

CMS is committed to working closely with States to clarify the contents of the State file submissions and the BAE policy for HCBS. The data that CMS receives from the States identifying full-benefit dual-eligible individuals receiving HCBS will generate copay level 3 (\$0) for these individuals, effective January 1, 2012. Plan sponsors must use this information to update their own systems as necessary to reflect \$0 Part D cost sharing for their qualified Part D enrollees. Refer to Chapter 13, §60.2, of the *Prescription Drug Benefit Manual* for additional guidance on cost-sharing requirements for institutionalized full benefit dual eligible individuals.

90—MODEL OF CARE (MOC)

42 CFR §422.101; §422.152(g)(2)(ix)

90.1 General

As provided at 42 CFR §422.101(f), SNPs must develop and implement a MOC that provides the structure for care management processes and systems that will enable them to provide coordinated care for special needs individuals. An MA organization must design separate MOCs to meet the special needs of the target population for each SNP it offers.

Plans should implement a MOC that has goals and objectives for the targeted population, a specialized provider network, uses nationally-recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and that adds services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

All SNP MOCs must include the following elements:

- (1) Description of SNP-specific Target Population;
- (2) Measurable goals;
- (3) Staff structure and Care Management Roles;
- (4) Interdisciplinary Care Team;
- (5) Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
- (6) MOC Training for Personnel and Provider Network;
- (7) Health Risk Assessment;
- (8) Individualized Care Plan;
- (9) Communication Network;

(10) Care Management for the Most Vulnerable Subpopulations; and

(11) Performance and Health Outcome Measurement.

Descriptions in the MOC should include multiple specific examples and/or a case study example that is specific to each element. We describe the eleven elements in further detail in the subsections below.

Pursuant to §422.152(g)(2)(ix), the SNP MOC must be evidence-based. All SNPs are required to implement an evidence-based MOC. SNPs must articulate how this requirement is met, and measure the extent to which evidence-based care management is an on-going process, but they may utilize a methodology of their choosing to ensure that the MOC is evidence-based.

Examples of compliance with this requirement include, but are not limited to:

- (1) A SNP medical director or medical advisory committee can monitor peer-reviewed medical journals to infuse research supported systems and practices into its care management model;
- (2) A SNP can contract with providers who use nationally recognized clinical protocols developed by professional specialty groups or federally funded research (e.g., National Guideline Clearinghouse, AHRQ); or
- (3) A SNP can contract with providers who are accredited by nationally recognized quality and health care safety accreditation organizations whose standards assure evidence-based practice.

CMS examines differences in MOCs by SNP type in order to address potential conflicts between MOCs established by States and CMS MOC requirements, and to work with States to integrate their measures into ours. We will also review the SNP MOC during audits, which may be part of regularly scheduled MA organization audits.

90.2 Description of SNP Target Population

42 CFR §422.102(f)(2)(i)

This MOC element provides a detailed and in-depth description of the population being served. The description includes multiple specific examples and/or a case study type of example specific to this factor. Below, we outline the specific information that different SNP types must include when describing their target population.

- C-SNP: The incidence and prevalence of the specific diseases in the plan's target population;
- D-SNP: Medicare and Medicaid characteristics of the target population; and
- I-SNPs: A description of patient attributes and the type of LTC facility where the beneficiary resides.

90.3 Measurable Goals

42 CFR §422.101(f)(1)(ii)

As part of this MOC element, SNPs must describe their specific care management goal in measurable terms that indicate how the plan will know whether the goals have been achieved.

At a minimum, care management goals must include:

- Improving access to essential services such as medical, mental health, and social services;
- Improving access to affordable care;
- Improving coordination of care through an identified point of contact;
- Improving seamless transitions of care across healthcare settings, providers, and health services;
- Improving access to preventive health services;
- Ensuring appropriate utilization of services; and
- Improving beneficiary health outcomes (specify MAO selected health outcome measures).

The description of these clearly measurable goals should include benchmarks for those goals, the specific time frames within which the SNP expects to achieve these goals, and the criteria by which the SNP will determine achievement. SNPs should also describe corrective actions that they would take if they are unable to meet measurable goals within the expected timeframe.

90.4 Staff Structure and Care Management Roles

42 CFR §422.101(f)(2)(ii)

SNPs must provide a detailed and in-depth description that identifies all staff, both employed and contracted, who perform administrative functions (e.g., process enrollments, verify eligibility, process claims).

At a minimum, the description of staff structure and roles must include:

- Specific details about the personnel who coordinate benefits, plan information, data collection and analysis for beneficiaries, network providers, and the public;
- Identification of the specific employed or contracted staff that perform clinical functions (e.g., coordinate care management, provide clinical care, educate, etc.); and
- Identification of the specific employed or contracted staff that perform administrative and clinical oversight functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines).

90.5 Interdisciplinary Care Team (ICT)

42 CFR §422.101(f)(1)(iii)

All SNPs must have an interdisciplinary care team (ICT) to coordinate the delivery of services and benefits.

At a minimum, the description of the ICT must include:

- How the SNP will determine the composition of the ICT. This description includes specific examples that are part of a protocol or standard operating procedure (SOP). SNPs may either adopt a standard team construct, or may consider each beneficiary's risk assessment results to develop a unique team. How the beneficiary will participate in the ICT whenever feasible. This element describes the process for facilitating the inclusion of the beneficiary in the meetings with the ICT and should include education and outreach efforts, the communication process, resources, and how the beneficiary has ongoing access to the ICT.
- How the ICT will operate and communicate. This element describes reviews of communication strategies, service standards with each member of the ICT, assessments, and administrative data. The element should also identify the personnel that revise the Plan of Care (POC), if needed, and should explain how the data/records are being kept so every member of the ICT has secure access to them. The plan should also document the frequency of communication and review.

90.6 Specialized Provider Network

42 CFR §422.101(f)(1)

At a minimum, SNPs must include the following elements in its description of its specialized provider network:

- Facilities pertinent to the care of the targeted special needs population (e.g., inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging, etc.);
- Medical specialists (e.g., cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists, etc.);
- Behavioral and mental health specialists (e.g., drug counselors, clinical psychologists, etc.);
- Nursing professionals (e.g., registered nurses, nurse practitioners, nurse managers, nurse educators, etc.);
- Allied health professionals (pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc.);
- How the plan determines that their facilities and providers are actively licensed and competent;
- Who determines the services beneficiaries will receive (e.g., who serves as the gatekeeper, how is the beneficiary connected to the appropriate service provider, etc.);
- How the provider network coordinates with the ICT and the beneficiary to deliver specialized services;
- How the plan assures that specialized services are delivered to the beneficiary in a timely and quality way;
- How reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan;
- How services are delivered across care settings and providers; and

- How the plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.

The SNP should describe the specialized expertise in the MA organization's provider network that corresponds to the target population including facilities and providers (e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.). This MOC element must also describe how the MA organization determined that its network facilities and providers were actively licensed and competent. The SNP must also describe who determines which services beneficiaries will receive (e.g., if there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider).

SNPs must additionally describe how their provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it ensures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, and how services are delivered across care settings and providers). This element should also describe the procedures that the plan uses to ensure that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, and written protocols providers send to MAO Medical Director for review).

90.7 MOC Training for Personnel and Provider Network

42 CFR §422.102(f)(2)(ii)

This MOC element must describe how the SNP conducts initial and annual MOC training including:

- Training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing);
- How the plan assures and documents completion of training by employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, and electronic training record);
- Personnel responsible for oversight of the MOC training; and
- Actions the plan will take when the required MOC training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, and incentives for training completion).

90.8 Health Risk Assessment

42 CFR §422.101(f)(i); 42 CFR §422.152(g)(iv)

At a minimum, the health risk assessment must describe the following:

- The health risk assessment tool the MAO uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial, functional, and cognitive needs, medical and mental health history);
- When and how the initial health risk assessment and annual reassessment are conducted for each beneficiary (e.g., initial assessment within 90 days of enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, and written form completed by beneficiary);
- The personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, and psychologist); and
- The communication mechanism the MAO institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification and secure electronic record).

SNPs are not only required to conduct an initial comprehensive health risk assessment, but also a comprehensive annual reassessment. The health risk assessment includes a medical, psychosocial, cognitive, and functional assessment that guides care management and accounts for health status changes. We expect the SNP to conduct the initial risk assessment within 90 days of enrollment and the annual risk assessment within 12 months of the last risk assessment, or as often as the health of the enrollee requires.

The 90-day rule applies to initial health risk assessments for new enrollees and current enrollees who do not have a documented health risk assessment as of January 1st of the current calendar year. Current enrollees with documented health risk assessments must have an annual reassessment within the current calendar year, no later than one year after their last documented health risk assessment. Because special needs individuals are likely to have variable health status and need more frequent assessments, SNPs should adjust the annual reassessment to coincide with health status changes, rather than a fixed schedule based on an initial assessment date.

At any time that a SNP is required to submit a SNP proposal, it is required to submit a copy of the health risk assessment tool in HPMS as a part of its SNP proposal. The timeline for submitting the tool will mirror the timeline for SNP proposal submission/MA application for the current contract year. There is no template available in HPMS for health risk assessment submission. CMS will review all new health risk assessment tools and notify SNPs with deficient tools.

90.9 Individualized Care Plan

42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(v)

Each SNP's ICT must consult with the beneficiary to develop a comprehensive individualized care plan that addresses the beneficiary's particular needs. The individualized care plan must include a description of the following elements:

- Which personnel develop the individualized plan of care and how the beneficiary is involved in its development as feasible;

- The essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, and add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life);
- The personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the ICT, beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified);
- How the plan of care is documented and where the documentation is maintained (e.g., accessible to ICT, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, and secured for privacy and confidentiality);
- How the plan of care and any care plan revisions are communicated to the beneficiary, ICT, MA organization, and pertinent network providers; and
- Essential care management elements, including goals and objectives for each individual in order to measure outcomes and determine if needs have been met, standard and specialized services and benefits that meet the specialized needs that the SNP identified in the initial and subsequent risk assessments, and measurable outcomes that enable the SNP to determine the effectiveness of the care management plan. (Note: A measureable outcome is the quantification of results from an intervention that demonstrates change from baseline status. The SNP must identify its goal or baseline beneficiary status, the intervention(s) employed, and the results of the intervention(s) in order for CMS to determine a measureable outcome.).

The care plan should ensure that stratification of needs, on-going evaluation, and assessment of members is matched to services and benefits in which the sickest and most vulnerable beneficiaries receive care proportionate to their increased needs.

90.10 Integrated Communication Network

42 CFR §422.101(f)(2)(v); 42 CFR §422.152(g)(x)

SNPs must coordinate the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and beneficiaries. This MOC element must describe the following:

- The plan's communication network structure (e.g., web-based network, audio conferencing, and face-to-face meetings);
- How the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies;
- How the MAO preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, and interactive websites); and
- The personnel having oversight responsibility for monitoring and evaluating communication effectiveness.

90.11 Care Management for the Most Vulnerable Subpopulations

42 CFR §422.102(f)(2)(iv)

In the description of this MOC element, SNPs must describe how they identify their most vulnerable beneficiaries, and must describe the add-on services and benefits that they deliver to their most vulnerable beneficiaries.

90.12 Performance and Health Outcome Measurement

42 CFR §422.102(f)(1)(ii)

This MOC element must include a description of the following:

- How the plan will collect, analyze, report, and evaluate the MOC (e.g., specific data sources, specific performance and outcome measures, etc.);
- Who will collect, analyze, report, and act on to evaluate the MOC (e.g., internal quality specialists and contracted consultants);
- How the plan will use the analyzed results of the performance measures to improve its MOC (e.g., internal committee and other structured mechanism);
- How the evaluation of the MOC will be documented and preserved as evidence of the effectiveness of the MOC (e.g., electronic or print copies of its evaluation process);
- How the plan will communicate improvements in the MOC to stakeholders (e.g., webpage for announcements, printed newsletters, bulletins, announcements); and
- The personnel having oversight responsibility for monitoring and evaluating the MOC effectiveness (e.g., quality assurance specialist, consultant with quality experience).

90.13 Change of Residence Requirement for I-SNPs

If an I-SNP enrollee changes residence, the SNP must have appropriate documentation that it is prepared to implement a CMS-approved MOC at the enrollee's new residence in another institution, or in another setting that provides an institutional level of care.

For example, if one of the SNP's community enrollees require placement in a LTC facility, the SNP must have contracted facilities to accommodate these individuals and a plan for caring for them in the new, more restrictive environment. If the MA organization did not submit a plan for caring for residents of long term care facilities, the MA organization would be required to give the beneficiary the option to disenroll. Refer to Chapter 2, §30.3.4, of the *Medicare Managed Care Manual* for information on special enrollment procedures for institutionalized individuals.

100—QUALITY IMPROVEMENT

42 CFR §422.152, §422.153, and §480.140

As an MA product, SNPs have the same performance improvement requirements as their parent MA organizations, but SNP quality improvement requirements are tailored to the special needs individuals that the SNP serves. Pursuant to 42 CFR §422.152(c)-(d), SNPs must conduct both a chronic condition improvement program (CCIP) and a quality improvement project (QIP) targeting the special needs population that it has selected to serve. Refer to the forthcoming revision to Chapter 5 of the *Medicare Managed Care Manual* for further guidance on SNP quality improvement requirements.