quality performance process. ■ Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B). 	<p><i>Enter corresponding page number and section here</i></p>

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
<ul style="list-style-type: none"> ▪ Process the SNP uses or intends to use to determine if goals/outcomes are met. There must be specific benchmarks and timeframes, and the SNP must specify the re-measurement plan for goals not achieved. 	
<p>Element B: Measurable Goals & Health Outcomes for the MOC</p> <ul style="list-style-type: none"> ▪ Identify and clearly define the SNP’s measurable goals and health outcomes; describe how identified measurable goals and health outcomes are communicated throughout the SNP; and evaluate whether goals were fulfilled from the previous MOC. Responses must include, but not be limited to, the following: <ul style="list-style-type: none"> ▪ Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC Element 1. ▪ Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT. ▪ Enhancing care transitions across all healthcare settings and providers for SNP enrollees. ▪ Ensuring appropriate utilization of services for preventive health and chronic conditions. ▪ Identify the specific enrollee health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used. ▪ Describe in detail how the SNP establishes methods to assess and track the MOC’s impact on the SNP enrollees’ health outcomes. ▪ Describe in detail the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met. ▪ Provide relevant information pertaining to the MOC’s goals as well as appropriate data pertaining to the fulfillment the previous MOC’s goals. ▪ For SNPs submitting an initial MOC, provide relevant information pertaining to the MOC’s goals for review and approval. ▪ If the MOC did not fulfill the previous MOC’s goals, indicate in the MOC submission how the SNP will achieve or revise the goals for the next MOC. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element C: Measuring Patient Experience of Care (SNP Enrollee Satisfaction)</p> <ul style="list-style-type: none"> ▪ Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP enrollee satisfaction. ▪ Explain how the results of SNP enrollee satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results. 	<p><i>Enter corresponding page number and section here</i></p>
<p>Element D: Ongoing Performance Improvement Evaluation of the MOC</p> <ul style="list-style-type: none"> ▪ Explain in detail how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated. ▪ Describe the SNP’s ability to improve, on a timely basis, 	<p><i>Enter corresponding page number and section here</i></p>

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
<p>mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process.</p> <ul style="list-style-type: none"> ■ Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders. 	
<p>Element E: Dissemination of SNP Quality Performance related to the MOC</p> <ul style="list-style-type: none"> ■ Explain in detail how the SNP communicates its quality improvement performance results and other pertinent information on a routine basis to its multiple stakeholders, which may include but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel and staff, SNP provider networks, SNP enrollees and caregivers, the general public, and regulatory agencies. ■ This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad-hoc communication with the various stakeholders, such as: a webpage for announcements, printed newsletters, bulletins, and other announcement mechanisms. ■ Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A. 	

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- 1296 (CMS-10565). The current expiration date is **TBD**. The time required to complete this information collection is estimated to average 3-6 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.