

Model of Care Scoring Guidelines for Contract Year 2022

FOR PLANS SUBMITTING IN FEBRUARY 2021 WITH IMPLEMENTATION ON
JANUARY 1, 2022

THE SNP TEAM

Table of Contents

Introduction	2
Model of Care	4
MOC 1: Description of SNP Population (General Population)	4
Element A: Description of Overall SNP Population.....	4
MOC 1 Element B: Subpopulation—Most Vulnerable Beneficiaries.....	7
MOC 2: Care Coordination	9
MOC 2 Element A: SNP Staff Structure.....	9
Element B: Health Risk Assessment Tool (HRAT).....	12
MOC 2 Element C: Individualized Care Plan (ICP)	14
MOC 2 Element D: Interdisciplinary Care Team (ICT)	16
MOC 2 Element E: Care Transition Protocols	18
MOC 3 Provider Network.....	21
MOC 3 Element A: Specialized Expertise.....	21
MOC 3 Element B: Use of Clinical Practice Guidelines and Care Transition Protocols	23
Element C: MOC Training for the Provider Network.....	25
MOC 4: MOC Quality Measurement and Performance Improvement.....	27
MOC 4 Element B: Measureable Goals and Health Outcomes for the MOC	29
MOC 4 Element C: Measuring Patient Experience of Care (SNP Member Satisfaction)	31
MOC 4 Element D: Ongoing Performance Improvement Evaluation of the MOC	32
MOC 4 Element E: Dissemination of SNP Quality Performance Related to the MOC	33

Introduction

As written in the Memorandum to Medicare Advantage Special Needs Plans, the purpose of this statement is to remind “Medicare Advantage (MA) Special Needs Plans (SNPs) of the recent changes to the Model of Care (MOC) submission requirements. The Bipartisan Budget Act of 2018 (BBA 2018) Section 50311 modified the MOC requirements for C-SNPs in section 1859 (b)(6)(B)(iii) of the Social Security Act. Specifically, section (B)(iv) of the Bipartisan Budget Act requires that beginning in contract year (CY) 2020 and subsequent years, Chronic Condition (C-SNPs) will submit a MOC annually for evaluation and approval by the National Committee for Quality Assurance (NCQA). Therefore, all C-SNP MOCs will receive a one-year approval. This requirement does not apply to Dual (D-SNPs) or Institutional (I-SNPs) SNP types.”

This
page
intentionally
left
blank

Model of Care

MOC 1: Description of SNP Population (General Population)

Identification and a comprehensive description of the SNP-specific population are integral components of the model of care (MOC). All elements in this standard depend on a complete population description that addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations (if relevant). SNPs must include a complete description of specially tailored services for beneficiaries considered especially vulnerable (refer to Element 1B), using specific terms and details (e.g., members with multiple hospital admissions within three months, “medication spending above \$4,000”).

Element A: Description of Overall SNP Population

The organization’s MOC description of its target SNP population must:

1. Describe how the health plan staff will determine, verify, and track eligibility of SNP beneficiaries.
2. Describe the social, cognitive, and environmental factors, living conditions and co-morbidities associated with the SNP population.
3. Identify and describe the medical and health conditions impacting SNP beneficiaries.
4. Define the unique characteristics of the SNP population served.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Element stem: Target population characteristics*

The organization’s description of its target population is an integral component of the MOC narrative that provides a fundamental foundation on which the other

elements build to develop a comprehensive program that fully addresses the continuum of care for its beneficiaries. Information about national population statistics is insufficient.

The organization's MOC must show how it identifies its members and must describe the target population that includes specific information on the characteristics of the population it intends to serve. This information must include specific components that characterize its beneficiaries, such as average age, gender and ethnicity profiles, the incidence and prevalence of major diseases, chronic conditions and other significant barriers faced by the target population.

The organization may use beneficiary information from other product lines (e.g., Medicare Advantage or Medicaid plans) as an example of the intended target population if the plan does not have members, or it must provide details compiled from the intended plan service area.

Factor 1: Determine, verify, and track eligibility

The organization must have a process for identifying, verifying, and tracking SNP beneficiaries to ensure eligibility for appropriate care coordination services. The MOC description must include information on the relevant resources (systems or data collection methodology) used to perform these tasks.

Factors 2 & 3: Identify health conditions

The MOC description includes specific information on the current health status of its SNP beneficiaries and characteristics that may impact their status. Factor 2 should include descriptions of the demographic, social and environmental factors, and living conditions associated with the SNP population such as average age, gender, ethnicity and potential health disparities associated with certain groups, such as language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs or barriers that may interfere with conventional provision of health care or services, caregiver considerations or other concerns. Factor 3 should identify and describe the medical and cognitive factors, co-morbidities and other health conditions that affect SNP beneficiaries.

Factor 4: Define unique characteristics of the SNP population (plan type)

Each SNP type (Chronic [C-SNP], Dual-Eligible [D-SNP] or Institutional [I-SNP]) description must include the unique health needs of beneficiaries enrolled in each plan as well as limitations and barriers that may pose challenges affecting their overall health:

- *C-SNPs:*

- Describe chronic conditions, incidence and prevalence as related to the target population covered by the C-SNP.
- The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., multiple co-morbidities, lack of care coordination between multiple providers)
- *D-SNPs*:
 - Describe dual-eligible members, such as full duals or partial duals.
 - The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., gaps in coordination of benefits between Medicare and Medicaid, poor health literacy).
- *I-SNPs*:
 - Specify the facility type and provide information about facilities where SNP beneficiaries reside (e.g., long term care facility, home, or community-based services).
 - Include information about the types of services, as well as about the providers of specialized services.
 - The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., dementia, frailty, lack of family/caregiver resources or support).

MOC 1 Element B: Subpopulation—Most Vulnerable Beneficiaries

The organization must have a complete description of the specially tailored services it provides to its most vulnerable members that:

1. Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries.
2. Explains in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries.
3. Illustrates the relationship between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.
4. Identifies and describes established relationships with partners in the community to provide needed resources.

Summary of changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factor 1: Define most vulnerable beneficiaries*

Although the definition of “SNP beneficiary” typically implies members requiring additional care and services, the description focuses on the sickest or most vulnerable SNP members.

The organization’s MOC must include a robust and comprehensive definition that describes who these members are (i.e., what sets them apart from the overall SNP population), the methodology used to identify them (e.g., data collected on multiple hospital admissions within a specified time frame; high pharmacy utilization; high risk and resultant costs; specific diagnoses and subsequent treatment; medical, psychosocial, cognitive or functional challenges) and specially tailored services for which these beneficiaries are eligible. 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 may use beneficiary information from other product lines (e.g., Medicare Advantage or Medicaid plans) as an example of the intended target population if the plan does not have members, or it must provide details compiled from the intended plan service area.

Factors 2 & 3: Correlation between demographic characteristics and clinical requirements

The organization's MOC definition of its most vulnerable beneficiaries must describe the demographic characteristics of this population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factors) and specify how these characteristics combine to adversely affect health status and outcomes and affect the need for unique clinical interventions.

The definition must include a description of special services and resources the organization anticipates for provision of care to this vulnerable population.

Factor 4: Establish relationships with community partners

The organization's MOC must describe its process for partnering with providers within the community to deliver needed services to its most vulnerable members, including the type of specialized resources and services provided and how the organization works with its partners to facilitate member or caregiver access and maintain continuity of services.

MOC 2: Care Coordination

Regulations at 42 CFR §422.101(f)(ii)-(v) and 42 CFR §422.152(g)(2)(vii)-(x) require all SNPs to coordinate the delivery of care and measure the effectiveness of the MOC delivery of care coordination. Care coordination helps ensure that SNP beneficiaries' health care needs, preferences for health services and information sharing across health care staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, high-quality patient services (including services furnished outside the SNP's provider network) that ultimately lead to improved health care outcomes. The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no element must be interpreted as being of greater importance than any other. Taken together, all five sub-elements must comprehensively address the SNP's care coordination activities.

MOC 2 Element A: SNP Staff Structure

The organization's MOC must:

1. Describe the administrative staff's roles and responsibilities across all health plan functions, including oversight functions that directly or indirectly affect care of beneficiaries enrolled in the SNP.
2. Describe the clinical staff's roles and responsibilities, including oversight functions as noted in factor 1.
3. Describe how staff responsibilities coordinate with the job title (provide organization chart).
4. Describe contingency plans used to address ongoing continuity of critical staff functions.
5. Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.
6. Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.
7. Describe actions the organization takes if staff do not complete the required MOC training.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	20%
	The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation **Factor 1: Administrative staff roles and responsibilities**

The organization's MOC defines staff roles and responsibilities across all health plan functions for personnel that directly or indirectly affect the care coordination of SNP beneficiaries.

The organization's MOC must identify and describe the specific employed and contracted staff responsible for performing administrative functions, including:

- Enrollment and eligibility verification.
- Claims processing.
- Administrative oversight.

Factor 2: Clinical staff roles and responsibilities

The organization must identify and describe the employed and contracted staff that perform clinical functions, including:

- Direct beneficiary care and education on self-management techniques.
- Care coordination.
- Pharmacy consultation.
- Behavioral health counseling.
- Clinical oversight.

Staff oversight responsibilities must include any license and competency verification that relates to the specific population being served by the organization (e.g., geriatric training for I-SNP providers or special training for physicians and other clinical staff for a C-SNP services beneficiaries with HIV/AIDS); data analyses for utilization of appropriate and timely health care services; utilization review; and provider oversight to ensure use of appropriate clinical practice guidelines and integration of care transition protocols.

Factor 3: Coordination of responsibilities and job title

To show how staff responsibilities identified in the MOC are coordinated with job title, the organization must provide a copy of its organization chart and, if applicable, a description of instances when a change to staff title/position or level of accountability is required to accommodate operational changes in the SNP.

Factor 4: Contingency plan

The organization must have a contingency plan (or plans) in place to avoid a disruption in care and services when existing staff can no longer perform their roles and meet their responsibilities. The organization's MOC must identify and describe contingency plans to ensure ongoing continuity of critical staff functions.

Factors 5: Initial and annual MOC training

The organization must conduct initial and annual MOC training for its employed and contracted staff. The MOC must describe the training strategies and content, as well as the methodology the organization uses to document and maintain training records as evidence that staff have completed MOC training. Contracted staff do not include physicians or other providers that the organization contracts with as part of the provider network. Documentation must include a complete description of the types of trainings and specific examples of slides or training materials. Descriptions may also include but are not limited to: results of MOC competency testing. If the training plan is not currently operational, the organization's MOC must provide a complete description of the plan's training contents.

Factor 6: Maintaining training records

The organization must provide the methodology it uses to document and maintain training records as evidence that staff have completed MOC training such as examples of dated attendee lists, web-based attendance confirmation, and electronic training record. This includes tracking and storage of documentation. Contracted staff do not include physicians or other providers that the organization contracts with as part of the provider network.

Factor 7: Actions if training is not completed

The organization's MOC must explain challenges associated with employed and contracted staff completing training and must describe the specific actions the organization will take when the required MOC training has not been completed or has been found to be deficient.

MOC 2 Element B: Health Risk Assessment Tool (HRAT)

Regulations at [42 CFR §422.101\(f\)\(i\)](#); [42 CFR §422.152\(g\)\(2\)\(iv\)](#) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP. The organization’s MOC includes a clear and detailed description of the policies and procedures for completing the HRAT.

1. Describe the process (P&P’s) for completing the HRAT, how the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary (Element 2C).
2. Process for how the organization then disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and subsequently how the ICT uses that information (Element 2D).
3. Provides a detailed description of how the organization conducts the initial HRAT and annual reassessment for each beneficiary.
4. The detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable), the HRA results including how the results are communicated back to the ICT, PCP, and other applicable providers.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation The content of and methods used to conduct the HRAT have a direct effect on the development of the ICP and ongoing coordination of ICT activities. The HRAT must assess the medical, functional, cognitive, psychosocial, and mental health needs of each SNP beneficiary.

Factors 1 & 2: Use and dissemination of HRAT information

The organization must include a description of how the HRAT is used to develop and update, in a timely manner, the ICP for each beneficiary and how the HRAT information is disseminated to and used by the ICT.

Factor 3: Initial HRA and annual reassessment

The organization must complete the HRAT for each beneficiary, for initial assessment, and must complete an HRAT annually thereafter. At a minimum, the organization must conduct initial assessment within 90 days of enrollment and must conduct annual reassessment within one year of the initial assessment.

"As part of the model of care under clause (I) of subparagraph (A) of the BBA 2018, the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individualize care plan under clause (ii) (II) of such subparagraph." This statement is repeated under MOC Element 2C as the results of each assessment must be incorporated into the beneficiaries' care plan.

The description must include the methodology used to coordinate the initial and annual HRAT for each beneficiary (e.g., mailed questionnaire, in-person assessment, phone interview) and the timing of the assessments. There must be a provision to reassess beneficiaries, if warranted by a health status change or care transition (e.g., hospitalization, change in medication, multiple falls). The organization must describe its process for attempting to contact beneficiaries and have them complete the HRAT, including provisions for beneficiaries that cannot or do not want to be contacted or complete the HRAT.

Factor 4: Plan and rationale

The organization's MOC must describe its plan and explain its rationale for reviewing, analyzing, and stratifying HRAT results. It must include the mechanisms for communicating information to the ICT, provider network, beneficiaries and/or their caregivers and other SNP personnel who may be involved with overseeing a beneficiary's plan of care. If the organization uses stratified results, the MOC must explain how the SNP uses the results to improve the care coordination process.

MOC 2 Element C: Individualized Care Plan (ICP)

Regulations at 42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP. The organization's ICP description must address factors 1-5.

1. The essential components of the ICP.
2. The process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change.
3. The personnel responsible for development of the ICP, including how beneficiaries and/or caregivers are involved.
4. How the ICP is documented, updated and where it is maintained.
5. How updates and modifications to the ICP are communicated to the beneficiary and other stakeholders.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factor 1: ICP essential components*

The organization must develop an ICP for each beneficiary, to deliver appropriate care to the beneficiary. The organization's ICP must include, but is not limited to:

- The beneficiary's self-management goals and objectives.
- The beneficiary's personal healthcare preferences.
- A description of services specifically tailored to the beneficiary's needs.
- Role of the beneficiaries' caregiver
 - Identification of goals (met or not met).

- If the beneficiary's goals are not met, the organization's MOC must describe the process for reassessing the current ICP and determining the appropriate alternative actions.

Factors 2: ICP development process

The organization's MOC must describe the process for developing the ICP at a minimum, detail how the results of the initial assessment and annual re-assessment and are included in the ICP. The MOC must also include a description of how it determines the frequency for review and modification, as appropriate, as the beneficiary's health care 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 member's ICP.

Factor 3: Personnel responsible

The organization's MOC must detail the personnel responsible for developing the ICP. The description of responsible staff must include roles and functions, professional requirements, and credentials necessary to perform these tasks, as well as how the beneficiary or their caregiver/representative is involved in the ICP development. The MOC must also include a description of how the organization determines how often to review and modify, as appropriate, the ICP as the beneficiary's health care needs change.

Factor 4: ICP documentation and maintenance

The organization's MOC must describe how the ICP is documented and updated and where the documentation is maintained so it is accessible to the ICT, provider network and beneficiaries and/or their caregivers.

Factor 5: Updates and modifications

The organization's MOC must describe how the organization communicates ICP updates and modifications to beneficiaries and/or their caregivers, the ICT, applicable network providers, other SNP personnel and stakeholders, as necessary.

MOC 2 Element D: Interdisciplinary Care Team (ICT)

Regulations at 42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv) require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP. The organization’s MOC must describe the critical components of the ICT as addressed in factors 1-4.

1. How the organization determines the composition of ICT membership, including addition of team members to address the unique needs of beneficiaries.
2. How the roles and responsibilities of the ICT members (including beneficiaries and/or caregivers) contribute to the development and implementation of an effective interdisciplinary care process.
3. How ICT members use the outcomes to evaluate, contribute and continually manage, and improve the health status of SNP beneficiaries.
4. How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factor

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factor 1: ICT membership*

The organization’s MOC must describe the composition of the ICT, including how the SNP determines ICT membership and the roles and responsibilities of each member. The description must specify how the expertise, training and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries. The BBA 2018 also requires, at a minimum, the description to include how the organization verifies team member training and expertise in an applicable specialty for the targeted beneficiaries.

The organization must:

- Explain how the SNP facilitates the participation of beneficiaries and their caregivers as members of the ICT.
- Describe how the beneficiary's HRAT and ICP are used to determine the composition of the ICT; including where additional team members are needed to meet the unique needs of a beneficiary.
- Explain how the ICT uses health care outcomes to evaluate processes established to manage changes or adjustments to the beneficiary's health care needs on a continuous basis.

Factors 2 & 3: ICT member roles and responsibilities

The organization's MOC must describe how it uses clinical managers, case managers and others who play critical roles in providing an effective interdisciplinary care process; and how beneficiaries and/or their caregivers are included in the process, are provided with needed resources and how the organization facilitates access for beneficiaries to ICT team members.

Factor 4: Communication plan

The MOC must describe the SNP's communication plan for promoting regular exchange of beneficiary information within the ICT. The MOC must show:

- 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.
- How the SNP maintains effective and ongoing communication among SNP personnel, the ICT, beneficiaries and/or their caregivers, 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).
- How communication is conducted with beneficiaries who have hearing impairments, language barriers and cognitive deficiencies.

MOC 2 Element E: Care Transition Protocols

Regulations at 42 CFR §422.101(f)(2)(iii-v); 42 CFR §422.152(g)(2)(vii-x) require all SNPs to coordinate the delivery of care. The organization’s MOC describes the care transition protocols as addressed in factors 1-6.

1. How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.
2. Describe the personnel responsible for coordinating the care transition process.
3. Explain how the organization transfers elements of the beneficiary’s ICP between health care settings when the beneficiary experiences an applicable transition in care.
4. Describe the process for beneficiaries to access their personal health information to facilitate communication with providers in other healthcare settings or specialists.
5. Explain how beneficiaries and/or caregivers will be educated about the beneficiary’s health status to foster appropriate self-management activities and the expectation for demonstrating understanding of appropriate self-management.
6. Detail how and when the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

Summary of changes

- No changes to this element.

Scoring	100%	50%	0%	80%	20%
	The organization meets all 6 factors	The organization meets 3 factors	The organization meets no factors	The organization meets 4 - 5 factors	The organization meets 1 - 2 factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation **Definitions**

- **Health care setting:** The provider from whom or setting where a member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for a member’s medical care.

- Settings include home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility and outpatient/ambulatory care/ surgery centers.
- **Transition:** Movement of a member from one care setting to another as the member's health status changes.
 - For example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- **Transition process:** The period from identification of a member who is at risk for a care transition through completion of a transition.
 - This process includes planning and preparation for transitions and the follow-up care after transitions are completed.

Factor 1: Continuity of care

Older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated; thus, an organization must work actively to coordinate transitions. The organization must specify the process and rationale for connecting beneficiaries with the appropriate providers.

Factor 2: Care transition personnel

The organization must identify and describe the personnel (e.g., case manager) responsible for coordinating the care transition process and for ensuring that follow-up services and appointments are scheduled and performed.

Factor 3: Applicable transitions

The organization must ensure that elements of the beneficiary's ICP are transferred between health care settings when the beneficiary experiences a transition in care. The MOC must describe the steps that take place before, during and after a transition in care has occurred for this process.

Factor 4: Beneficiary personnel health information

Beneficiaries and/or their caregivers need access to beneficiaries' personal health information in order to communicate about care with healthcare providers in other health care settings and/or health specialists outside their primary care network. The organization must describe the process for ensuring that SNP beneficiaries and/or their caregivers have access to and can adequately use personal health information to coordinate care for the beneficiary.

Factor 5: Self-management activities

The MOC must describe how beneficiaries and/or their caregivers will be educated about their condition, how they will demonstrate understanding of changes in their condition (improvement, stable or worsening), and use of appropriate self-management activities. For example, they should be educated about signs and symptoms signaling a change in their condition and how to respond to such changes. Self-management activities can include regular assessment of progress, goal setting and problem-solving support to reduce crises and improve health outcomes.

Factor 6: Notification of point of contact

The organization must describe the process it uses to notify beneficiaries and/or their caregivers of the personnel responsible for supporting them through transitions between any two care settings.

MOC 3 Provider Network

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. The SNP is responsible for a network description that must include 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. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP provider networks.

MOC 3 Element A: Specialized Expertise

Regulations at 42 CFR§422.152(g)(2)(vi) require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries. The organization must establish a provider network with specialized expertise that describes components of the network.

1. How providers with specialized expertise correspond to the target population identified in MOC 1.
2. How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.
3. How the SNP documents, updates and maintains accurate provider information.
4. How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation The organization must have an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population.

Factor 1: Specialized network

The provider network's specialized expertise may include, but is not limited to, internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists and other specialists that address the needs of the SNP's target population identified in MOC 1. The network also includes facilities that provide care for beneficiaries.

Factors 2 & 3: Licensure and certification

The organization must describe how it determines that its providers have and maintain active licenses and are competent to provide specialized health care services to SNP beneficiaries (e.g., confirmation of applicable board certification), The MOC should describe how it maintains current information on providers to ensure an accurate provider network directory.

Factor 4: Collaboration with the ICT

The MOC must describe how providers in the network collaborate with members of the ICT and help contribute to each beneficiary's ICP, including how providers either deliver or coordinate care, particularly specialized services. The MOC must describe how providers communicate beneficiary care needs to the ICT and to other stakeholders or providers, how the organization shares information (e.g., as reports on services) with the ICT and how providers incorporate relevant clinical information into beneficiaries' ICPs.

MOC 3 Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

Regulations at 42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix)require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols. The organization must oversee how network providers use evidence-based medicine, when appropriate.

1. Explain the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP’s target population.
2. Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries.
3. Provide details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made for clinically complex members and incorporated into the ICP, communicated to the ICT, and acted upon by the ICT.
4. Describe how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factor 1: Utilization of guidelines and protocols*

Evidence-based clinical guidelines and protocols promote the use of nationally recognized and accepted practices for providing the right care at the right time. The organization must monitor how network providers utilize these guidelines, when appropriate. The organization may use electronic databases, Web

technology, manual medical record review or other methods to oversee use of clinical practice guidelines.

Factors 2 & 3: Exceptions to guidelines

Certain clinical practice guidelines and protocols may not always be appropriate for some patients with complex health care needs. In these cases, the organization must include their process to identify challenges to using clinical practice guidelines and nationally recognized protocols for certain beneficiaries with complex health care needs and for factor 3 - detail how the decision to modify or ignore such guidelines is made, incorporated into the patient's ICP, communicated with the ICT and acted on by the patient's ICT or by other providers.

Factor 4: Care transition protocols

Care transitions offer challenges for organizations to maintain continuity of care. The organization must explain how it oversees network providers to ensure that they follow the required care transition protocols outlined in MOC 2, Element E.

MOC 3 Element C: MOC Training for the Provider Network

Regulations at 42 CFR§422.101(f)(2)(ii) require that SNPs conduct MOC training for their network of providers. The organization’s MOC must describe oversight of provider network training.

1. Detail initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.
2. Describe how the organization documents evidence of training (records) on the MOC training.
3. Explaining challenges associated with the completion of MOC training for network providers.
4. Describe the specific actions taken when the required MOC training is deficient or has not been completed.

Summary of changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factor

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation **Factor 1: Initial and annual training**

The MOC must describe (process) how the organization provides initial and annual training for network providers and any out-of-network providers seen by beneficiaries on a routine basis; and must detail training documents and materials, including how training is conducted (e.g., in-person meetings, computer-based training), how often training occurs, training materials and examples of detailed training content beyond the Table of Contents. For initial submissions, the description details the content of the training materials or provides slide examples. For renewal submissions, the description must include a sampling of actual slides or written materials used for trainings for providers.

Factor 2: Evidence of training

The MOC must describe how the organization documents and maintains records (e.g., copies of dated attendee lists, Web-based training confirmation,

electronic training records, physician attestation) as evidence that it makes training on the MOC available and offers it to all network providers.

Factors 3 & 4: Deficient or incomplete training

The MOC must describe specific actions taken by the organization if providers do not receive the required training and must explain challenges (e.g., geographically distant network, very large number of providers in network) associated with completion of the MOC trainings for network providers. The MOC also describes actions the organization takes to offer incentives or other best practices to encourage provider training participation and compliance. Stating appropriate action will be taken is insufficient and will not meet the requirement of this factor.

MOC 4: MOC Quality Measurement and Performance Improvement

Regulations at 42 CFR §422.152(g) require that all SNPs conduct a quality improvement program that measures the effectiveness of its MOC.

The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver health care services and benefits to its SNP beneficiaries in a high-quality manner. Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change.

The leadership, managers and governing body of a SNP organization 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.

Element A: MOC Quality Performance Improvement Plan

The organization must develop a MOC quality performance improvement plan that includes details described in factors 1-4.

1. Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.
2. Describes the process for how the plan collects information including: specific data sources, performance, and beneficiary health outcome measures it used to continuously analyze, evaluate and report MOC quality performance.
3. Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.
4. Describes how SNP-specific measureable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B. The process includes how it determines if goals are met (specific benchmarks and time frames)

Summary of changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation Definition

Quality measurement and performance improvement: A collaborative process for improving an organization’s ability to deliver high-quality health care services and benefits to SNP beneficiaries.

Factors 1

The organization’s MOC must describe how the quality performance improvement plan specific to the MOC, is designed to detect whether the overall MOC structure effectively accommodates beneficiaries’ unique health care needs.

Factors 2

The MOC must describe the SNP’s process for continuous collection, analysis, evaluation and reporting on quality performance based on the MOC. The MOC must describe the frequency of these activities.

Factors 3

The MOC must provide details about how the key personnel listed in factor 3 are involved in internal quality performance processes. It should provide information about which personnel are involved, their role in analyzing quality performance information and the decision-making authority given to such personnel.

Factors 4

The organization must specify data used for analyses and must identify clear measures to determine if stated goals or outcomes are achieved. Measures must have specific benchmarks and time frames for achieving outcomes and must specify the remeasurement plan for goals not achieved.

MOC 4 Element B: Measureable Goals and Health Outcomes for the MOC

The organization must identify and clearly define measurable goals and health outcomes for the MOC. The organization's MOC must include factors 1-5.

1. Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.
2. Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level.
3. Describe how the SNP establishes methods to assess and track the MOC's impact on SNP beneficiaries' health outcomes.
4. Describe the processes and procedures the SNP will use to determine if health outcome goals are met.
5. Describe the steps the SNP will take if goals are not met in the expected time frame.

Summary of changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factor 1: Identify goals*

A description of measurable goals must include benchmarks, specific time frames and how achieving goals will be determined. Responses should include, but not be limited to:

- Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC 1.
- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT.
- Enhanced care transitions across all health care settings and providers for SNP beneficiaries.
- Ensuring appropriate utilization of services for preventive health and chronic conditions.

Factor 2: Identify health outcome measures

For the stated health outcome measures, the organization must include the specific data sources it will use for measurement. The MOC should describe the specific measures the organization will use to meet the overall quality goals detailed in factor 1, including expected timeframes for meeting those goals.

Factors 3 & 4: Track and assess goals

The MOC must describe the methods the organization uses to assess and track how its overall quality program, including the goals and specific measures it uses, affect the health outcomes of its beneficiaries. This must include the data collected, how it is collected and frequency for collection and analysis.

For factor 4, the MOC must describe how it determines if the goals described in factor 1 are met. Please provide or reference your statement from 4A regarding goals not met.

Factor 5: Steps if goals not met

The organization must describe the actions it will take if it determines that goals are not met within the specified timeframes.

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

The organization's MOC must address the process of measuring SNP member satisfaction by including items addressed in factors 1-4.

1. Describe the specific SNP survey used.
2. Explain the rationale for the selection of a specific tool.
3. Describe how the results of patient experience surveys are integrated into the overall MOC performance improvement plan.
4. Describe the steps taken by the SNP to address issues identified in member survey responses.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factors 1–4*

The MOC must describe the types of surveys used to assess SNP member experience, the rationale for the use of a specific tool and how results are integrated into the overall performance improvement plan.

Member feedback can include information about the overall SNP program or program staff (e.g., ICT or case managers), the usefulness of the information disseminated by the organization and the member's ability to adhere to recommendations.

Methodology. The organization must describe how it receives feedback from a broad sample of members, not only those who contact the organization to share feedback. Member feedback may be obtained by conducting focus groups or through member experience surveys. The organization must describe how it analyzes feedback to identify and address issues. Feedback must be specific to the experience with the SNP overall programs being evaluated.

The organization must be able to describe the methodology it uses to collect patient experience surveys, including the sample size used.

MOC 4 Element D: Ongoing Performance Improvement Evaluation of the MOC

The organization's MOC description must describe factors 1-4.

1. How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.
2. How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.
3. The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.
4. How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factor

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factors 1–4*

The organization must provide a written description of the ongoing performance improvement evaluation of its MOC that addresses each of the factors. This process must describe how the organization will use the results to assess and evaluate its quality performance indicators on a continual basis, including how the organization improves its ongoing performance by incorporating lessons learned. Lessons learned must be documented and communicated with key stakeholders.

MOC 4 Element E: Dissemination of SNP Quality Performance Related to the MOC

The organization must address the process for communicating its quality improvement performance by addressing factors 1-4.

1. Describing how performance results and other pertinent information are shared with multiple stakeholders.
2. Stating the scheduled frequency of communications with stakeholders.
3. Describing the methods for ad hoc communication with stakeholders.
4. Identifying the individuals responsible for communicating performance updates in a timely manner.

Summary of changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Model of Care

Scope of review

Look-back period

Explanation *Factors 1–4*

The organization describes how quality performance results are routinely shared with stakeholders and specifies the frequency of these communications and how ad hoc and other unplanned communications are disseminated.

The organization’s plan to disseminate information must include individuals responsible for providing communication (as described in MOC 2, Element A). The MOC must describe methods for communication (regular and ad hoc) with stakeholders and time frame for communication with stakeholders, who may include, but are not limited to:

- SNP leadership.
- SNP management groups.
- SNP boards of directors.
- SNP personnel and staff.
- SNP provider networks.
- SNP beneficiaries and caregivers.
- The general public.
- Regulatory agencies.