Program Audit Data Request
Special Needs Plans - Care Coordination
Supplemental Questionnaire

Name of Sponsoring Organization: Click or tap here to enter text.

Contract Numbers: Click or tap here to enter text.

Name and Title of Person Completing Questionnaire: Click or tap here to enter text.

Date Completed: Click or tap to enter a date.

This questionnaire is designed to assist CMS in understanding the unique qualities of your organization's SNP program operations. Separate questionnaires may be provided for each entity/operating system showing the CMS contracts that are applicable to each completed questionnaire (*if multiple questionnaires are completed, they must be zipped together and uploaded to HPMS as a single file*). We recognize that your time is valuable and appreciate your availability to provide responses to our questions regarding your SNP program operations. The responses to these questions may be discussed during the SNPCC audit.

Please enter your responses to the questions below and upload the completed form to HPMS within 5 business days of receiving your audit engagement letter.

1. **Has your organization experienced any default enrollments, Plan Benefit Package (PBP) mergers, acquisitions, or plan consolidations within the 12 months preceding the date of the engagement letter? If so, please describe the circumstance.**

   Click or tap here to enter text.

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

   Click or tap here to enter text.

3. **Describe your organization's internal system utilized for tracking Health Risk Assessments (HRAs), Individualized Care Plans (ICPs), and Interdisciplinary Care Team (ICT) decisions and activities.**

   Click or tap here to enter text.

4. **Do you use an online member portal to share information with enrollees (i.e., health**

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literacy, ICP)? If yes, how do you determine which enrollees have access and are able to use the portal?

Click or tap here to enter text.

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

   Click or tap here to enter text.

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

   Click or tap here to enter text.

7. **Describe the process for tracking Model of Care training for ICT-implicated staff and First Tier, Downstream, and Related Entities (FDRs).**

   Click or tap here to enter text.

8. **Describe the outreach policy pertaining to HRA administration and ICP development. Describe the process for enrollees who are unable to be reached or who decline to participate.**

   Click or tap here to enter text.

9. **List all FDRs that you contract with that conduct SNP related care coordination activities and indicate what function(s) they perform.**

   Click or tap here to enter text.

10. **(For D-SNPs) Does your organization arrange for State Medicaid carve-out services for specific populations (e.g., LTSS and/or behavioral health)? If yes, please provide a brief overview of the program.**

    Click or tap here to enter text.

unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1395 (Expires MM/DD/CCYY). This is a mandatory information collection. The time required to complete this information collection is estimated to average 390 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.