Please be advised that the following examples are provided as guidance only and are not all-inclusive of the requirements for the elements and factors. Additional details and specific documentation may be required.

MOC 1A Factor 1
The organization’s MOC description of its target SNP population must:

Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

Example
D-SNP example: The plan receives enrollment applications directly from beneficiaries via the sales agent. The enrollment data analyst reviews the application and checks eligibility via the Medicaid state system. Beneficiaries who are not identified in the Medicaid system as having a qualifying category of eligibility are pended for 21 days or until the end of the month (whichever is later) at which time the enrollment data analyst reviews the state Medicaid system to confirm eligibility before processing the member’s enrollment request or denying the enrollment request.

On a monthly basis, all SNP members’ Medicaid eligibility is verified with the state Medicaid agency. Members identified as not meeting the SNP eligibility requirements are notified and are given a grace period of 90 days, starting the first of the following month, to regain Medicaid eligibility or they will be disenrolled from the SNP plan. Prior to disenrollment, the enrollment data analyst reviews each member identified as losing their Medicaid eligibility by querying the state Medicaid system. The member will either be disenrolled for loss of SNP eligibility or take the necessary action for reinstatement.

MOC 1A Factor 2
Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population.

Example
In this C-SNP, 57% of members were male with an average age of 75 years and older. There is a disproportionate share of low income members, and members frequently require social services, including assistance with activities of daily living (ADLs), assistance within their homes and with transportation. A large percentage of our C-SNP members tend to have a lower health literacy level compared to other Medicare members.

MOC 1A Factor 3
Identify and describe the medical and health conditions impacting SNP beneficiaries.

Example
Our C-SNP (Diabetes Mellitus) notes: 20% of the population is diagnosed with DM. While CVD and CHF and decreased kidney function diagnoses are often correlated, members with these conditions also tend to have comorbidities including neurological disorders (2%), musculoskeletal disease (2%), pulmonary disease (5%), kidney disease (30%) and psychiatric disorders (25%). (A plan should also include an approximate percentage of the comorbidities.)
MOC 1A Factor 4
Define the unique characteristics of the SNP population served.

Example

Of the 36,000 members currently enrolled in the SmartHealth DM C-SNP, 53 percent are under 65 years old, 69 percent are female and 55 percent speak English as their primary language. The majority of members are White (37.16 percent) or Black (33.51 percent)...

SmartHealth operates in 4 counties (Harford, St. Phillip, Delaney and Whitewater) and is expanding operations into 2 Eastern counties (Harrison and Great View). According to our initial analysis we have identified that almost 60 % of our dual eligible population has a cardiovascular disease (including Congestive Heart Failure, Coronary Artery Disease and Hypertension among others). Diabetes (55 %) is the highest co-morbid condition noted in the target population. This plan is situated in urban areas where the inhabitants are undereducated, experience language deficits and show a high prevalence of mental health issues (schizoid-affective disorders and substance/alcohol abuse). The population has a tendency towards emergent rather than planned medical visits and conditions escalate the need for acute or inpatient/skilled treatment. SmartHealth's I-SNP members are community-based with a social worker assigned to a group of no more than twenty individuals. Living in the community provides a certain level of independence but maintains added oversight for continuous care coordination such as medication compliance and access to medical, behavioral health and other needed services. The average age range is 42 to 66 with conditions that include but are not limited to...

MOC 1B Factor 1
Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries.

Example

SmartHealth has processes in place to identify those members who we consider the most vulnerable within our population. The most vulnerable members are at higher risk of poor outcomes and increased service utilization related to the combination of medical and social issues such as.... They may require additional services and specialized programs beyond those available to our general SNP members to assist in management of their complex needs. For example..., (enter examples of additional services or resources). We use multiple reports (enter reports used) to identify the most vulnerable members and to evaluate the severity of their illnesses and need for enhanced services or specialized programs. Certain codes alert the team of analysts and care managers to these most vulnerable members. We use these unique codes to analyze diagnoses and demographics, and community and environmental trends impacting the population. In addition, data collected from the health risk assessment or pharmacy utilization data is used to identify those who may require additional services such as...
MOC 1B Factor 2

Explains 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.

Example

Our most vulnerable members have multiple chronic and complex medical and behavioral conditions which may lead to multiple hospital re-admissions or complex medication regimens and may experience functional, social, and environmental issues that limit their access to medical services. As this is a service area expansion, we expect to see some common characteristics noted in our plans in surrounding counties e.g., sensory or communication issues such as language, hearing or cognitive difficulties, disability and related issues that impact access to health care services or create specific health challenges such as minimal physical activities, lack of appropriate transportation or impaired mobility, which may increase fall risks. These members may also experience caregiver issues including loss of a caregiver, vulnerability to abuse or neglect and an unstable home environment, low literacy levels resulting in difficulty understanding health issues or how to access care.

MOC 1B Factor 3

Illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.

Example

Characteristics of our most vulnerable members include but are not limited to: multiple chronic conditions, diagnosis of dementia or other cognitive impairments, social isolation e.g. lacking or limited support systems in the community, and challenges to accessing care e.g. language or cultural barriers and frail conditions. SmartHealth has an established policy and procedure that facilitates the identification of these members, especially those who are at risk or vulnerable, who may benefit from services provided by community organizations. The coordination process refers and links members into helpful community programs and resources that address special needs, including but not limited to: economic, legal, housing, psychosocial and medical services, as appropriate for the member, that are not Medicaid or Medicare benefits. These services are integrated into the member’s individual care plan and may be coordinated with the assistance of community health centers, protective and legal services, state agencies to establish Medicaid eligibility, translation services and church-based food pantries.
MOC 1B Factor 4

Identifies and describes established relationships with partners in the community to provide needed resources.

Example

SmartHealth has the following resources available to support and assist SNP beneficiaries with clinical, behavioral/mental health, social, environmental/housing, financial and other personal health and supportive needs.

| Cell Phone Programs – Free or discounted cellular service for income eligible consumers | Adult Protective Services /Elder Abuse to obtain specific Local Department of Social Services APS |
| Mobile Crisis Service Center – Services for people experiencing or a risk or a psychological crisis who requires mental health intervention, information and referrals, linkage to appropriated treatment | South Carolina Office of Mental Health |
| Caregiver Relief Services | Food Bank for South Carolina (Soup Kitchens) |
| South Carolina Department for the Aging | South Carolina Department of Health and Human Services |

MOC 2A Factor 1

Describe the administrative staff’s roles and responsibilities, including oversight functions.

Example

SmartHealth has defined staff roles and responsibilities across all the health care plan functions that are necessary to support the model of care proposed for the C-SNP serving our members diagnosed with diabetes and the companion or comorbid disorders (e.g. cardiovascular, renal and neurological). Documentation includes job description and education or training/skills necessary to complete assigned tasks. This list of administrative functions is not all-inclusive. Plans must detail all staff as well as provide an organizational chart.

The enrollment and eligibility supervisor oversees the functions performed by the coordinators, including but not limited to eligibility verification procedures, documentation of findings, communications, work flow using the systems and policies and procedures established and maintains up-to-date knowledge of Medicare and Medicaid eligibility requirements to incorporate into operations and ensure compliance. The member services representative serves a point of contact for questions, problem-solving and access to care for members. In addition, he/she provides accurate, prompt, and courteous service in response to written and telephonic inquiries from members. And finally, acts as point of contact for inquiries from the public/prospective members about SmartHealth, its benefits, services and other information. The credentialing coordinator gathers and verify credentials from
contracted and employed providers, including license, DEA, education and training, sanctions, malpractice history...

**MOC 2A Factor 2**

**Describe the clinical staff’s roles and responsibilities, including oversight functions.**

**Example**

Case Managers help facilitate care coordination by working to implement the discharge plans and transition the beneficiary to the next setting. For example talking with the beneficiary and their caregiver to ensure that both understand the discharge instructions and medication reconciliation. Case Managers further facilitate care coordination by ensuring beneficiary continuity of care requirements are met by arranging for DME, coordinating previously scheduled appointments to ensure known out-of-network providers have an agreement with SmartHealth to provide the services and accept Medicare rates, facilitate transitions of care from hospital to SNF, or SNF to home, etc., and help beneficiaries in coordinating social services and contacting state programs.

Member drug regimens may be reviewed at the request of the physician or member. The role of the pharmacy department is to manage the pharmacy program in order to improve costs and beneficiary outcomes; including: internal medication error identification and reduction system; this includes, but is not limited to: ongoing drug-drug interaction review; generic substitution, simplification of therapy, avoidance of medications deemed inappropriate for the elderly, and poly-pharmacy or poly-prescribers.

**MOC 2A Factor 3**

**Describe how staff responsibilities coordinate with the job title.**
SNPs may provide one overall chart or display one for each unit e.g. business operations, customer service operations or case management to name a few.

Example

MOC 2A Factor 4

Describe contingency plans used to address ongoing continuity of critical staff functions.

Example

SmartHealth Plan has thorough policy to manage a contingency plan, the Disaster Recovery plan has been implemented to assure continuity of care and access to our system of information. A summary of the process is described in the following paragraphs.

Our main goals are:

- To restore the services in the Disaster Recovery (primary) site
- This server has a tape drive installed that can read the backup tapes from our production server and on a daily basis the most recent backup image is transmitted via ftp from the production server to our primary site.
  - In the event the production system becomes unavailable, the information between the two servers will be synchronized with the most recent backup image.

Description further details staff responsible for implementing and providing oversight during critical periods, frequency of plan review and updates, maintaining ongoing communications including release of information during the recovery period).

MOC 2A Factor 5

Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.

Example

SmartHealth’s initial and annual MOC training is computer-based. The electronic educational system allows us to log attendance lists and follow up on education delivered. The training incorporates various competencies related to specific job functions. Strategies include web based training modules such as business overview, Integrity and Compliance, Fraud and Abuse, Cultural Competency, HIPPA and Confidentiality. Job function content includes the use of Orientation Guides, directed self-paced learning, didactic modules, and mentoring for a minimum of 4 weeks as well as classroom training.
MOC 2A Factor 6

Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.

Example

SmartHealth documents completion of MOC initial and annual training through a corporate wide electronic learning management system. This system combines elements of a traditional learning management system with an individual development planning tool that includes additional resources for personal and professional development.

On the system’s home page, staff can complete required training, enroll and take courses, track their completion; and view their history of courses taken. The website provides access to a wide variety of development opportunities for employees, teams, leaders, and senior leaders. The automated system generates lists of attendance and sends reminders to employees and managers for those who have a record of incomplete training. Contracting organizations also receive initial and yearly updates to MOC strategies through provider information, manuals, and access to web based education and instruction.

MOC 2A Factor 7

Describe actions the organization takes if staff do not complete the required MOC training.

Example

Failure to complete the training within the designated timeframe may result in corrective actions ranging from providing reminder e-mails about trainings, phone calls to the PCP, and other outreach.

The types of CAPs are based on the significance; such as complete lack of training or lack of response to completing the orientation exams or attestations.
MOC 2B Factor 1

How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary (Element 2C).

Example

General Health Risk Assessment

Please complete this form by entering your answers in the space provided. Schedule an appointment with your doctor for a Health Risk Assessment. Bring your completed form with you to that appointment.

Your name: __________________________

Date of birth: _________________________

Gender: □ Male  □ Female

Weight (in pounds): ____________________

Height: ______________________________

Body frame size: □ Small  □ Medium  □ Large

Race: □ African-American  □ American Indian/Alaskan Native  □ Asian  □ Caucasian  □ Hispanic/Latino  □ Other  □ Don't Know

Gender-specific: female

At what age did you have your first menstrual period? ______________________

How old were you when your first child was born? ____________________________

About how long has it been since your last mammogram (breast x-ray)? ________________

How many women in your natural family (mother and sisters only) have had breast cancer? ________________

How often do you examine your breasts for lumps? _____________________________

When did you last have your breasts examined by a nurse or physician? ________________

Have you had a hysterectomy operation (removal of your uterus)?

□ Yes  □ No

When did you last have a pap smear? _____________________________

About how long has it been since you had a recital exam? ________________________

Gender-specific: male

About how long has it been since you had a recital or prostate exam? ________________

My health and family history

Has a health care provider ever said that you or a member of your immediate family has or has had any of the following? (Please check any that apply)

□ Cancer  □ Diabetes  □ Heart attack  □ Heart disease  □ High blood pressure  □ High cholesterol  □ Stroke

Which describes your blood pressure? (Please check one)

□ High  □ Normal  □ Low  □ I don’t know

If you know your blood pressure reading, please enter here: ________________________

Which describes your total cholesterol?

□ High  □ Normal  □ Low  □ I don’t know

If you know your total cholesterol level, please enter here: ________________________

Tobacco use

Describe your tobacco use. (If you check “Never used tobacco,” skip to Nutrition section.)

□ Never used tobacco  □ Used to smoke or chew  □ Still smoke or chew

How many years has it been since you smoked cigarettes fairly regularly? ______________________

How many cigarettes a day do you, or did you, smoke? ____________________________

How many cigars do you smoke each day? _____________________________

How many pipes or cigars do you usually smoke each day? ________________________

How many times per day do you usually smoke soft/mild tobacco? ____________________

Nutrition

How often do you eat: At least 6 servings of bread, cereal, rice and pasta?

□ At least 2 servings of fruit? ____________________________________________________

□ At least 3 servings of vegetables? ______________________________________________

□ At least 2-3 servings of meat and dairy products (milk and cheese)? __________________

□ Fatty meats like sausage, steak, roasts or deep fried foods? ________________________

□ Rich breads (doughnuts, croissants) and fried grains (chips)? ______________________

□ Rich desserts (ice cream, custard, pies and cakes)? ______________________________

Alcohol

How many drinks of alcoholic beverages do you have in a typical week? ______________

Injury

How many miles per year do you drive in a car, truck or van? ________________

□ How many miles per year do you ride on a motorcycle? ________________________

□ On a typical day, how do you usually travel? ___________________________________

□ What percent of the time do you usually buckle your safety belt when driving or riding? ______________

□ If you ride a motorcycle or ATV (all-terrain vehicle), what percent of the time do you wear a helmet? ______________
SmartHealth utilizes a standardized, comprehensive approach to collecting, analyzing and communicating information collected via the health risk assessment tool (HRAT). The HRAT is a combination of several assessments that focus on the medical, psychosocial, cognitive and functional needs and disabilities of members of our target population and identifies current and future health risks. The HRA is completed by the Care Manager (a Nurse Practitioner (NP), or Registered Nurse (RN)) within 30 days of the member’s enrollment into the plan and is conducted in the member’s home. The assessment includes a full medication review (prescribed, over-the-counter medications, vitamins and herbal supplements; discussions with the member’s PCP occur; review of the HRA for prioritization of problems and interventions and need for community resources, identification of co-morbidities associated with common conditions found in this dual eligible population such as: chronic obstructive pulmonary disease, cardiovascular disease, cerebral vascular disease and diabetes.

The evaluation also includes but is not limited to an assessment of: home safety, safety with mobility and equipment in the home, falls risk, functional limitations and decreased activities of daily living and the process for inclusion into the member’s individual care plan (ICP).
MOC 2B Factor 2

How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information (Element 2D).

Example

Information collected from the HRA determines the risk level using SmartHealth’s risk stratifying methodology for each member and is used to develop the ICP. The system stratifies members into 3 categories (high, medium or low) based on member condition and level of care needs. The results are shared with all ICT members, including the member, via telephone, fax, mail, or in the case of providers, through the secure web portal. The ICP is the main tool used to document changes and communications between members of the ICT. Information in the ICP is maintained in member health records and preserved on the organization’s secure server. Each ICT member or ancillary provider has access as applicable.

MOC 2B Factor 3

How the organization conducts the initial HRAT and annual reassessment for each beneficiary.

Example

SmartHealth staff completes the initial member assessment within thirty (30) days of enrollment and a semi-annual reassessment within one hundred and eighty (180) days of the last assessment. An initial face-to-face, comprehensive, in-home visit by a Registered Nurse is the preferred method. Nurse Practitioners complete the HRAT for I-SNP members. In the event of unstable conditions or based upon high-risk assessed scores, members may receive frequent or additional monthly home visits throughout the year based upon the professional judgments of the Care Managers and the ICT. For instances where the initial visit is not scheduled within the first thirty (30) days or if the member declines an in-home visit, a telephonic health risk assessment is conducted.

MOC 2B Factor 4

The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

Example

SmartHealth’s care managers, registered nurses, are responsible for reviewing and analyzing the HRA through the system which has the ability to data mine the specific risk criteria. Others involved in the review of member health care needs are those involved in the member’s ICT such as physicians, nurse practitioners, pharmacists, psychologists, therapists, specialists and social workers. At the member level, the data is reviewed by the ICT which sets the services most appropriate for the member to receive and the frequency of plan to member outreach. This information allows the Care Manager to identify members needing a higher level of care management, services and monitoring. The health risk profile also allows the Care Manager and ICT to be proactive and target interventions. Using a multidisciplinary
team approach structured to address the member’s particular needs, the ICT, led by the Care Manager, develops the ICP with the involvement of the beneficiary, to the extent possible. Again, the information in the ICP is maintained in member health records and preserved on the organization’s secure server. Each ICT member or ancillary provider has access as applicable.

**MOC 2C Factor 1**
*The essential components of the ICP.*

**Example**

SmartHealth includes the following essential components in the ICP:

- **Results of the Health Risk Assessments** - The Individualized Care Plan (ICP) is developed by the Care Manager after his/her review and analysis of the member’s HRA and involvement of the ICT. The HRA is the driving force in determining services and determining the risk level for the member....
- **Goals/Objectives** - The ICP is composed of several key elements that allow the Care Manager to focus on setting goals and interventions for the member based on the member’s identified problems, i.e. chronic illnesses, psychosocial impairments, living situation issues, and personal goals. The care plan is developed in collaboration with the member and personal goals are a large factor for consideration....
- **Special Services and Benefits** - Special services and benefits are included in the member’s plan of care according to the needs identified on the Health Risk Assessment.
- **Outcome Measures** - The outcomes of goals are measured and documented in the care plan.
- **Preference for Care** - The ICP address specific preferences for care (e.g. addressing specific service providers, taking into consideration likes and dislikes)

**Add-on Benefits and Services for Vulnerable Beneficiaries** - The ICP also addresses add-on benefits and services for vulnerable beneficiaries such as those with dementia, IV drug abusers, frequent falls, member’s utilizing 9 or more medications, unmanaged chronic disease, end-of life matters or no relationship with a PCP.

*Add-on benefits include those benefits provided above & beyond those provided to the general SNP population.*

**MOC 2C Factor 2**
*The process to develop the ICP, including how often the ICP is modified as beneficiaries’ health care needs change.*

**Example**

Member care plans are reviewed and revised by the member’s care manager, in coordination with the member’s primary care practitioner. All members of the ICT are involved in the development and review of the ICP. The member, whenever feasible is a vital component of the ICT and is involved in the development and review of his/her plan of care. In addition, specialists involved in the care of the member are involved in the development and review of the plan of care. Revisions are based upon the hanging health needs of the member, as identified in the HRA and feedback from providers. Care plans are reviewed and revised according to the following frequency:
• Every six months, following completion of the Health Risk Assessment.

• When there has been a change in the member’s condition (i.e. hospitalization, new onset of chronic condition and change in psychosocial function). Included in the ICP revision is an evaluation of the identified goals and whether they have been met.

**MOC 2C Factor 3**

The personnel responsible for development of the ICP, including how beneficiaries and/or caregivers are involved.

Example

The care manager, with the involvement of the member and his/her caregiver or member representatives, works with the member’s PCP as well as auxiliary care providers to identify and prioritize problems, implement interventions and deliver services and a comprehensive treatment plan. The care managers are Registered Nurse. The model of coordination is member-centered and emphasizes member engagement, member empowerment, developing strengths and understanding vulnerabilities.

The care manager develops the individualized care plan with the member and/or authorized caregiver or representative after review of the initial comprehensive HRA and completion of the member medical status, assessment and risk level assignment. In addition, SmartHealth reviews and notifies the ICP as the member’s needs change. SmartHealth’s MOC ensures care plan interventions are designed to educate, empower, and facilitate the member’s involvement in the development of his/her care plan. The care plan identifies the member’s specific services and benefits to be provided that have measurable outcomes and goals. The care manager discusses the care plan with the member and facilitates that the information is given to the member to make feasible choices regarding his/her health and providers of service.

**MOC 2C Factor 4**

How the ICP is documented, updated and where it is maintained.

Example

The member care plan is created, maintained, revised, documented and stored in the electronic care management system. It is available to the internal plan staff that are ICT members, such as care managers, social workers and member services specialists. The plan of care is shared with the external ICT either by fax, secure email, by mail or telephonically. The member is mailed a hard copy of his/her plan of care. External ICT members may also access the member’s plan of care through the secure web portal on the plan website. Revisions to the care plan are shared in similar methods. The care manager is integral to any and all communications as he/she coordinates all services included in the care plan with the providers, the PCP and the member. Communication of the care plan occurs at enrollment and continues every six months during the semi-annual assessment of members, in the event of change in
condition, new onset of disease, medication changes, completion of set goals and/or interventions, during/after a hospitalization or change in level of care, and referral to behavioral health services.

All members of the ICT have the opportunity to review and provide comment on the ICT. The PCP is faxed a copy which he/she is asked to sign as evidence of collaboration. Once received by the plan, the document is scanned into the member record. Member care plan information can be updated via care management system and shared with all ICT member through easily queried reports. The plan of care is stored electronically in care management system. To ensure the plan of care is preserved from any form of destruction, SmartHealth maintains sophisticated policies and procedures relating to HIPAA and information systems back-up and disaster recovery procedures. SmartHealth preserves all plan information in accordance with industry standards related to data redundancy and confidentiality. All plan staff are educated initially and annually thereafter regarding maintenance of member medical information confidentiality.

MOC 2C Factor 5

How updates and modifications to the ICP are communicated to the beneficiary and other stakeholders.

Example

The plan of care and any revisions to the plan of care are communicated to the member, ICT, plan staff and network providers. After initial care plan is formulated and after significant changes in the member’s health status, the care plan is updated and shared with the ICT. The care manager is directly responsible for documenting changes in the care plan. The care manager is also responsible for communicating these changes with the member and the other ICT members. Once the changes in the care plan are agreed to by the member, the care manager documents them in the electronic care management system and then generates a hard copy of the plan and faxes it to the PCP and other ICT members. The member is mailed a hard copy as well…. The care manager also communicates telephonically with the ICT members to relay changes in the member’s health status that trigger revisions to the POC. All members of the ICT are allowed opportunity to provide comments or input as needed. The care manager is also able to scan the revision into care management system and attach it to the care plan as means of recording the changes. All revisions are automatically timed and dated so that viewers are able to see when issues are expired or added.

MOC 2D Factor 1

How the organization determines the composition of ICT membership.

Example

In addition to the member and family/caregivers, the ICT is comprised of various disciplines whose primary purpose is to coordinate the delivery of services and benefits that address the member’s specific needs. Members of the ICT are determined by analysis of the member’s initial health risk assessment and/or subsequent follow-up assessments as well as the member's care plan. After a member is enrolled in the plan, he/she is assigned to a care manager. The care managers are registered
nurses who all have experience throughout the long term care continuum, including home care. 
SmartHealth makes every effort to match our members with care managers who have similar cultural 
and lingual attributes to ensure communication between the two is effective. Depending on the unique 
needs of the members, the care manager determines the other appropriate members of the members 
care team. The primary care physician is at the core of the team with specialists added. At a minimum, 
the ICT members include the member, care manager, primary care physician/practitioner, specialists, 
home and community-based services providers, caregivers and/or family and a medical director. In 
addition, SmartHealth has access to a wide variety of internal team members e.g. health educators, 
health coaches, pharmacists, nurse practitioners, social workers and behavioral health specialists. These 
ICT team members work closely with community based resources that may be added to the ICT as 
needed....

MOC 2D Factor 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

Example

The member’s Interdisciplinary Care Team (ICT) is responsible for developing the individualized care plan 
based upon assessments, discussions with the member, recommendations by care management, and 
input from Primary Care Physician (PCP) and other providers treating the member. The member is at the 
center of the care team along with his/her physician. The care manager is the link between the two to 
assist the physician and the member achieve the goals outlined in the comprehensive care plan. The ICT 
also works to ensure comprehensive care plan includes measurable and clear goals and objectives, 
measurable outcomes, as well as all appropriate services for the member.

The comprehensive care plan is developed by the ICT during the first month of the enrollee’s 
membership. After the member completes a comprehensive assessment, he/she is assigned to a care 
manager who identifies the other participants of the member’s ICT based upon the assessments 
conducted and communicates with the member and the primary care physician. SmartHealth makes 
every effort to include the member and/or his or her caretaker in the development of the ICP and ICT 
meetings. ICT meeting attendance is open to members, families or caregivers when available and willing 
to participate in meaningful discussion concerning the member.

MOC 2D Factor 3

How ICT members contribute to improving the health status of SNP beneficiaries.

Example

ICT contribution to improving the health status of the SNP members by:
• Analyzing and incorporating the results of the initial and ongoing health risk assessment into an ICP
• Collaborating to develop and update an ICP for all members.
• Managing the medical, cognitive, psychosocial, and functional needs of members in a timely, cost- 
effective manner.
• Communicating and coordinating the care plan with members, providers and their caregivers.
• Making recommendations for the members to have access to additional needed services, including participation in intensive care management, chronic care disease and other special programs.

After the HRA is complete, the care manager communicates telephonically with the ICT to develop the comprehensive care/service plan for the member. Meetings with the member are prescheduled with the member’s agreement and are coordinated by the care manager. Meetings are scheduled via notices and Microsoft Outlook for all ICT members. Each care manager is responsible for creating the master schedule of ICT meetings for all assigned members as communicating these meetings to the ICT. Home visits will be made to the member’s home, as necessary, by the care manager. In the event the member is unable or unwilling to be an active participant in his/her care, SmartHealth will conduct the following outreach.

**MOC 2D Factor 4**

*How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.*

**Example**

Communication and collaboration among the members of the ICT, clinically directed by the PCP and supported and managed by the care manager, is the foundation of SmartHealth's integrated approach to coordinated care. This approach adds considerable value to dual eligible beneficiaries and their providers from whom communication and coordination of services may be difficult. To promote effective and efficient communication, ICT members communicate via many ways such as phone calls, secure email, secure web portal, web-conferencing, conference calls, written documents and reports and face-to-face meetings. The care manager acts as the main point of contact and is responsible for collecting information from all providers and incorporating all into the central repository, the plan of care. SmartHealth directs staff to document in the record on a real-time basis through the care management system. All internal members of the ICT can access the latest information regarding the member. ICT members may document directly in the record or are able to scan and store related documents in the record as well. The care manager disseminates reports generated through the proceedings of the ICT to the primary care physician and the other ICT members within five business days of the meeting. ICT members may review the documented outcomes of the meeting real-time in care management system. The member is mailed a written version of the comprehensive care plan as well as updates, thereafter.

**MOC 2E Factor 1**

*How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.*

**Example**

SmartHealth uses care transitions protocols to ensure that all SNP members have a smooth and safe transition between health care settings. SmartHealth maintains standardized practices and systems to ensure timely and thorough communications between and among SmartHealth and all involved
providers to optimize support to the participant and minimize complications related to care setting transitions, and facility (hospital/skilled nursing facility) admissions and readmissions. Our priorities and focus include care coordination and care transition, as well as the monitoring of hospitalizations and readmissions to support improved health care of covered beneficiaries. When participants are transitioning from one healthcare setting to another, SmartHealth will ensure that care management, the ICT and involved providers follow safe and effective protocols to facilitate a smooth transition from one setting to another. SmartHealth accomplishes this through timely and early identification of the participant’s need for such care setting transition, a standardized and well documented process for communication among settings and related Care Management/ICT determinations and actions. The participants remain a significant and integral part of the care transition process and participate in planning from one care transition setting to another. To the extent possible, SmartHealth embeds care transitions documentation and related work flow requirements into its care management system that has been customized by SmartHealth to meet the needs of the model of care for all dual populations.

MOC 2E Factor 2

The personnel responsible for coordinating the care transition process.

Example

Health Services Specialists - provide operational and clerical support to the Health Services teams. They distribute faxed clinical review information to nurses; fax the hospital determination log to facilities...

Inpatient Review Nurses - Case Managers are typically on-site at select hospitals and they conduct medical necessity and discharge planning reviews for members who are admitted. They will also provide information to the member and the member’s family on what to expect upon discharge and support the member through the transition and discharge process; makes appropriate CM referrals for post discharge follow up (telephonic review, Care Transition Coaching and others (i.e., Complex Care Management Program, behavioral health...); report any potential Quality of Care issues...

Care Transition Coach (CTC) - is a nurse or social worker who follows patients across care settings after leaving the hospital as part of the Care Transitions Coaching program. SmartHealth's Case Management department has adopted the strategies designed to ensure proper follow up and case management after a hospital stay....

MOC 2E Factor 3

How the organization transfers elements of the beneficiary’s ICP between health care settings when the beneficiary experiences an applicable transition in care.

Example

The organization transfers the SNP member’s ICP between healthcare settings during the care transition process. Prior to a transition in care, the plan identifies a planned transition is going to occur by requiring pre-certification for the following services: elective inpatient admissions, skilled nursing facility admissions, long term acute care, acute inpatient rehabilitation and home health services....
During planned and unplanned transitions, the plan sends the member’s ICP when a member transitions from each of the following settings. This includes communicating changes in health care status or beneficiary Plan of Care. Home to Inpatient Facility - the plan runs a daily SNP inpatient census that displays newly captured admissions. A case management coordinator uses this list to send SNP Member ICPs to the receiving facility within one business day of the notification of the unplanned transition and/or within one business day of the planned admission.

Inpatient to Skilled Nursing Facility (SNF): The responsibility of sending information for this transition is given to the inpatient facility and monitored by SmartHealth. The inpatient facility completes the discharge instructions, which the SNF facility uses as the admission care plan information. It is supplemented by attached admission orders.

Planned Outpatient, Ambulatory Care, and Surgery Center Transitions: Select outpatient, ambulatory care and surgery center procedures require health plan authorization; however, all are planned and scheduled by the rendering providers. Therefore, the plan entrusts member communication and support of these transition types to the authorized provider.

MOC 2E Factor 4

How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.

Example

Members who complete the HRA tool are mailed care plans and they are encouraged to share them with their providers to facilitate communication during the transition process. These care plans are written at or below a 6th grade reading level to ensure that members are able to use and understand them. In these letters, members are provided with the telephone number and contact information for the Care Management department. Care managers can work with the member or caregiver to update the care plan, mail updated care plans to the member or share care plan information with the member’s PCP or treating physician in any care setting. Members are also encouraged to complete and maintain their Personal Health Record (PHR) which contains member goals, a medication list, allergies, questions for providers, member conditions and “red flags” and should be shared at all visits to the member’s doctor or to the treating facility. SmartHealth works with members to complete the PHRs and ensure that they understand how to use them. Finally, SmartHealth developed an online member portal that has the capability to share care plans with members and caregivers.

MOC 2E Factor 5

How beneficiaries and/or caregivers will be educated about the beneficiary's health status to foster appropriate self-management activities.

Example

When a member is ready to be discharged home, a social worker and a RN is sent to the home within 48 hours to evaluate that member's home environment, perform a new health assessment as well as a
psychosocial evaluation. We also evaluate the home for any DME necessary to keep member safe. Working with the PCP, care managers will help educate the member and their families on member’s diagnosis and changes in health and encourage members to monitor and report changes in their health to the CM and PCP. This is also done during the weekly/monthly contacts and will be documented in care management system.

MOC 2E Factor 6

How the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

Example

The use of SmartHealth’s online portal will allow both members and family members to have access to their medical record, members of their ICT and changes in transition of care. When a member experiences a transition in care, they are immediately transferred to the transition team who contacts the family members as well as the new setting (i.e. hospital, rehabilitation center) to see what the plan of care is as well as a potential discharge date. This is documented in the care management system. A social worker is sent out to the new setting to evaluate member and reach out to the D/C planners to maintain optimal contact/planning. The member’s care manager is the point of contact for the member and/or caregivers throughout the transition process. This is communicated to the beneficiary and family via phone calls by the care manager to stay in touch on a routine basis.

MOC 3A Factor 1

How providers with specialized expertise correspond to the target population identified in MOC 1.

Example

The network includes contracted providers with specialized clinical expertise pertinent to the targeted C-SNP membership. This includes: practitioners specializing in geriatric medicine, internists/primary care physicians (PCP), and endocrinologists to manage diabetes as well as specialist to manage member comorbidities such as cardiologists, nephrologists and orthopedic surgeons. The network is not limited to the aforementioned providers and includes other specialist as determined by member diagnosis nurses, behavioral health specialists, social workers for care coordination, benefit and housing needs, social or medical equipment and resources as applicable. Available facilities for our chronic DM SNP includes acute care hospitals and tertiary medical centers, dialysis centers, acute care rehabilitation facilities, laboratory providers, skilled nursing facilities (SNF), pharmacies, radiology facilities, outpatient diabetes management and cardiac rehabilitation centers and wound care centers.

MOC 3A Factor 2

How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.

Example
Our health plan maintains credentialing, monitoring and re-credentialing procedures that include standard verifications e.g. licensure, sanctions, and professional liability claims history. There is a monthly process to monitor all credentialed and non-credentialed providers that have an active provider number. Providers are also required to notify the plan of any material change in the information including privileges, licensure, and ability to perform professional duties or change in OIG Sanction or GSA debarment status. All practitioners and facilities are re-credentialed within 36 months of the previous credentialing decision to identify any changes in a practitioner’s licensure, sanctions, certification, clinical privileges, competence or health status that may affect the practitioner’s ability to serve our members. The process also includes an assessment of the provider’s performance as part of our network

**MOC 3A Factor 3**

**How the SNP documents, updates and maintains accurate provider credentialing information.**

**Example**

"For Service Areas/Medical Centers in which a SmartHealth is located, the process of collecting, verifying, and evaluating licenses and credentials will be integrated for the purposes of participation and privileges in SmartHealth and SmartHealth’s hospital, staff membership and/or privileges even though the ultimate approval by both.

Credentialing: The credentialing and recredentialing process is initiated by receipt of a completed application. Competency to provide specialized care includes written and verbal verification to include letter from a primary source, report transmitted from electronic databases that are maintained by the primary source, internet reports from approved databases or a documented review of cumulative reports released by a primary source of credentials data. Credentials and Privileges are evaluated initially and based on setting as stated: (a) Hospital setting: at least every twenty-four (24) month; and (b) Ambulatory (medical office) setting: at least every thirty-six (36) months. The Credentialing and Privileging Committee may review any provider’s practice at any time, including between recredentialing cycles, to consider additional information relevant to that practice. The committee may decide at any time to take action regarding a provider’s credentialing. Such action or decision may include, but is not limited to, the suspension, termination, limitation or revocation of credentialing. Written notification of such decision of action will be made to the provider.

Licensing: All Providers must have a current, valid and unrestricted state license, registration, certification and/or other authorization to practice from the appropriate licensing board. SmartHealth obtains notification from the licensing agency that it performs primary source verification of education and training. Licensing is monitored daily. For State licenses, DEA licensures, Board Certification, Radio/Fluoro permits, Malpractice insurance and life support certifications (ACLS, BLS, PALS). Email notifications are sent for initial notification to Providers at least 30 days in advance as a reminder to provide updated licenses. The local medical centers work with a Regional Credentialing Department to resolve issues, such as suspensions or other related issues. SmartHealth accesses routine reports on a monthly basis of licensing board sanctions to detect restrictions. These are used to trigger the Credentialing and Privileging Committee review, as described above.
Provider Directory: The online provider directory is the primary source for SmartHealth with member’s also being able to access their medical records through their personal web portal. The physician directory allows members to compare physicians on criteria, including language, gender, education and specialty certifications. In addition to specialized training, the physician directory lists the physician biography.

MOC 3A Factor 4

How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.

Example

At SmartHealth, we recognize that the primary care physician (PCP) is the ICT member who determines ultimately which services the member will receive. The member is at the center of the ICT and the PCP is the clinical driver of all the care the member receives. The PCP works collaboratively with the Care Manager, who is the single point of contact for all ICT members involved in the care of a member. The member’s Care Manager acts as the coordinator of services and is the person who executes/authorizes services for the member with ongoing input from the other ICT members. The Care Manager helps to ensure member access to specialists and other needed services. The other ICT members contribute to care planning and utilization as the members care needs change over time.

The Care Manager documents all communication regarding clinical needs of the member in the system. Reports on services delivered are incorporated into the care management record to maintain a complete and up-to-date member record and disseminated to applicable ICT members. Information obtained from the PCP, specialists, hospitals and other providers is incorporated into the individual plan of care, which is sent to the PCP electronically, via fax or written correspondence.

MOC 3B Factor 1

Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols.

Example

SmartHealth monitors network providers to ensure the use of nationally recognized clinical practice guidelines where indicated or appropriate. This policy is reviewed annually by the Chief Medical Officer and Clinical Quality Director and approved by the Quality Committee to ensure MOC effectiveness. Oversight includes monitoring the provision of services to ensure providers adhere to nationally recognized clinical practice guidelines in clinical care; clinical services are appropriate and timely; follow-up on provision of services and benefits; seamless transition of care across settings and providers; and targeted medication and medical record reviews. Results of monitoring is housed in our electronic database. Additions and deletions to protocols are updated in the database and on our website upon approval. Clinical Practice Guidelines are obtained through the National Guideline Clearinghouse, National Institute of Health (NIH), American Diabetes Association (ADA), and various Physician Associations. CCG’s are approved by the Quality and Performance Improvement Committees (QPI) for provider network review. The guidelines are reviewed, revised and approved on an annual basis, using nationally-recognized evidenced based literature. The guidelines are developed with input from
community physicians via the Quality Assurance and Performance Improvement Committee and approved by the QPI. Member education material, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. A random sample of provider records is reviewed for compliance with one or more clinical practice guidelines. The guidelines are disseminated annually to providers (changes are also communicated as they occur) via the provider manual, newsletters, targeted mailing to specialty providers, and the provider page of the website.

**MOC 3B Factor 2**

**Identifying and documenting instances where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries.**

**Example**

To assist providers to use appropriate clinical practice guidelines, SmartHealth conducts ongoing data mining of pharmacy and medical/behavioral health claim data and medical record information to identify gaps in care. Results of the analysis produces clinically recommended services derived from evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claims data at least monthly for all members. Select clinical practice guideline measures are incorporated into a PCP report card, which are distributed twice a year, contain the physician’s performance on the identified guidelines, compared to the risk-adjusted performance of a specialty-matched peer group. On an annual basis, the QM team collects data and reports on provider compliance with clinical practice guidelines.

The data collected is used to identify opportunities for provider education or program changes to improve performance. SmartHealth has not experienced any challenges where clinical practice guidelines or nationally-recognized protocols do not fit the needs of our beneficiaries with complex healthcare needs. Should such a situation arise, the medical director, in conjunction with the chief medical officer will confer with the beneficiary’s treating physicians and other experts, as needed, to agree on an appropriate deviation for the beneficiary. SmartHealth maintains an agreement with the National Review Institute of America (NRiOA) and Guideline Solutions giving the medical director and chief medical officer access to nationally recognized specialists and subspecialists for consultation in applicable areas.

**MOC 3B Factor 3**

**Providing details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT.**

**Example**

SmartHealth expects its practitioners to utilize the adopted guidelines in their practices, and recognizes the inability of the guidelines to address all individual member circumstances as the guidelines are not intended to address all individual variations. As complex members have multiple chronic conditions leaving the decisions to modify or not follow CPG(s) the responsibility of the case managers, providers and the ICT. Providers are asked to supply additional clinical documentation and/or professional
citations when initial authorization requests do not meet specific QM Care Guideline criteria. The information is reviewed by the chief medical officer or the medical director in order to evaluate whether the deviation from CPGs is appropriate under the stated circumstances. A specific guideline developed may be the wrong choice for the individual member. Clinical guidelines are only one option for improving the quality of care, but the Alliance does not predominately rely on this option. The ICT allows for all participating members and their interdisciplinary care team (ICT) to discuss interventions on the ICP that are not part of the CPG and the benefits or consequences of not following the CPG for that member. The ICP would then be updated or written to address the goals and interventions discussed in the ICT. This process is facilitated by the CM, who is charged with ensuring that the ICP includes an explanation regarding why CPGs were not followed. PCP’s, members and member care givers are given updated versions of the ICP to reflect the changes.

MOC 3B Factor 4

Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

Example

Physicians and providers involved in the ICP are directed to use the plan of care as a tool to maintain alignment and consistency with treatment goals. They are also directed to communicate updated information related to the plan of care directly to the beneficiary’s care manager or by entering information through the provider web portal as a care plan note. The SmartHealth provider network management policies and procedures document the process for linking members to services including care transitions. The plan oversees care transitions by adhering to the Transition of Care policy and procedure and the Transition of Care program description outlined in MOC 2 Element E. All members admitted to an acute hospital or sub-acute facility (i.e., SNF, Rehabilitation facility), must meet the clinical guidelines for admission.

SmartHealth network providers are made aware of these requirements in the Provider Manual, received during provider orientation and available electronically on the website. Planned transitions from the members’ usual setting of care to another setting, such as elective inpatient admissions, require prior authorization by the plan. As noted in the Provider Manual, providers must submit an authorization request. Subsequent to the authorization request being approved, providers and members receive written confirmation of service prior authorization, and the plan maintains paper and electronic files on all authorization requests in order to facilitate the transfer of this information from one care setting to another. When an unplanned transition from the members’ usual setting of care to another setting, such as an inpatient acute facility setting, the plan receives notification of the admission from the facility and obtains an initial clinical review from the facility.

Subsequent to receiving the notification SmartHealth notifies the primary care provider of the admission within 2 calendar days of the receipt of transition notification to support continuity of care upon discharge. The SmartHealth Medical Director provides oversight of the Transition of Care program, which includes establishing and maintaining active relationships with array of community providers (physicians, facilities, hospitalists, etc.), and conducting physician-to-physician discussions regarding the plan of care for members in unplanned transition and planned transitions when appropriate. As a part of the Transition of Care program, the concurrent review nurse confers with the Medical Director for case
review in preparation for physician-to-physician calls. In an effort to maintain continuity of care during transitions, the CM also assists members with establishing follow-up PCP appointments following a transition of care discharge, and assists with coordinating any services that have been ordered such as, DME delivered, RN or home health visits, as a part of the discharge care plan, with the PCP as needed.

**MOC 3C Factor 1**

**Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.**

**Example**

Training for providers on the Model of Care will be delivered through provider seminars and through a web-based interactive training program. The seminars are delivered by experienced staff members from the Provider Network Management and Care Coordination Departments. A Care Coordination Manager or Director is available to answer questions on clinical aspects of the Model of Care. Training is provided annually and at the time of contracting to providers via: physician and provider workshops, hospital staff and provider meetings (this includes out-of-network providers as applicable), and provider forums. Information on the training topics is provided to Providers who did not attend a session through written provider communication materials. Provider alerts and electronic Provider newsletters are created and distributed. Training content includes but is not limited to: policies and procedures, including focused campaigns on Model of Care, Care Gaps, clinical guideline adherence and functionality available through the Provider Web Portal. To ensure consistency in the training content, standard presentation materials and handouts, accompanied by speaking points, are used. Participants are also given printed materials to reinforce key points of the training.

**MOC 3C Factor 2**

**Documenting evidence that network providers receive MOC training.**

**Example**

During the new and annual provider orientations, in which providers are given the Model of Care training, the provider manual, drug formulary, the provider directory, and referral authorization form, providers complete the Provider Orientation sign-in sheet and an attestation of training. Similarly non-network providers, who have seen over 5 SmartHealth members or who have 5 encounters with are also sent the MOC training information by mail and asked to submit an attestation confirming their review of the information. The Provider Network Management Department supports the Manager of Medicare Initiatives in tracking completion of provider trainings by keeping a copy of the signed attendance sheet and attestation, copies of which are preserved in the SmartHealth systems database.

**MOC 3C Factor 3**

**Explaining challenges associated with the completion of MOC training for network providers.**

**Example**

SmartHealth identified the following potential challenges associated with completion of MOC training by network providers e.g. large volume of providers across the service area; capturing modifications to physician rosters by hospital system and/or large physician group practices; provider participation on
multiple health plan panels leading to administrative issues of proper compliance. In addition, providers may miss scheduled training sessions due to time limitations, sudden increase in member needs and plan scheduling or staffing resources.

MOC 3C Factor 4
Taking action when the required MOC training is deficient or has not been completed

Example
While we facilitate in-person training as applicable to in house staff, the MOC training module is also contained in our online educational platform (web based); the SNP Operations department documents those associates who complete or fail to complete the annual training, as well as monitor new hire training. Ad hoc or annual reports are maintained on the Plan’s intranet site. Failure to complete the training within the designated timeframe may result in corrective actions ranging from temporary suspension of privileges for practitioners and leave without pay and subsequent termination for administrative staff. (This may be an extreme action but plans need to describe the corrective action it will take to ensure completion of training).

MOC 4A Factor 1
Describes how the organization delivers appropriate services to SNP beneficiaries, based on their unique needs.

Example
SmartHealth has developed a Model of Care that uses evidence-based best practices, and is continually reviewed for performance improvement opportunities. The model focuses on coordination and continuity of care for optimal outcomes and the effective use of resources. SmartHealth closely coordinates with our network providers on the care of members, person-specific planning, clinical guidelines and the consideration of treatment options. At the time of enrollment, SmartHealth collects case-specific information through various standardized and customized assessments. Those assessments are documented and integrated into our care management system, which permits us to have a complete snapshot of a member’s needs and care plan at any time. The care management system generates data and, in addition to the regular performance analyses, various additional metrics are considered and revised by the SmartHealth quality improvement team.

The QI plan is the framework for monitoring, evaluating, and identifying opportunities for improving the quality and appropriateness of services provided to SmartHealth beneficiaries. The quality program is also used to meet regulatory requirements. This systematic process includes identifying opportunities through an identified set of routine scheduled and ad hoc reporting processes. SmartHealth evaluation methods permit tracking of specific complaints, and the ability to assess trends and establish a corrective action plan to be implemented and assure that the plan is effective in improving the identified problem.

MOC 4A Factor 2
Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance.
Example

In order to carry out processes for continuous collections, analyses, evaluation and reporting on quality performance, the Quality Improvement Department (QID) has designed an MOC evaluation protocol.

Specific data sources used to analyze, evaluate and report MOC quality performance include: inter-departmental reports (such as utilization reports), MOC internal audit tool and the data collected for such, MOC evaluation, CMS MOC audit results, etc. Measurements relevant to identifying MOC performance measures include the outlined MOC goals and their identified benchmarks.

Quarterly, the QID will use the audit tool described above, to assure that processes relevant to the MOC are carried out accordingly. All perspective departments are given a 1-3 week time frame to provide the required data. After collection of this data (usually via email or inter-office delivery), the QID uses the audit tool, approved MOC and CMS guidelines as a guide to analyze and evaluate performance. Departments will be advised, individually, regarding results of MOC audit and given recommendations by the QID. The quarter following the internal audit, reports/results of quality performance as discovered during audit will be presented during the Quality Improvement Committee. At this time the chief medical officer and/or medical directors will provide additional feedback to departments, as necessary.

Additionally, key departments servicing the C-SNP members are required to participate in the Quality Improvement Committee in order to raise questions or concerns regarding processes and to provide relevant reports and results. The QID provides feedback and support, as needed.

MOC 4A Factor 3

Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.

Example

The Quality Assurance and Performance Improvement (QAPI) department, along with various departmental directors, are involved internal quality performance process. The Director, QAPI works with the plan departments to collect, analyze, report on data for evaluation of the MOC. Different reports are generated based on the specific needs at the time. The QAPI department in consultation with the Medical Director and staff performs analysis. These analyses are brought before QAPI Committee on a monthly basis. Additionally, other resources that we involve could be:

- the Medicare Quality Improvement Organization (QIO) that provides reports on Medicare Part D and provides assistance with some state requirements
- Contracted vendor that conducts surveys and provides analysis on the CAHPS and member satisfaction surveys.
- Contracted vendor that conducts patient record surveys to report on HEDIS measures and conducts the annual data validation audit.
- Pharmacy Benefit Management (PBM) - Part D resource supporting collection and analyses of pharmacy utilization management and medication therapy management program data as well as patient safety reports.
• Care manager and/or care manager supervisors, reviews, generates, and analyzes all reports related to the evaluation of the Model of Care. Care managers and/or supervisors makes recommendations for action to appropriate committees and provides the follow-up in the quality work plan to ensure the recommendations are implemented as approved and appropriate.

MOC 4A Factor 4

Describes how SNP - specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B.

Example

MOC goals reset annually to encourage SmartHealth practitioners to provide preventive services, acute care services, and chronic disease management at the highest standards of current healthcare quality. Benchmarks are developed based on the most up-to-date data available for industry-wide performance (example: HEDIS Medicare Advantage HMO percentiles) and prior performance within SmartHealth (example: year-to-year comparison of hospital readmissions). Progress toward goals the organization has established for healthcare quality measures from HEDIS, CAHPS and HOS results, and Part D medication adherence is reported on a quarterly basis. Internal reports on elements such as hospital and SNF utilization, disease management program effectiveness, member complaints and grievances, and credentialing reviews are analyzed on a quarterly basis to ensure overall performance is maintained.

Performance improvement is an ongoing process. When goals are not met, analysis of barriers and identification of opportunities for improvement are completed by the case manager or the performance manager team, as well as by the medical officers and/or QM committee who provide guidance on recommended corrective actions with specific timeframes and goals for improvement and plans for re-measurement. Specifically, when evaluating MOC performance, the Plan, Do, Check and Act (PDCA) format is used to address results that fall below expected goals. This includes planning the improvement, doing or performing the intervention, checking the results, and acting to stabilize and continue improvement. Based on the analysis of these contributing factors, the case managers and others plan improvements to include process changes, required resource allocation, expected results, and timeline to achieve results. This is an ongoing process to check or monitor results and act to stabilize and continue the improvement. On a semi-annual basis, the results and recommended actions/impact are reported to the QM committee by the regional clinical managers with assistance from the QM department.

MOC 4B Factor 1

Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.

Example

The SNP measurable goals described in the table detail additional process and member health outcome measures, including data sources and performance goals, used to evaluate the Model of Care. Results are collected and evaluated for each plan. Each measure has a different measurement frequency in accordance with the data sources used to collect the measure, time needed to impact the measure, or
regulatory requirements. Unless specified otherwise, the timeframe for meeting each goal is one measurement year. All measures not meeting the specified goal within the timeframe will be evaluated for a Quality Improvement Project. Measures tied to regulatory requirements such as CMS network adequacy standards will be escalated to leadership for remediation.

**MOC 4B Factor 2**

Identify specific beneficiary health outcomes measures used to measure overall SNP population health outcomes.

**Example**

<table>
<thead>
<tr>
<th>Goal Focus</th>
<th>Topic</th>
<th>Measurement Methodology /Data Source</th>
<th>Measurable Objective</th>
<th>Benchmark</th>
<th>Benchmark Source</th>
<th>Measurement Frequency/Timeframe to Meeting Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving access to essential services such as medical, mental health, and social services</td>
<td>Provider Network Access and Availability</td>
<td>Internal Survey</td>
<td>Access to providers:</td>
<td>100%</td>
<td>Internal</td>
<td>Annually/1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>After Hours: 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urgent Care within 24 hours: 95%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Non Urgent Care within 48 hours: 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Routine Primary Care within 30 days: 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider Network Adequacy</td>
<td>Quest Analytics Report</td>
<td>Time and Distance Requirements:</td>
<td>100% Pass, 0 Fails</td>
<td>CMS</td>
<td>Annually/ 1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Micro : 100% Pass</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>Metro : 100% Pass</td>
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<td></td>
<td></td>
<td></td>
<td>Large Metro : 100% Pass</td>
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<td></td>
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<td>Rural : 100% Pass</td>
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</tr>
<tr>
<td></td>
<td>Member Complaints about</td>
<td>Report</td>
<td>&lt; 4 complaints/10 00</td>
<td>NA</td>
<td>NA</td>
<td>Semi-annually/ 1 Year</td>
</tr>
</tbody>
</table>
In the example above, the organization not only provided a table detailing the focus, measureable goals, the benchmarks, and the frequency of each goal, the MOC narrative provided further clarification regarding the data sources and how each goal’s timeframe is one measurement year.

**MOC 4B Factor 3**

**Describe how the SNP establishes methods to assess and track the MOC's impact on SNP beneficiaries' health outcomes.**

**Example**

SNP Measureable Goals were developed considering the unique characteristics of and prevalence of chronic conditions seen within our membership and also include network adequacy, utilization and member satisfaction-related measures. Goals are chosen by reviewing the needs of the SNP target population and considering the health outcomes that the Plan is most likely to impact positively or negatively. Process measures were also selected to support the root cause analysis of negative outcome measures as well as the early identification and remediation of process breakdowns that could affect membership. The addition of or removal of SNP Measurable Goals must be reviewed and approved by the QA committee. Many measures such as those relating to utilization and readmissions are tracked on a continuous basis through daily census or other internal reports and reported in a variety of forums and ad hoc meetings. Health outcomes are monitored through the use of the monthly reports which provide member specific compliance data for routine health screenings, lab values that are a variance from suggested benchmark levels, and missed PCP visits. These reports are utilized by the Case Management department to identify members who need an intervention. By comparing the current data to the previous year, we can determine improvements year over year.

**MOC 4B Factor 4**

**Describe the processes and procedures the SNP will use to determine if health outcome goals are met.**

**Example**
The results of the various performance indicators are presented and reviewed at the appropriate measurement intervals, and at least annually, by clinical leadership including the managers/directors of case management, quality improvement (QI) leads, the VP of health services, and the medical director. Results and conclusions are then reported to the QIC. Wherever possible, measures have an established goal or benchmark against which individual plans may compare their performance thereby allowing for the objective and consistent identification of goals met as well as variances. For each measure, a quantitative analysis is performed by the appropriate department leader to assess the plan’s performance against prior performance, the plan goal and the benchmark for the measure, as applicable. We collect data on our processes and population characteristics specific to each market (not just SNP) to provide context and insight into each market’s outcomes measures and performance.

Identified remediation activities and interventions are multifaceted and include direct outreach to members to address preventive health measures.

**MOC 4B Factor 5**

**Describe the steps the SNP will take if goals are not met in the expected time frame.**

**Example**

Actions taken when goals are not realized

1. Quality Improvement investigates and follows-through with report and recommended actions.
2. Care management staff and/or providers are notified about the deficiency and the corrective action plan is established.
3. Care management staff and/or providers are placed in plan for performance improvement activities for the identified deficiency.
4. Members are notified through mail and we site about new quality initiatives and performance improvement projects.

**MOC 4C Factor 1**

**Describing the specific SNP survey used.**

**Example**

In addition to collecting CAHPS data, an annual member satisfaction survey is a paper survey (Exhibit 1.) that SmartHealth mails to a random sample of members in each market where the plan conducts business. The expectation is to gather enough data to achieve a 95% confidence interval for each major segment within our Member base. This survey has been conducted with small variations since 2007. The 35-question survey covers the following topics:

- Access to Care (5 questions pertaining to timeliness ease of obtaining care);
- Personal Doctor (4 questions pertaining to physician communication and effectiveness);
- Prescription Coverage (3 questions pertaining to communication and its effectiveness);
- Plan Representatives (3 questions pertaining to communication and its effectiveness);
- Communication (8 questions addressing types, preference and effectiveness); and
- Overall Satisfaction.
Case management program survey is sent to all members who participated in case management after their cases are closed. We also conduct an active case survey once a year in order to balance perception of immediate and sustained experiences. The case management survey is paper-based and contains questions for the following topics:

- Experiences with the Case Manager
- Reactions to Information received
- Reaction to tools that help manage patient’s health
- Overall Satisfaction

Dashboards are provided monthly for closed cases indicating change from previous time periods. Summaries and complete analysis of data is conducted quarterly and annually.

The Customer Experience department develops these surveys in conjunction with other relevant departments such as Health Services or Quality. The Customer Experience department deploys the surveys according to the specified timeframes, collects and reports results.

**MOC 4C Factor 2**

**Explaining the rationale for the selection of the specific tool.**

**Example**

The topics included in the member satisfaction survey were based on CMS findings from the CAHPS survey as important drivers to the healthcare experience. They were validated through focus groups and individual conversations with members who expressed the importance of each factor in determining quality of care perception and needs within the healthcare environment. Topics were further validated using correlation coefficients and scatter grams to determine primary strengths and opportunities. CAHPS survey data is also collected and thoroughly analyzed to identify opportunities for improvement; however, since the CAHPS data includes responses from all MA members, not just SNP, SmartHealth’s proprietary member satisfaction survey allows us to collect comparable data at the individual SNP plan level. The case management satisfaction tool was developed based on NCQA requirements and evaluates the primary functions and services performed by case managers. The survey focuses on the quality of member interactions and member’s perception of the case manager’s assistance in improving his or her health status. The case management teams evaluate results annually to determine opportunities for improvement.

Based on feedback preferences from members and other customers, a paper collection method was determined as the most effective way in which to gather satisfaction data from the members; nevertheless, we have observed low response rates. Other methods, such as Interactive Voice Response (IVR) calls, personal phone calls, and focus groups, will be used to supplement data collection methods in the future in order to determine most effective and preferred method of communication from the members themselves.

**MOC 4C Factor 3**

**Describing how results of patient experience surveys are integrated into the overall MOC performance improvement plan.**
Example

Such findings from member satisfaction surveys are reported at Quality Improvement Committee (QIC) meetings and shared with relevant shared services departments as well as marketing staff. Survey results are evaluated against internal plan processes, operations and observations to determine opportunities for improvement. The QI staff evaluate CM member satisfaction and CAHPS survey results and determine where interventions are required, tracking these opportunities and interventions on the annual QI work plans. Case management satisfaction survey results are analyzed at least annually and the results are shared with the market CM departments. The analysis and review of the survey results to determine the need for intervention is included each year on the annual QI work plan reviewed at monthly QIC meetings. Case management teams are responsible for analyzing the results and determining the appropriate interventions, if needed.

MOC 4C Factor 4

Describing steps taken by the SNP to address issues identified in survey responses.

Example

The Quality improvement staff from all survey results and determine where interventions are required, tracking these opportunities and interventions on the annual QI work plans. QI Committee members then request that work groups design interventions to address those areas and report status updates and progress to the QIC throughout the year.

The steps taken to address member satisfaction data are the same as the steps in the overall QI process with the exception that raw data and analysis are not presented at the QIC. Rather, the results are presented at the SNP level with the expectation that they will be able to incorporate into the SNPs QI plan maintained by the market QI Director or Manager.

MOC 4D Factor 1 and 2

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.

Example

SmartHealth’s performance and activity reports build towards measurement of the efficacy of our health management programs. The results of quality performance indicators are used to support ongoing improvement of the Model of Care and continually assess and evaluate quality. The medical director and the director of Quality and Performance Improvement (QAPI) have oversight responsibility for monitoring and evaluating the effectiveness of the MOC. The QAPI committee of the board of managers is chaired by the medical director, and meets on a monthly basis. The medical director and the director of QAPI present and review performance data and analyses at the meetings of the QAPI committee. At these meetings, participants discuss and plan for opportunities to improve the MOC. Discussions also include identifying priorities for the allocation of resources to improve the MOC, and setting any revised goals for quality, availability and continuity of care for members. The medical
director and the director of QAPI are responsible for follow-up actions, implementation plans and/or additional analyses that are called for by the QAPI committee. Additional staff supporting efforts to improve the MOC:

- Director, Care Management
- Director, Marketing and Outreach
- Director, Information Systems & Technology
- Director, Provider Relations and Contracting
- Director, Intake and Enrollment
- Care Manager Supervisors and Care Managers

Our reports are focused on specific SNP subpopulations, HEDIS measures, and those elements of importance to the quality assurance and utilization review functions. Data are analyzed considering variations in many factors including demographics of the population, the reasons for grievances and appeals, and the overall effectiveness of the program. All those components help us to identify possibilities for improvement of our MOC. Care managers and the ICT are provided with reports that assist them to understand and address the health status of the members. Additional measures are collected through encounter data to determine access/availability of care and appropriate use of services. HEDIS results, including national and local comparisons, are used to report and measure progress and opportunities for improvement. All posterior findings and recommendation are presented to the QAPI committee for incorporation in to the QIP towards to the improvement of the model of care.

**MOC 4D Factor 3**

The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

**Example**

SmartHealth has established a committee structure and meeting schedule that promotes accountability and appropriate resource allocation, as well as routine data collection, analysis and timely remediation of variances as well as timely implementation of action items derived from lessons learned in the course of MOC performance evaluation. Furthermore, SmartHealth has continued to improve its reporting systems and databases to promote timely and flexible initial as well as follow up data collection to assist with root cause analysis and to improve the evaluation and prioritization of proposed interventions. For example, SmartHealth is now able to receive and respond to real-time HEDIS data instead of having to wait for annual HEDIS data results. This real-time data access has allowed us to respond timely to member health outcomes results and intervene as appropriate. The measures are now monitored through a monthly data refresh and disseminated to all departments via a monthly set of reports. These reports are available at the patient-level and physician-level and reflect members who are missing preventive screenings, medication refills, and missing PCP visits. One of the specific reports identifies members who are missing four or more preventive screenings. This targeted approach improves our ability to ensure that members are receiving the attention necessary to enhance their self-management skills and improve overall care.

**MOC 4D Factor 4**
How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

Example

SmartHealth’s QI program activities including the Model of Care are maintained, per regulatory requirements, for ten years, in an electronic format generated by the plan’s information and care management systems. SmartHealth documents and preserves an annual quality project work plan that identifies specific activities, programs, and studies that support the quality plan, organizational goals, and objectives. The quality assurance program includes the measurable improvement goals identified in the MOC. The majority of these activities are carried over from year to year, as is the case with regulatory measurements and reporting requirements. This annual work plan is developed based on governmental requirements, the results of the annual quality evaluation, and input from SmartHealth committees, providers, and beneficiaries. The evaluation of the MOC is also documented through the minutes, work plans and actions of various committees involved in analyzing and improving the MOC such as utilization review, quality and performance improvement, pharmacy and therapeutics, and peer review. These committees meet on a regular basis to analyze the trends. Each committee maintains a log of the minutes and proposals. The logs of the committees are submitted to the QI committee in order to analyze where we are with respect to reaching goals and improving the MOC.

SmartHealth makes information about improvements to the MOC available to providers and beneficiaries on at least an annual basis and more often if needed. To achieve true integration and initiate collaborative activities, information about the MOC and other quality program activities are communicated to SmartHealth’s provider network, posted on the plan website, and made available to beneficiaries, community partners, and stakeholders.

MOC 4E Factor 1

Describing how performance results and other pertinent information are shared with multiple stakeholders.

Example

Provider Communication

SmartHealth communicates SNP Model of Care improvements and/or performance results to providers using the following mechanisms:

- Prior to each contract year, all providers receive on-line access to and copies of the provider manual. Material changes and improvements to the SNP Model of Care are communicated in the “Special Needs Plans Model of Care” section. Annual face-to-face SNP MOC training may be conducted by the Network Operations or Health Services teams to communicate improvements to providers.
- May also communicate MOC improvements and performance results to providers through educational content on the plan’s website.
- Case managers may interact with providers to discuss any changes in the MOC and address any impact to members’ care plans.
- MOC performance results may be communicated at physician advisory committee meetings
- Network operations communicates performance results to providers via systems reports as well as reports on individual patients

Personnel Communication

SmarthHealth communicates SNP MOC improvements and/or performance results to personnel using the following mechanisms:

- Annual on-line training and notifications sent via the online training module
- Benefits by plan name are posted annually on an intranet for all associates to access
- Staff on-the-job trainings
- Weekly update emails
- Staff meetings
- Performance improvement workgroup meetings
- Changes and improvements to the MOC are communicated via oversight and quality improvement committees/work groups and Board of Directors Meetings.

Member Communication:

SmarthHealth communicates SNP MOC improvements and/or performance results to members using the following mechanisms:

- Member newsletters are published quarterly and mailed to the member’s home address. The public web site also contains the newsletter information, updated plan benefit information and access to provider directories and medication information. Ad hoc communication may be posted on the web site as well.
- Each member receives a member health statement twice a year which advises the individual member of their personal compliance with preventive screenings and prescription refills.
- The Evidence of Coverage alerts members that Quality Improvement Program information is available upon request.

Regulatory Agency Communication:

SmarthHealth communicates SNP MOC improvements and/or performance results to regulatory agencies using the following mechanisms:

- The plan submits SNP applications and MOC filings which include MOC or QIP improvements as needed. Select performance results may be included as well although they are not required. These documents are submitted annually or at least every three years.
- The Plan submits its care management efficacy results, care transitions analysis, and ER and hospital admissions analyses annually as part of the NCQA Structure and Process submission.
- The Plan submits QI projects and chronic care improvement programs for each of its SNP plans annually. These submissions include measures selected to determine the impact of the interventions as well as performance results.
MOC 4E Factor 2

Stating the scheduled frequency of communications with stakeholders.

Example

Regular communications to stakeholders take place at specified intervals. SNP MOC improvements or performance results are included in communications as determined by the ICC or plan clinical and/or operations leadership. Examples of regular communications and their scheduled frequencies are below:

Plan Leadership:

- Communications via weekly reports
- Interdisciplinary Care Committee – Quarterly
- Corporate Quality Improvement Committee – Monthly ( Quarterly ICC reports)
- Board Reports - Quarterly
- Plan Personnel and Staff:
  - Communications via “Weekly Reports”
  - Communication via weekly, biweekly or monthly staff meetings or workgroups
  - SNP Model of Care Training - annually

Plan Beneficiaries and Caregivers:

- Member Newsletters – Quarterly
- Member Health Statements – Bi-annually
- Summary of Benefits – Annual
- Health Risk Assessments letters – Annual
- Care Plan Letters – Annual (for members who complete their HRAs or have an Administrative HRA)

Regulatory Agencies:

- SNP Applications and MOC filings – Annual or at least every 3 years
- Quality and documentation reviews such as the NCQA Structure and Process submission – Annual or as determined by regulatory agencies
- Quality Improvement Projects and Chronic Care Improvement Program- Annual

Provider Networks:

- Provider Newsletters – Quarterly
- Provider Manuals – Annual
- SNP Model of Care Training – Annual
- Physician Advisory Committee Meetings – Quarterly
- POD/IPA Reports – At least Quarterly
MOC 4E Factor 3

Describing the methods for ad hoc communication with stakeholders.

Example

Ad hoc communications to stakeholders take place through a number of methods. SNP MOC improvements or performance reports are communicated as determined by the ICC or Plan clinical and/or operations Leadership. Examples of ad hoc communication methods to different stakeholders are included below:

Plan Leadership:

- Email
- Weekly Reports
- Telephone
- Committee Meetings
- In-person meetings
- Plan intranet
- Plan Personnel and Staff:
  - Email
  - Weekly Reports
  - Training
  - Staff Meetings
  - Telephone
  - Workgroups
  - In-person meetings
  - Plan intranet

Plan Beneficiaries and Caregivers:

- U.S. Mail
- External Plan Website
- Interactive Voice Response (IVR) calls
- Telephone call
- Email
- In-person communication

Regulatory Agencies

- Email
- Telephone
- Health Plan Management System
- Provider Networks
- Fax Blasts
- IPA/POD meetings
- Telephone
- Email
MOC 4E Factor 4

Identifying the individuals responsible for communicating performance updates in a timely manner.

Example

The results of the annual Model of Care performance evaluation are shared internally at the interdisciplinary care committee. It is the responsibility of the quality department including the SNP program manager, quality improvement director supporting SNPs and/or the VP of Quality to determine how best to coordinate the dissemination and communication of results. The evaluation must be approved by the interdisciplinary care committee; however, the evaluation is disseminated prior to the meeting for review, editing and discussion as needed. Typically the evaluation is shared with directors of case management, the market quality improvement leads and the VPs of Health Services within each market and at the shared services level. Upon approval, it is the responsibility of the interdisciplinary care committee to determine if additional communications are needed and who the responsible individuals should be.

Results may be shared with the QI committee chaired by the medical senior director who also may determine if additional internal or external communications are required to internal stakeholders such as the board of directors or external stakeholders such as providers. The QI committee will ensure that communications are deployed timely. Typically the SNP program manager and quality improvement director will draft the content and coordinate the development of SNP performance communications impacting all markets via associate and provider trainings, provider newsletters, member newsletters and the external SmartHealth website. Should a business unit or department change a process that impacts the implementation of the Model of Care, it is the obligation of the department head or process owner to communicate this information to the Shared Services Quality department who will then determine how to disseminate the information to additional stakeholders.