Model of Care Requirements for Medicare Advantage Special Needs Plans

Introduction

Under section 1859(f)(1) of the Social Security Act (the Act), Medicare Advantage (MA) special needs plans (SNPs) are able to restrict enrollment to MA beneficiaries who are: (1) institutionalized individuals, who are currently defined in 42 CFR § 422.2 as those residing or expecting to reside for 90 days or longer in a long-term care facility, and institutionalized equivalent individuals who reside in the community but need an institutional level of care when certain conditions are met; (2) individuals entitled to medical assistance under a State plan under Title XIX; or (3) other individuals with certain severe or disabling chronic conditions who would benefit from enrollment in a SNP.

As outlined at 42 CFR § 422.2, SNPs are a specific type of MA coordinated care plan that provides targeted care to individuals with unique special needs, and are defined as:
1) Institutionalized or institutionalized-equivalent beneficiaries (I-SNPs)
2) Beneficiaries who are dually eligible for both Medicare and Medicaid (D-SNPs), and
3) Beneficiaries who have a severe or disabling chronic condition(s) (C-SNPs).

Section 1859(f)(7) of the Act requires that all MA SNPs be approved by the National Committee for Quality Assurance (NCQA). As a component of the MA application and renewal process, SNPs are required to submit Models of Care (MOCs) through the Health Plan Management System (HPMS). A MOC is a narrative submitted to the Centers for Medicare & Medicaid Services (CMS) by the SNP that describes the basic quality framework used to meet the individual needs of its enrollees and the infrastructure to promote care management and coordination. SNP MOCs are also considered a vital tool for quality improvement.

MOC approval is based on NCQA's evaluation using scoring guidelines developed by NCQA and CMS for the Secretary of the Department of Health and Human Services. The MOC elements cover the following areas: MOC 1: Description of the SNP Population; MOC 2: Care Coordination; MOC 3: Provider Network; and MOC 4: Quality Measurement & Performance Improvement. Based on the SNP type and MOC scores, with the exception of C-SNPs, all other SNPs receive an approval for a period of one, two, or three years. C-SNPs may only receive a one-year approval.

Care Management Plan Outlining the Model of Care

Attachment A includes MOC Elements 1-4 and represents the minimal requirements for MOC development. SNPs must address each of the elements and sub-elements. A SNP's policies and procedures approved by NCQA should align with the relevant CMS regulations specified at § 422.101(f) and all MOC requirements outlined in Attachment A. CMS also notes that the MOC requirements are distinct from the CMS SNP Audit Protocol[1], and SNPs are audited based on

[1] : https://www.cms.gov/files/zip/medicare-part-c-and-part-d-program-audit-protocols-cms-10717.zip-2

these standards, accordingly.

For all SNP types, using the tables in Attachment A, list the page number and section of the corresponding description for each element in your MOC. Once you have completed Attachment A, upload it into HPMS along with your MOC.

For D-SNPs, within HPMS, complete the questionnaire contained in Attachment B and upload it along with your MOC. It is intended to capture information unique to D-SNPs.

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Attachment A

Model of Care Matrix ~~Upload~~ Document ~~For Initial Application and Renewal~~

Table 1: Contract Information

Contract Information	Applicant's Information Field
SNP Contract Name (as provided in HPMS)	*Enter Contract Name here*
SNP CMS Contract Number	*Enter Contract Number here (Also list other contracts where this MOC is applicable)*

MOC Element 1 ~~A~~: Description of the Overall SNP Population

~~The identification and~~ A 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~~ and provides the foundation for care coordination, the provider network and quality performance and improvement. 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. It must provide an overview that fully~~ and addresses the full continuum of care, ~~of current and potential SNP beneficiaries,~~ including end of life needs and considerations, for current and potential SNP enrollees. ~~if relevant to the target population served by the SNP.~~ The description of the SNP population must include, but not be limited to, the following:

MOC Element 1A: Description of the Overall SNP Population and Most Vulnerable Enrollees

- ~~Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.~~
- Identify the specific SNP type and whether the MOC submission is an initial, renewal, or off-cycle.
  - For C-SNPs: Identify the chronic condition(s)
  - For I-SNPs: Identify the setting(s) in which your enrollee population resides (i.e., skilled nursing facility, community, other residential or institutional settings, etc.).
    - For D-SNPs: Indicate if the D-SNP(s) are seeking to be fully integrated dual eligible (FIDE) SNP, highly integrated dual eligible (HIDE) SNP, coordination only D-SNP, or includes multiple SNP types. Describe the eligibility categories and criteria for the D-SNP (Qualified Medicare Beneficiary (QMB Only); QMB Plus; Specified Low-Income Medicare Beneficiary (SLMB Only); SLMB Plus; Qualifying Individual (QI); Qualified Disabled and Working Individual (QDWI); Full Benefit Dual Eligible (FBDE). Describe the overall benefit structure and how care is coordinated.
- Provide the following information for each SNP type, differentiating between the general SNP enrollees and the most vulnerable enrollees:
  - Demographic information including a detailed profile of the population demographics (e.g., average age, gender, ethnicity, language, education

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level, socioeconomic status, etc.).

- A detailed profile of the medical status, including health conditions, social, cognitive, environmental aspects, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.
- ~~Identification and d~~A description ~~ption of~~ of the ~~health~~ conditions and/or other factors impacting the health of SNP ~~beneficiaries~~enrollees, including the most vulnerable, providing specific information about actual and/or potential health disparities, ~~other characteristics that affect health such as, population demographics~~ (e.g., ~~average age, gender, ethnicity, and potential health disparities associated with specific groups such as:~~ language barriers, deficits in health literacy, poor socioeconomic status, housing, food, transportation insecurities, cultural beliefs/barriers, caregiver considerations, ~~other~~etc.) and the associated challenges these characteristics pose.
- A description of how the SNP addresses enrollee needs related to social determinants of health.

~~Define unique characteristics for the SNP population served:~~

- ~~C-SNP: What are the unique chronic care needs for beneficiaries enrolled in a C-SNP? Include limitations and barriers that pose potential challenges for these C-SNP beneficiaries.~~
- ~~D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.~~
- ~~I-SNP: What are the unique health needs for beneficiaries enrolled in an I-SNP? Include limitations and barriers that pose potential challenges for these I-SNP beneficiaries as well as information about the facilities and/or home and community-based services in which your beneficiaries reside.~~

Note: SNPs must differentiate between the general SNP population from the most vulnerable enrollees.

MOC Element 1B: ~~Sub-Population:~~ Services for the Most Vulnerable ~~Beneficiaries~~Enrollees

~~As a SNP, you must include a complete description of the specially tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members 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 members, as well as detail additional benefits above and beyond those available to general SNP members. Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:~~

- ~~A description of~~ Describe the internal health plan procedures (i.e., methodology and specific criteria) ~~for~~ used to identify~~ing~~ the most vulnerable beneficiaries

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within the SNP and differentiate between the most vulnerable enrollees compared to those that are less resource intensive or have lower risk stratification scores.

- ~~A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with 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 beneficiaries.~~
- Describe in detail the specially tailored services for beneficiaries considered especially vulnerable and the additional benefits above and beyond those available to general SNP members.
  - Address how the SNP will meet enrollee needs throughout the full continuum of care, including end of life considerations.
  - ~~The identification and d~~Describe ~~ption of~~ the established partnerships with community organizations that ~~assist~~either provide, facilitate, or assist in identifying resources ~~in identifying resources~~ for the most vulnerable ~~beneficiaries~~enrollees and/or their caregivers, including the processes ~~that is used~~ to support and/or maintain ~~continuity of community~~ these partnerships and facilitate access to community services ~~by the most vulnerable beneficiaries and/or their caregiver(s)~~.
  - Include a list of the partnerships and available services specific to the service area.

Note: SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data.

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~~1.~~ MOC Element 2~~.~~: Care Coordination~~:~~

Care coordination involves deliberate organization and communication of health care activities with stakeholders, including providers both inside and outside of the SNP's network, to help~~s~~ ensure that ~~SNP beneficiaries'~~enrollees ~~-~~health care needs, preferences for ~~health~~ services and information sharing across health care settings ~~staff and facilities~~ are met ~~over time~~. Effective ~~C~~care coordination ~~maximizes the use of effective, efficient, safe, and high-quality patient services that~~ ultimately lead~~s~~ to improved enrollee ~~healthcare~~ outcomes. ~~, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries' 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 SNPs' care coordination activities.~~ The description of care coordination must include but not be limited to the following:

MOC Element 2A: SNP Staff Structure

- Fully define the SNP staff roles and responsibilities for both employed and contracted staff, across all health plan functions that directly or indirectly affect the care coordination ~~of beneficiaries enrolled in the SNP~~. This includes~~,~~ but is not limited to~~,~~ the identification and detailed explanation of:
  - ~~Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.~~
    - ~~Employed and/or contracted s~~Staff that perform clinical functions, such as~~:~~ direct ~~beneficiary~~enrollee care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, etc~~other~~.
    - ~~Employed and/or contracted s~~Staff that perform~~s~~ ~~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~~including staff responsibilities ~~identified in the MOC are coordinated with~~ and job titles related to care coordination. ~~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~~Describe the SNP's contingency plan(s) and disaster/emergency preparedness plans 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.

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- Renewal MOCs must provide detailed examples of training materials (e.g., slide deck, printed materials, etc.). Initial MOCs must provide a detailed description of training topics, and/or training materials, if available. Note that a general high-level overview of content is not sufficient.
- Describe how the SNP documents and maintains training records as evidence to ensure the MOC training provided to its employed and contracted staff was completed.
- Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff and describe what steps the SNP will take to ensure that MOC training(s) have been completed.

MOC Element 2B: Health Risk Assessment ~~Tool~~ (HRA~~T~~)

~~The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MOC include the following:~~

- Provide ~~A~~a ~~clear and~~ detailed description of the policies and procedures for completing the HRA~~T~~ including:
  - ~~Detailed explanation for h~~How the initial HRA~~T~~ and annual reassessment are conducted for each ~~beneficiary~~enrollee.
  - Which personnel conduct the initial HRA and annual reassessment and their level of licensure, as applicable.
  - How the HRA identifies the medical, functional, cognitive, psychosocial, mental health, and social determinants of health needs for each SNP enrollee.
  - ~~Description of~~Describe how the HRA~~T~~ is used to develop and update, in a timely manner, the Individualized Care Plan (ICP) ~~(MOC Element 2C)~~ for each ~~beneficiary~~enrollee and how the HRA~~T~~ information is disseminated to and used by the Interdisciplinary Care Team (ICT) for care management ~~(MOC Element 2D)~~.
  - ~~Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.~~
  - ~~A description of~~ Describe how the SNP ensures that the results from the initial HRA~~T~~ and the annual reassessment HRA~~T~~ conducted for each enrollee ~~individual~~ are addressed in the ICP~~individual's care plan~~.
  - Describe how the SNP addresses challenges associated with enrollees who decline to participate in HRA completion or are unable to be reached.
- Detailed plan ~~and rationale~~ for reviewing, analyzing, and stratifying ~~(if applicable)~~ the results of the HRA~~T~~, including the mechanisms to ensure communication of ~~that~~ information to the ICT~~nterdisciplinary Care Team~~, provider network, ~~beneficiaries~~enrollees and/or their caregiver(s) or designated representative, as well as other SNP personnel that may be involved with overseeing the SNP ~~beneficiary's~~ enrollee's ICP~~plan of care~~. ~~If~~

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Commented [MMCO1]: I added this question in to get a better understanding of the staff level and licensure plans use to conduct the HRAs. Such a question is also consistent with 2D where we ask about staff involved in developing the ICPs.

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~~stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.~~

- Describe how the SNP uses stratified results to improve the care coordination process.

MOC Element 2C: Face-to-Face Encounter

~~A face-to-face encounter must be conducted between the SNP and each consenting enrollee no less than on an annual basis. Face-to-face encounters can be conducted in-person or through remote technology, such as telehealth, and must occur within the first 12 months of enrollment. The face-to-face encounter is part of the overall care management strategy, and as a result, the MOC must include the following:~~

- ~~A clear and detailed description of~~Describe the policies, procedures, purpose, timing (within 12 months of enrollment and annually thereafter), and intended outcomes of the face-to-face encounter~~, including:~~
- ~~A description of~~Describe who will conduct the face-to-face encounter~~,~~ (e.g., employed and/or contracted staff)~~,~~, and how the encounter will be conducted.
- Describe the process used to obtain consent from enrollees to complete a face-to-face encounter and how the SNP verifies that the enrollee has granted consent prior to the face-to-face encounter.
- Describe how the SNP verifies that enrollees have participated in a face-to-face encounter between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan healthcare providers:
  - Detail the process for reviewing enrollee claims data and how it is used.
  - Identify responsible staff; and
  - Describe any follow-up communications with enrollee/caregiver, if applicable.
- ~~A description of~~ Describe the types of clinical functions, assessments and/or services that may be provided during the face-to-face encounter and how health concerns and/or active or potential health issues are ~~will be~~ addressed ~~during the face-to-face encounter, and~~. This includes a description of how the SNP will conduct care coordination activities ~~through~~ and ensure that appropriate follow-up, referrals and scheduling are completed as necessary.

MOC Element 2D: Individualized Care Plan (ICP)

- ~~The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiaries' caregiver(s); and identification of goals met or not met.~~
  - ~~When the beneficiary's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.~~
- ~~Explain~~ Describe the process for developing the ICP, ~~and~~ which SNP personnel are responsible ~~for the development of the ICP~~, and how the ~~beneficiary~~ enrollee and/or ~~his/her~~their caregiver(s) or representative(s) ~~is~~are involved in ~~its~~the development.

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~~and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary's ICP.~~

- ~~Describe how the ICP is documented and updated, including updates based on more recent HRAT information, as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).~~
- Describe how the SNP will incorporate the following requirements into the ICP: enrollee self-management goals and objectives to meet their medical, functional, cognitive, psychosocial, mental health, and social determinants of health needs identified in the HRA (based on enrollee preferences for delivery of services and benefits); how often goals will be evaluated; the enrollee's personal health care preferences; description of services specifically tailored to the enrollee's needs; and role of the caregiver(s).
- Describe how often SNP personnel review and update and/or modify the ICP based on the evaluation of enrollee goals, changes in health care needs/status and/or recent HRA information, etc.
- ~~Explain~~Describe how updates and/or modifications to the ICP are communicated to the ~~beneficiary~~enrollee and/or their caregiver(s), the ICT, ~~applicable~~ network providers, other SNP personnel and ~~other~~ stakeholders as necessary.
- Describe how the ICP is maintained (documented, updated etc.), and the methods for ensuring access by the appropriate stakeholders, ICT, provider network, enrollees and/or caregiver(s), etc.
- Describe how the SNP provides enrollees and/or their caregivers with copies of or electronic access to their ICP.
- D-SNPs: Describe how the ICP coordinates Medicare and Medicaid services and, if applicable, the D-SNP or affiliated Medicaid plan provides these services, including long-term services and supports and behavioral health services.

MOC Element 2E: Interdisciplinary Care Team (ICT)

- Provide a ~~detailed and~~ comprehensive description of the composition of the ICT, ~~,~~ including ~~e~~ 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 ~~beneficiaries~~enrollees, and how the ICT members contribute to improving the health status of enrollees~~SNP beneficiaries. If a stratification model is used for determining SNP beneficiaries' 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~~.
  - ~~Explain~~ Describe how the SNP ~~facilitates the participation of~~informs and invites ~~beneficiaries~~enrollees, and their caregivers to participate as active members of the ICT.
  - Describe how the ~~beneficiary's~~enrollee's HRA~~T (MOC Element 2B)~~ and ICP ~~(MOC Element 2C)~~ are used to determine the composition of the ICT~~:~~.

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including those cases where additional team members are needed to meet the unique needs of the individual ~~beneficiary~~enrollee.

- ~~Explain~~Describe how the ~~ICT~~ SNP ~~uses~~analyzes enrollee health care needs and ~~healthcare~~ outcomes data to implement changes and/or adjustments to the ICT composition~~evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs on a continuous basis~~.

- ~~Identify and explain the use of~~Describe how clinical managers, case managers or other~~s who play critical roles in~~ plan staff ensure~~ing an effective~~that the SNP's interdisciplinary care process~~es is being conducted~~ are effective in meeting enrollee needs.
- Provide a ~~clear and~~ comprehensive description of the SNP's communication plan that ensures the exchange~~s~~ of ~~beneficiary~~enrollee information ~~is occurr~~occurs~~ing~~ regularly ~~within~~amongst the ICT, and includ~~es ing~~ but is not ~~be~~ limited to~~,~~ the following:
  - ~~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~~ Describe how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, ~~beneficiaries~~enrollees, caregiver(s), community organizations and other stakeholders.
  - Describe ~~T~~the types of evidence used to verify that communications have taken place, (e.g., ~~written~~ ICT meeting minutes, documentation in the ICP~~,~~ etc ~~other~~.)
  - Describe ~~H~~how communication is conducted with ~~beneficiaries~~enrollees who have hearing, visual or other impairments, language barriers and/or cognitive deficiencies and those that need information provided in alternate formats or other languages (verbal or written).
  - D-SNPs: Explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable.

Element F: Care Transitions Protocols

- ~~Explain~~ Describe how care transitions protocols are used to maintain continuity of care for SNP beneficiaries, including ~~. Provide details and specify the~~ the process ~~and rationale~~ for connecting the ~~beneficiary~~enrollee to the appropriate provider(s), services, community resources, etc., regardless of network affiliation.
- Describe which personnel (e.g., case manager) are responsible for coordinating care ~~transition process~~ and ensuring that follow-up services and appointments are scheduled and performed, and how the enrollee and/or their caregiver(s) is informed on their SNP point of contact throughout the transition process ~~as defined in MOC Element 2A~~.
- ~~Explain~~Describe how the SNP ensures elements of the beneficiary's ICP and/or other relevant information are transferred between healthcare settings (e.g., community, hospital or institutional settings) when the ~~beneficiary~~enrollees ~~experiences~~experience

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a~~n applicable~~ transition in care, either planned or unplanned. ~~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 ~~beneficiary~~enrollee and/or caregiver(s) have access to and can adequately utilize ~~the beneficiaries'~~their personal health information to ~~facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network~~ share with other providers, help facilitate care, make informed decisions, etc.
- Describe how the ~~beneficiary~~enrollee and/or caregiver(s) will be educated about ~~indicators that his/her~~ their condition, signs/symptoms ~~has~~ of improve~~d~~ment or worsening, self-management techniques, when to contact their provider(s), ~~ed~~ and how they will demonstrate ~~their~~ understanding of this information~~those indicators and appropriate self-management activities~~.
- D-SNPs: Explain how the plan coordinates with providers of any Medicaid covered services during a care transition, where applicable.
- ~~Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.~~

MOC Element ~~3.~~3. SNP Provider Network~~:~~

The SNP Provider Network is a network of health care providers who are contracted to provide health care services to SNP ~~beneficiaries~~enrollees. The SNP is responsible for maintaining a network ~~description~~ that ~~must~~ includes relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population. ~~as identified in MOC 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 for its SNP Provider Network:~~ The description of the SNP provider network must include but not be limited to the following:

MOC Element 3A: Specialized Expertise

- Provide a ~~complete and~~ detailed description of the specialized expertise available to ~~SNP beneficiaries~~enrollees in the SNP's 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 ~~interdisciplinary team~~ 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~~Describe 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 ~~beneficiaries~~enrollees. Specialized expertise may ~~include, but~~include but is not limited to~~:~~ internists~~al medicine~~, endocrinologists, cardiologists, oncologists, nephrologists, mental health ~~specialists~~providers, etc~~other~~.
- Describe how providers collaborate with the ICT and SNP enrollees, ~~(MOC Element 2D) and the beneficiary,~~ contribute to the ICP ~~(MOC Element 2C)~~ and ensure the delivery of necessary specialized services. For example, describe~~:~~ how providers communicate SNP ~~beneficiaries'~~enrollee care needs to the ICT and other stakeholders~~:~~, how specialized services are delivered ~~to the SNP beneficiary~~ in a timely and effective ~~way~~manner~~;~~, and how ~~reports~~ relevant information/data ~~regarding services rendered are~~ is shared with the ICT and ~~how relevant information is~~ incorporated into the ICP.
- Describe how the SNP maintains current information on providers, including the process and frequency used to make updates to ensure an accurate provider network directory.

MOC Element 3B: Use of Clinical Practice Guidelines & Care Transitions Protocols

- ~~Explain~~ Describe the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols, and the methods used to monitor, track and verify compliance. ~~This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.~~

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- ~~Define~~Describe how the SNP ~~any challenges encountered with~~ overse~~e~~sing enrollees ~~patients with~~whose complex health care needs require ~~where~~ clinical practice guidelines and nationally-recognized protocols ~~may need~~ to be modified to fit the unique needs of vulnerable SNP enrollees~~beneficiaries.~~ Also describe ~~Provide details regarding~~ how these decisions are made, incorporated into the ICP ~~(MOC Element 2C),~~ and communicated with the ICT ~~(MOC Element 2D) and acted upon~~.
- ~~Explain~~Describe how the SNP ~~providers~~ ensures care transitions protocols are ~~being~~ used both internally and by contracted providers to maintain continuity of care ~~for the SNP beneficiary as outlined in MOC Element 2E~~.

MOC Element 3C: MOC Training for the Provider Network Staff

- Describe ~~Explain, in detail,~~ how the SNP conducts initial and annual MOC training for provider staff, including both in-network ~~providers~~ and out-of-network providers (note: out-of-network providers include providers seen by ~~beneficiaries~~enrollees on a routine basis.). Provider staff may include care coordination staff, admin staff, other clinical or support staff, etc.
- Acceptable approaches to training may include ~~This could include, but not be limited to:~~ printed instructional materials, face- to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.
    - Renewal plans must provide detailed examples of training materials (e.g., slide deck, printed materials, etc.). Initial plans must provide a detailed description of training topics (not a general high-level overview of content) and/or training materials, if available.
- Describe how the SNP tracks, verifies ~~documents~~ and maintains training records as evidence of MOC training for their network provider staff~~s~~. 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~~ attestations, etc ~~of MOC training~~.
- Describe ~~Explain~~ any challenges associated with the completion of MOC training for both in-network and out-of network providers staff, and ~~describe what specific actions~~ provide strategies the SNP Plan will ~~take~~implement to facilitate compliance ~~when the required MOC training has not been completed~~ (e.g., how the SNP will work with providers to connect with the appropriate staff and facilitate completion of the trainings) ~~or is found to be deficient in some way~~.

MOC Element ~~4~~4: MOC Quality Measurement & Performance Improvement~~:~~

The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver high quality health care services and benefits to ~~its~~ SNP ~~beneficiaries~~enrollees in a ~~high-quality~~timely 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 SNPs' leadership

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team, ~~managers and~~ and governing body ~~of a SNP organization~~ must have a comprehensive quality improvement program in place to measure its current level of performance, a methodology for assessing improvement and distributing ~~and determine if organizational systems and processes must be modified based on~~ performance results.

SNPs are required to establish measurable goals related to the 1) overall MOC performance, and 2) enrollee health outcomes for the SNP population. MOC Element 4A establishes the SNPs' overall quality performance improvement plan. MOC Element 4B establishes the goals for the overall MOC performance, such as improving access and affordability, care coordination, etc., and goals for enrollee health outcomes, such as improving rates for preventive services and screenings, medication adherence, etc. The description of the MOC quality measurement and performance improvement plan must include but not be limited to the following:

MOC Element 4A: MOC Quality Performance Improvement Plan

- Describe ~~Explain, in detail,~~ the overall quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP ~~beneficiaries~~enrollees. The ~~quality performance improvement~~ plan must be designed to ~~detect~~determine whether the overall MOC structure effectively accommodates enrollees ~~beneficiaries'~~ unique health care needs, while delivering high quality care and services. The plan must address but not be limited to improving access to and coordination of care, member/provider satisfaction, and program effectiveness. ~~The description must include, but is not limited to, the following:~~
- Describe how the SNP leadership team and other SNP personnel and stakeholders are involved with the internal quality performance process.
- Describe ~~T~~the ~~complete~~ process~~,~~ by which the SNP continuously collects, analyzes, ~~evaluates and reports~~ evaluates, reports on quality performance and supports ongoing improvement of the MOC. ~~based on the MOC by using specified data sources, performance and outcome measures. The MOC must also describe the frequency of these activities~~.Also describe the processes used by the SNP to determine if goals/outcomes are met/not met, the use of benchmarks, timeframes for measurement and re-measurement when goals are not achieved.
- Describe how the goals established for the overall MOC performance and enrollee health outcomes (as outlined in MOC 4B) are integrated into the overall performance improvement plan.
- Describes what the SNP does to systematically identify which enrollees receive no covered Medicare services during a defined period of time and action taken by the SNP to identify and connect with these enrollees.
- ~~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).~~
    - ~~Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the~~

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~~re-measurement plan for goals not achieved.~~

MOC Element 4B: Measurable Goals ~~& Health Outcomes for the MOC~~

- ~~Identify and clearly define~~Describe the SNP's measurable goals for the 1). Overall MOC performance and 2). Enrollee health outcomes for the SNP population as a whole. ~~and describe how identified measurable goals and health outcomes are communicated throughout the SNP organization. Responses must include but not be limited to, the following:~~ All goals must be measurable and specific, contain relevant information, data source(s), frequency for measurement, etc. and describe how the goals are communicated throughout the SNP and to stakeholders.
- Provide relevant information on how the SNP will achieve the MOC's goals, including the frequency of evaluation and the process the SNP uses or intends to use to determine if goals/outcomes are met (including specific benchmarks, timeframes, etc.).
- Indicate whether the SNP achieved the previous MOC's goals:
  - MOC renewals must specify if the goals of the previously approved MOC were met or not met and include results and a plan of action of action if not met.
  - If the MOC did not fulfill the previous MOC goals, indicate how the SNP will achieve or revise the goals for the next MOC.
  - For SNPs submitting an initial MOC, provide relevant information pertaining to the MOC's goals, e.g., include the specific goals, data sources, frequency for measurement, etc.

  - ~~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 beneficiaries.~~
  - ~~Ensuring appropriate utilization of services for preventive health and chronic conditions.~~
- ~~Identify the specific beneficiary 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 beneficiaries' 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.~~
- ~~For MOC renewals: Include appropriate data pertaining to the fulfillment or achievement of the previous MOC's goals.~~
- ~~If the MOC did not fulfill the previous MOC goals, the plan must describe how it will achieve or revise the goals for the plan's next MOC implementation.~~

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Overall MOC Performance Goals

- Provide a description of the **overall MOC performance goal(s)** using the criteria outlined above. Examples may include, but not be limited to:
  - Improving access and affordability of care for the SNP population.
  - Improvements made in care coordination and appropriate delivery of services through the direct alignment with the HRA, ICP, and ICT.
  - Enhancing care transitions across all providers and healthcare settings.

Enrollee Health Outcomes Goals

- Provide a description of the **enrollee health outcome** goal(s) for the overall SNP population using the criteria outlined above. Examples may include but not be limited to:
  - Appropriate utilization of services for chronic conditions
    - Improving hemoglobin A1c rate levels in enrollees with diabetes
    - Improving medication adherence
    - Lowering all cause readmissions
  - Preventive Health Services
    - Improving rates of breast cancer or colorectal screenings
    - Improving rates of depression screenings
    - Improving influenza, pneumonia, RSV or shingles vaccination rates

MOC Element 4C: Measuring Patient Experience of Care (SNP Member Satisfaction)

- Describe the specific SNP survey(s) used and the rationale for selection of a particular tool(s) to measure ~~SNP beneficiary~~enrollee satisfaction.
- Detail the methodology used to collect survey data and specify the sample size for each survey used.
- ~~Explain~~ Describe how the results of ~~SNP member~~enrollee satisfaction surveys are analyzed and integrated into the overall MOC performance improvement plan and used to implement new programs that target areas for improvement. ~~, including specific steps to be taken by the SNP to~~
- Describe the process used to address issues identified in ~~response to~~ the survey results.

~~**Element D: Ongoing Performance Improvement Evaluation of the MOC**~~

- ~~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, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process~~
- ~~Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.~~

MOC Element ~~E~~4D: Dissemination of ~~SNP~~MOC Quality Performance Results ~~related to the MOC~~

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- ~~Explain~~Describe~~,~~ 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 teams, ~~SNP management groups, SNP~~ board~~s~~ of directors, ~~SNP~~ personnel & staff, ~~SNP~~ provider networks, ~~SNP~~ ~~beneficiaries~~enrollees and caregivers, the general public, and regulatory agencies ~~on a routine basis~~.
  - 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~~ webpages ~~for announcements;~~ printed newsletters~~;~~, bulletins~~;~~, and other forms of media ~~announcement mechanisms~~.
- Identify the individual(s) responsible for communicating performance updates/results in a timely manner ~~as described in MOC Element 2A~~.
- Describe how the performance improvement updates/results will be documented and shared with key stakeholders.

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Attachment B
Dual Eligible Special Needs Plan Model of Care Questionnaire

Medicare Advantage (MA) organizations with at least one dual eligible special needs plan (D-SNP) must complete this questionnaire along with the Model of Care (MOC) submission. MA organizations should assume responses are at the contract level.

1. Please tell us about your D-SNP's care coordination process:
   - Does every enrollee have an assigned, consistent care coordinator? (Yes or No)
   - Does the D-SNP delegate care coordination functions to the provider level? (Yes or No)
   - Does the D-SNP contract with first tier, downstream, or related entities (FDRs) that conduct care coordination activities such as administering health risk assessments (HRAs) or outreach? (Yes or No)

2. Who conducts HRAs? (Please select all that apply)
   - In-house staff
   - Contracted staff
   - External vendor staff
   - Primary care providers (PCP) or other contracted providers
   - Enrollee's assigned care coordinator
   - Staff who only conduct HRAs

3. Which mechanisms does the D-SNP use to administer HRAs? (Please select all that apply)
   - Hard copy mail
   - Telephone
   - Video conference
   - In-person
   - Other

4. How does the D-SNP outreach to enrollees to maximize HRA completion? (Please select all that apply)
   - Mails letter to enrollee in advance of HRA
   - Sends text or email message to enrollee in advance of HRA
   - Calls enrollee from phone number that shows the plan's name in caller ID
   - Care coordinator conducts the HRA during a care coordination call
   - Other

5. When is the individualized care plan (ICP) updated? (Please select all that apply):

- After all hospitalizations
- After all skilled nursing facility (SNF) / nursing facility (NF) admissions
- After all emergency department visits
- After any known change in condition
- After any new major diagnosis social change (e.g., caregiver passing away)
- After every annual HRA reassessment
- After identification of long term services and supports (LTSS) needs
- After request from enrollee or caregiver
- Other

6. How are updates and/or modifications to the ICP communicated to the interdisciplinary care team (ICT), applicable network providers, other D-SNP personnel, and other stakeholders as necessary. (Please select all that apply)
   - Email
   - Hard copy mail
   - Electronic portal
   - Fax
   - Other

7. When the HRA identifies housing stability, food security, and/or access to transportation needs for enrollees, how does it generate a referral to community resources? (Please choose from the below responses):
   - Automatic referral generated
   - Referral made on case-by-case basis
   - The D-SNP does not refer to community resources

8. Describe how the D-SNP communicates with enrollees and caregivers about the ICT. (Please select all that apply):
   - Hard copy mail
   - Text message
   - Email message
   - Electronic portal
   - Fax
   - Other

9. Will D-SNP enrollees receive Medicaid services through Medicaid managed care? (Yes/No)
   - If Yes, will D-SNP enrollees receive Medicaid services from organizations other than the D-SNP or affiliates under the D-SNP's parent organization? (Yes/No)

- If Yes, for the purposes of coordinating Medicaid services per 42 CFR 422.107(c)(1), how will the D-SNP determine the Medicaid managed care plans in which the D-SNP enrollees are enrolled? (Please check all that apply)
  - D-SNP has an electronic data exchange with the state
  - D-SNP asks new enrollees as part of the annual HRA
  - Other

10. With which types of community organizations has the D-SNP established partnerships that assist in identifying resources for enrollees? (Please select all that apply):
    - Centers for independent living
    - Area agencies on aging
    - Protection & advocacy systems, such as those listed at the following link: https://acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems
    - State councils on developmental disabilities
    - Mental health services networks
    - Other N/A

11. Does the D-SNP ever use one HRA to meet all CMS and state requirements? (Yes or No)
    - If No, does the D-SNP coordinate its HRA with any state-required assessments (e.g., for HCBS)? (Yes/No)
    - If Yes, how does the D-SNP coordinate with the state on conducting the one HRA? (Please select all that apply):
      - The D-SNP obtains state-required assessment results from state Medicaid agency or independent entity that conducts the state-required assessment
      - The D-SNP conducts the HRA and shares the results with state Medicaid agency or independent entity responsible for assessing compliance with Medicaid requirements
      - Other

12. CMS will accept a Medicaid HRA that is performed within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA. Does the D-SNP use recently completed Medicaid HRAs in lieu of a separate HRA conducted by the D-SNP, if the Medicaid HRA meets the minimum Medicare HRA requirements? (Yes or No)

13. If the D-SNP or affiliated plan covers Medicaid services, can the enrollee's care coordinator directly authorize Medicaid services (Yes or No)?

14. Does the D-SNP identify whether enrollees are receiving services included in

their ICP, either through comparison of claims data against the ICP or through some other mechanism? (Yes/No)

15. Does the D-SNP systematically identify potential Medicaid covered services needs among its enrollees? (Yes/No)
    - If yes, the D-SNP tracks this information in its: (select all that apply)
        - Care management system
        - Customer service system
        - Appeals and grievances system
        - Other
    - If yes, the D-SNP offers assistance to those enrollees with:
        - Obtaining Medicaid covered services through helping the enrollee contact the Medicaid managed care plan or state Medicaid agency? (Yes/No)
        - Requesting authorization of Medicaid services? (Yes/No)
        - Navigating Medicaid appeals and grievances in connection with the enrollee's own Medicaid coverage regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan? (Yes/No)
        - Other

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