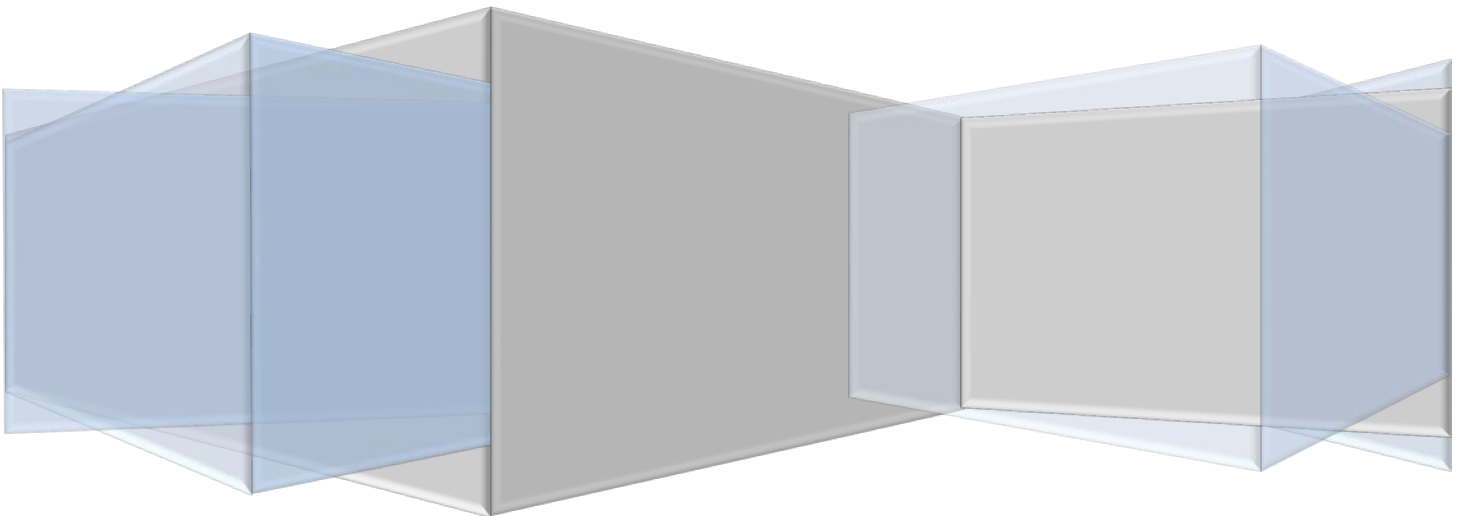




# Special Needs Plans Care Coordination (SNPCC)

## PROGRAM AUDIT PROTOCOL AND DATA REQUEST



**Program Audit Protocol and Data Request  
Special Needs Plans Care Coordination (SNPCC)**

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Purpose

To evaluate performance in the areas outlined in this Program Audit Protocol and Data Request related to Special Needs Plans Care Coordination (SNPCC). The Centers for Medicare and Medicaid Services (CMS) performs its program audit activities in accordance with the SNPCC Program Audit Data Request and applying the compliance standards outlined in this Program Audit Protocol and the Program Audit Process Overview document. At a minimum, CMS will evaluate cases against the criteria listed below. CMS may review factors not specifically addressed below if it is determined that there are other related SNPCC requirements not being met.

**Audit Elements Tested**

1. Care Coordination

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Not Applicable	Universe Integrity Testing	Universe Table 1: Special Needs Plans Enrollees (SNPE)	<p>Select 10 cases from Universe Table 1.</p> <p>Prior to field work, CMS will schedule a webinar with the Sponsoring organization to verify accuracy of data within Table 1 for each of the sampled cases. System data such as enrollment dates, dates of initial HRA, etc. will be verified.</p> <p>Review all cases selected for universe integrity testing. The integrity of the universe will be questioned if data points specific to the sample case(s) are incomplete, do not match, or cannot be verified by viewing the Sponsoring organization’s systems and/or other supporting documentation.</p> <p>Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled integrity testing webinar.</p>	<p>42 CFR § 422.504(e)</p> <p>42 CFR § 422.504(f)</p>
Care Coordination	1.1	<p>Universe Table 1: Special Needs Plans Enrollees (SNPE)</p> <p>Table 2IA: HRA Timeliness Impact Analysis (HRAT-IA)</p>	<p>Conduct a timeliness test at the universe level of enrollees who have been continuously enrolled for at least 90 days, to determine whether the Sponsoring organization conducted initial health risk assessments (IHRAs) within 90 days (before or after) enrollees’ effective date of enrollment. IHRA Timeliness assessments will be conducted using current enrollments, from Table 1. Assessments will be limited to individuals enrolled with effective dates within 12 months of the audit engagement letter.</p> <p>Request an impact analysis for any enrollee identified as not having an IHRA conducted to quantify the outreach made by the Sponsoring organization in an attempt to conduct the IHRA within 90 days of enrollment. Impact analysis review period is limited to the 12-month period prior to date of the engagement letter, to align with the timeliness test.</p> <p><i>*Outreach data points in Table 2IA are subject to validation, as requested by CMS.</i></p>	<p>42 CFR § 422.101(f)</p> <p>42 CFR § 422.152(g)</p>

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Care Coordination	1.2	<p>Universe Table 1: Special Needs Plans Enrollees (SNPE)</p> <p>Table 2IA: HRA Timeliness Impact Analysis (HRAT-IA)</p>	<p>Conduct timeliness test at the universe level of enrollees who have either been continuously enrolled for 365 days or more, or new enrollees who missed the deadline to complete an initial HRA, to determine whether the Sponsoring organization conducted timely annual health re-assessment HRAs (AHRAs).</p> <p>Request an impact analysis for any enrollee identified as having an untimely AHRA to quantify the outreach made by the Sponsoring organization in an attempt to conduct the AHRA within 365 days of the prior HRA completion date, or date of enrollment if no initial HRA was conducted.</p>	<p>42 CFR § 422.101(f)</p> <p>42 CFR § 422.152(g)</p>
Care Coordination	1.3	<p>Universe Table 1: Special Needs Plans Enrollees (SNPE)</p> <p>Associated Model Of Care (MOC)</p>	<p>Select a sample of 30 enrollees from Table 1 that reflect general composition of membership in each of the Sponsoring organization's plan types or PBPs. A minimum of 5 enrollees should be selected from each plan type. If there are less than 5 enrollees included in the universe for that plan type, then include them all in the sample. The remaining number of sampled enrollees should be from the plan type with the greatest representation in the universe. Also consider responses to Column IDs L and M in Universe Table 1 when selecting samples.</p> <p>Review the 30 selected samples to determine whether the completed HRA included a comprehensive initial assessment and reassessment(s) of the needs of the enrollees including, for example, the medical, psychosocial, cognitive, functional, and mental health needs.</p> <p>Sample selections will be provided to the Sponsoring organization the Thursday prior to the start of audit field work.</p>	<p>42 CFR § 422.101(f)</p>

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria Effective 01/01/2021</b>
Care Coordination	1.4	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review the 30 selected samples to determine whether the Sponsoring organization completed an individualized care plan (ICP) for each enrollee, designed to address needs identified in the HRA, consistent with the MOC.  Determine whether the ICP included measurable outcomes, inclusive of a timeframe for completion or evaluation if the outcome was not met, in accordance with the MOC.  Consider whether the ICP includes the following, in accordance with the MOC: <ul style="list-style-type: none"> <li>• The enrollee’s self-management goals and objectives.</li> <li>• The enrollee’s personal healthcare preferences.</li> <li>• A description of services specifically tailored to the enrollee’s needs.</li> <li>• Identification of goals (met or not met).</li> </ul>	42 CFR § 422.101(f)
Care Coordination	1.5	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review the 30 selected samples to determine whether the enrollees’ ICPs were reviewed and/or modified as there were changes to the enrollees’ health care needs.	42 CFR § 422.101(f)  42 CFR § 422.152(g)
Care Coordination	1.6	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation which may include, but is not limited to case management notes, ICT documentation, and systems information such as utilization management, claims data, and prescription drug events (PDE) for each of the 30 selected samples to determine whether the Sponsoring organization implemented the ICP.	42 CFR § 422.101(f)  42 CFR § 422.152(g)
Care Coordination	1.7	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation which may include, but is not limited to ICT notes and communications (amongst ICT members and/or with enrollees/caregivers) pertaining to each of the 30 selected samples to determine how the enrollee or the caregiver/representative was involved in the ICP development.	42 CFR § 422.101(f)  42 CFR § 422.152(g)

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria Effective 01/01/2021</b>
Care Coordination	1.8	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review systems for documentation which may include but is not limited to case management notes, ICT member notes and communications (e.g. documented phone calls, letters to/from providers regarding member care, etc.), and ICT meeting agendas/minutes pertaining to each of the 30 selected samples to determine whether the Sponsoring organization coordinated communication amongst its personnel, providers, and enrollees.	42 CFR § 422.101(f)
Care Coordination	1.9	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation for each of the 30 selected samples to determine whether each enrollee's: <ul style="list-style-type: none"> <li>• Care was managed by an interdisciplinary care team (ICT) comprised of appropriate clinical disciplines according to the SNP's approved MOC, as well as the inclusion of specialists when needed.</li> <li>• Primary care provider (PCP) was involved in coordination of care and communications (e.g., ICT meeting attendee lists or other documentation reflecting PCP interaction with ICT members).</li> </ul>	42 CFR § 422.101(f)
Care Coordination	1.10	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation for each of the 30 selected samples to determine whether the Sponsoring organization developed and implemented care transition protocols to maintain continuity of care as defined in the MOC. Documentation may include, but is not limited to: <ul style="list-style-type: none"> <li>• Case management and/or ICT notes.</li> <li>• Correspondence with the enrollee's PCP, specialists, hospital, skilled nursing staff, assisted living facility, etc.</li> <li>• Discharge planning and/or care setting transition discussions held with the enrollee, the enrollee's caregiver or authorized representative.</li> </ul>	42 CFR § 422.101(f)
Care Coordination	1.11	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation for each of the 30 selected samples to determine whether ICPs were developed and implemented by staff that met the professional requirements, including credentials, described in the MOC.	42 CFR § 422.101(f)

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria Effective 01/01/2021</b>
Care Coordination	1.12	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation for each of the 30 selected samples to determine whether each member of the enrollee’s ICT received training on the model of care.	42 CFR § 422.101(f)
Care Coordination	1.13	Universe Table 1: Special Needs Plans Enrollees (SNPE)  Associated Model Of Care (MOC)	Review documentation for each of the 30 selected samples to determine whether network providers caring for each of the enrollees received training on the model of care. Specifically, review documentation supporting that outreach was conducted/training materials were provided to network providers in accordance with the MOC. Noting every provider’s completion of training/certificate(s) is not necessary.	42 CFR § 422.101(f)

[Program Audit Data Request](#)

**Audit Engagement and Universe Submission Phase**

**Universe Submissions**

Sponsoring organizations must submit each universe, comprehensive of all contracts and Plan Benefit Packages (PBP) identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row. Descriptions and clarifications of what must be included in each submission and data field are outlined in the individual universe record layouts below. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each record layout. Sponsoring organizations must provide accurate and timely universe submissions within 15 business days of the audit engagement letter date. Submissions that do not strictly adhere to the record layout specifications will be rejected.

**Universe Requests**

1. Universe Table 1: Special Needs Plans Enrollees (SNPE) Record Layout

<b>Universe Record Layout</b>	<b>Scope of Universe Request</b>
Table 1	List of enrollees as of the date of the audit engagement letter



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**Please use the guidance below for the following record layout:**

**Universe Table 1: Special Needs Plans Enrollees (SNPE) Record Layout**

- List all current SNP enrollees as of the date of the audit engagement letter.
- List each enrollee only once.
- Include enrollees with disenrollment effective dates at the end of month in which the audit engagement letter is received.
- Exclude enrollments received before the date of the audit engagement letter that are not effective until the first day of the month following the audit engagement letter.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234) of the organization in which the enrollee is currently part.
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	Plan Type	CHAR Always Required	5	Enter type of SNP. Valid values are: <ul style="list-style-type: none"> <li>• D-SNP</li> <li>• C-SNP</li> <li>• I-SNP</li> </ul>

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
G	Enrollment Effective Date	CHAR Always Required	10	Enter the effective date of the most current/continuous enrollment for the enrollee with the Sponsoring organization.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	Most Recent Plan Change Effective Date	CHAR Always Required	10	Enter the date of last plan change within the continuous SNP enrollment.  Submit in CCYY/MM/DD format (e.g., 2020/01/01)  For a PBP change or consolidation event the Sponsoring organization must use the post-event effect date for the enrollee.  Enter None if there were no PBP or plan consolidation events.
I	Date of most recent HRA	CHAR Always Required	10	Enter the date of the enrollee's most recently completed HRA.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no HRA was completed (e.g. when enrollee refused the HRA or was unable to be reached).  If only the Initial HRA has been completed this date should equal the Initial HRA date.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
J	Date of previous HRA	CHAR Always Required	10	<p>Enter the date of the enrollee's previously completed HRA.</p> <p>Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>This is the date of the most recently completed HRA prior to the date entered in Column ID I.</p> <p>Enter None if another HRA was not completed (e.g. when enrollee refused the HRA or was unable to be reached).</p>
K	Date Initial HRA (IHRA) was completed	CHAR Always Required	10	<p>Enter the date of the enrollee's first HRA completion (within 90 days before or after the effective date of enrollment).</p> <p>HRA completion date is the date the HRA is returned completed to the Sponsoring organization by either the enrollee or the enrollee's representative.</p> <p>Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>Enter None if no HRA was completed within 90 days before or after the effective date of enrollment.</p> <p>Enter EXC-10 if the IHRA date is greater than 10 years ago.</p>
L	Enrollee Risk Stratification Level at time of audit engagement letter	CHAR Always Required	15	<p>Enter the enrollee risk level at time of the audit engagement letter.</p> <p>Enter None if no risk stratification level has been assigned.</p>

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Column ID	Field Name	Field Type	Field Length	Description
M	Date of most recent Individualized Care Plan (ICP)	CHAR Always Required	10	Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if the Sponsoring organization did not develop an ICP. If care plan is continuous, enter the date of the most recent update.
N	Was an Interdisciplinary Care Team (ICT) created/identified?	CHAR Always Required	1	Enter Y for Yes if the enrollee has an ICT assigned.  Enter N for No if the enrollee does not have an assigned ICT.

**Supplemental Documentation Submissions**

Sponsoring organizations must submit the requested documentation identified below in either a Microsoft Word (.docx), Microsoft Excel (.xlsx), or Adobe Portable Document File (.pdf).

Sponsoring organizations must submit this documentation within 15 business days of the audit engagement letter date, unless otherwise specified.

**Supplemental Documentation Requests**

1. Copies of selected Models of Care (MOC) and any (red-lined) updates to the original submissions.
2. SNPCC Supplemental Questionnaire- due within 5 business days of the audit engagement letter date.

**Audit Field Work Phase**

**Supporting Documentation Submissions**

During audit field work, CMS will review 30 enrollee samples selected from Table 1 to determine whether the Sponsoring organization is compliant with its Part C contract requirements. To facilitate this review, the Sponsoring organization must have access to, and the ability to save and upload screenshots of, supporting documentation and data relevant to a particular case, including, but not limited to:

- Completed enrollee Health Risk Assessment(s).
- Copy of the enrollee’s Individualized Care Plan (ICP).
- Care and case management documentation associated with the ICP (including claims, encounters, and Prescription Drug Events) submitted for the enrollee since the last HRA was completed. Specific documentation will be selected by the audit team based on the content of the ICP.
- Membership of the ICT with evidence of appropriate credentials.

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- Information on the Sponsoring organization’s process to confirm MOC training for network providers and ICT members and evidence of the Sponsoring organization’s confirmation.
- Meeting minutes
- Case files
- Telephone scripts
- Attendance records
- Policies and procedures

Sponsoring organizations must submit supporting documentation within 2 business days of the request.

**Root Cause Analysis Submissions**

Sponsoring organizations may be required to provide a root cause analysis using the Root Cause Template provided by CMS. Sponsoring organizations have 2 business days from the date of request to respond.

**Impact Analysis Submissions**

When noncompliance with contract and/or MOC requirements is identified on audit, Sponsoring organizations must submit each requested impact analysis, comprehensive of all contracts and Plan Benefit Packages (PBP) identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row. Descriptions and clarifications of what must be included in each submission and data field is outlined in the individual tables below. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each table. Sponsoring organizations must provide accurate and timely impact analysis submissions within 10 business days of the request. Submissions that do not strictly adhere to the record layout specifications will be rejected.

**Impact Analysis Requests**

1. Table 1IA: Care Coordination Impact Analysis (CC-IA) Record Layout
2. Table 2IA: HRA Timeliness Impact Analysis (HRAT-IA) Record Layout

<b>Impact Analysis Record Layout</b>	<b>Scope of Impact Analysis Request</b>
Table 1IA	Submit a list of enrollees impacted by the Care Coordination issue(s) identified during the 26-week period preceding the date of the audit engagement letter through the date the issue was identified on audit.
Table 2IA	Submit a list of enrollees who did not receive a timely initial and/or annual HRA within the 12-month period prior to the date of the engagement letter. Populate untimely cases with the appropriate outreach information for initial and/or annual HRAs as identified during the timeliness test.

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Please use the guidance below for the following record layout:

**Table 1IA: Care Coordination Impact Analysis (CC-IA) Record Layout**

- Include all enrollees impacted by the care coordination issue as specified in the request for an impact analysis.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234) of the organization in which the enrollee is currently part.
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	Plan Type	CHAR Always Required	5	Enter type of SNP. Valid values are: <ul style="list-style-type: none"> <li>• D-SNP</li> <li>• C-SNP</li> <li>• I-SNP</li> </ul>

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
G	Was an HRA conducted?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes only if the HRA was returned completed to the Sponsoring organization by either the enrollee or the enrollee’s representative.</li> <li>• N for No</li> </ul>
H	If an HRA was conducted, were needs identified?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if an HRA was not conducted</li> </ul>
I	If an ICP was created, were the identified needs addressed?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if no ICP created</li> </ul>
J	If an ICP was created, was enrollee or enrollee representative involved in its development?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if an ICP was not created</li> </ul>
K	Initial ICP Date	CHAR Always Required	10	Enter the date the initial ICP was completed.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if an initial ICP was not completed.
L	Date of Most Recent ICP revision	CHAR Always Required	10	Enter the date the ICP was most recently revised.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter NA if the enrollee’s ICP has not been completed or revised since the initial ICP was completed per Column ID K.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
M	Basis of most recent ICP	CHAR Always Required	16	<p>Enter basis for most recent ICP revision in Column ID L:</p> <ul style="list-style-type: none"> <li>• Initial</li> <li>• Annual, or</li> <li>• Change in Status</li> </ul> <p>Enter NA if the enrollee's ICP has not been completed or revised since the initial ICP was completed per Column ID K.</p>
N	Date of previous ICP revision	CHAR Always Required	10	<p>Enter the date the enrollee's ICP was previously revised compared to Column ID L.</p> <p>Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>In the case of an ICP that was revised on January 1, but then revised again on March 1 of the same year, March is the date of the most recent ICP revision, and January is the date of the previous ICP revision.</p> <p>Enter NA if the enrollee's ICP has not been completed or revised since the ICP was revised per Column ID L.</p>
O	Basis of previous ICP	CHAR Always Required	16	<p>Enter basis for previous ICP revision:</p> <ul style="list-style-type: none"> <li>• Initial</li> <li>• Annual, or</li> <li>• Change in Status</li> </ul> <p>Enter NA if the enrollee's ICP has not been completed or revised since the ICP was revised per Column ID L.</p>



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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
P	Did enrollee experience a hospitalization or other change in health status during the impact analysis request period?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
Q	If enrollee experienced a hospitalization or other change in health status during the impact analysis request period, was the ICP updated?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if the enrollee did not experience a hospitalization or other change in health status during the impact analysis request period.</li> </ul>
R	If enrollee experienced a hospitalization, was transitional care offered to the enrollee post-discharge?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if the enrollee did not experience a hospitalization.</li> </ul>
S	Was an ICT created?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
T	If an ICT was created, was the ICT involved in creating and updating the enrollee's ICP?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if an ICT was not created.</li> </ul>
U	Were ICT reviews conducted at least annually?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
V	Is there evidence that the PCP was invited to participate on the enrollee's ICT?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
W	Did all members of enrollee’s ICT receive annual MOC training?  ICT is specific to each enrollee’s individualized needs.	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes; use Y if the ICT Providers received the MOC training materials.</li> <li>• N for No</li> </ul> If contracted providers received the training materials within 1 year of engagement letter, ok to answer Yes.  Enrollees and family members are not required to receive MOC training.

**Please use the guidance below for the following record layout:**

**Table 2IA: HRA Timeliness Impact Analysis (HRAT-IA) Record Layout**

- Include all enrollees without a completed HRA or with an untimely HRA to quantify outreach attempts, as specified in the request.
- Impact analysis review period is the 12-month period prior to date of the engagement letter. Sponsoring organizations conducting HRA events within the 12-month period on a single enrollee should populate the IA record layout with the most recent HRA event that occurred during the applicable timeframe.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234) of the organization in which the enrollee is currently part.
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	Plan Type	CHAR Always Required	5	Enter type of SNP. Valid values are: <ul style="list-style-type: none"> <li>• D-SNP</li> <li>• C-SNP</li> <li>• I-SNP</li> </ul>
G	Enrollment effective date	CHAR Always Required	10	Enter the effective date of the most current/continuous enrollment for the enrollee with the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	IHRA completion date	CHAR Always Required	10	Enter the actual date the IHRA was completed. Submit in CCYY/MM/DD format (e.g., 2020/01/01) or enter NA if not completed.
I	Number of IHRA outreach attempts required by MOC	CHAR Always Required	2	Enter number of required outreach attempts per applicable MOC at time of enrollment.
J	Number of IHRA outreaches attempted	CHAR Always Required	2	Enter number of outreach attempts in numerical format.

**Program Audit Protocol and Data Request  
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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
K	Date of first IHRA outreach attempt	CHAR Always Required	10	Enter the date first attempt was made to conduct the IHRA.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).
L	Date of last IHRA outreach attempt	CHAR Always Required	10	Enter the date of the most recent attempt was made to conduct the IHRA.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).
M	Date of enrollee IHRA refusal	CHAR Always Required	10	Enter: <ul style="list-style-type: none"> <li>• refusal date in CCYY/MM/DD format,</li> <li>• NA if the enrollee did not refuse IHRA completion.</li> </ul>
N	Annual HRA (AHRA) due date	CHAR Always Required	10	Enter the date by which the AHRA should have been completed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
O	Was an AHRA completed?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA if AHRA was not yet due.</li> </ul>
P	AHRA completion date	CHAR Always Required	10	Enter the actual date the AHRA was completed.  Submit in CCYY/MM/DD format (e.g., 2020/01/01) or enter NA if the AHRA was not completed.
Q	Number of AHRA outreach attempts required by MOC	CHAR Always Required	2	Enter number of required outreach attempts per approved MOC at time of outreach event.
R	Number of AHRA outreaches attempted	CHAR Always Required	2	Enter number of outreach attempts made by Sponsoring organization.

**Program Audit Protocol and Data Request  
Special Needs Plans Care Coordination (SNPCC)**

Column ID	Field Name	Field Type	Field Length	Description
S	Date of first AHRA outreach attempt	CHAR Always Required	10	Enter the date first attempt was made to conduct the AHRA.  Submit in CCYY/MM/DD format (e.g., 2020/01/01) or enter NA if no outreach attempts were made.
T	Date of last AHRA outreach attempt	CHAR Always Required	10	Enter the date the most recent attempt was made to conduct the AHRA.  Submit in CCYY/MM/DD format (e.g., 2020/01/01) or enter NA if no outreach attempts were made.
U	Date of enrollee AHRA refusal	CHAR Always Required	10	Enter: <ul style="list-style-type: none"> <li>• refusal date in CCYY/MM/DD format</li> <li>• NA if the enrollee did not refuse AHRA completion.</li> </ul>
V	Date the HRA - Unable to Contact (UTC) Letter was sent to non-responding enrollee	CHAR Always Required	10	Enter the date the UTC letter was sent.  Submit in CCYY/MM/DD format (e.g., 2020/01/01) or enter NA, if no letter sent.

**Verification of Information Collected:** CMS may conduct integrity tests to validate the accuracy of all universes, impact analyses, and other related documentation submitted in furtherance of the audit. If data integrity issues are noted, Sponsoring organizations may be required to resubmit their data.

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 0938-1395 (Expires 05/31/2024). This is a mandatory information collection. 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. \*\*\*\*CMS Disclosure\*\*\*\* 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 [part\\_c\\_part\\_d\\_audit@cms.hhs.gov](mailto:part_c_part_d_audit@cms.hhs.gov).