CY2023 SNP Model of Care Training FAQs

As of January 26, 2022

Introduction

In collaboration with the Centers for Medicare & Medicare Services (CMS), the National Committee for Quality Assurance (NCQA) held training sessions for health plans in November and December 2021 to review the calendar year (CY) 2023 Special Needs Plan (SNP) Model of Care (MOC) requirements. These trainings addressed changes due to the implementation of Bipartisan Budget Act (BBA) of 2018[1] and also provided detailed information on the requirements for all MOC elements, including the new Face-to-Face Encounter element (MOC 2C). NCQA and CMS (SNP Project Team) received a variety of questions both during and following these training sessions. Given this, the SNP Project Team compiled the below frequently asked questions (FAQs) to serve as an informational resource for health plans. Following the below clarification statement and the general information section, the FAQs are organized by MOC element. In addition, a Resources section containing information on obtaining technical assistance and links to key training-related items has been included at the end of this document.

Clarification: Health Risk Assessment Policies & Reporting Practices

CMS and NCQA have received questions regarding Health Risk Assessment (HRA) policies and reporting practices based on the MOC 1 & 2 training session held on November 30, 2021. Medicare Advantage organizations offering SNPs must conduct initial and annual HRAs of individuals' physical, psychosocial, and functional needs, using a comprehensive risk assessment tool that CMS may review during oversight activities [see Social Security Act, § 1859(f)(5)(A)(ii)(I) and 42 CFR § 422.101(f)(1)(i)].

In addition, Medicare Advantage SNPs are required under 42 CFR 422.152(g)(2)(iv) to submit HRA completion data as a part of the CMS Part C Plan Reporting process. CMS provides further guidance to plans in the Part C Plan Reporting Technical Specifications found here: https://www.cms.gov/files/document/cy2021-part-c-technical-specifications.pdf. As noted in these Technical Specifications, only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. This means, for example, that HRAs completed using only claims and/or other administrative data would not be acceptable for the purposes of meeting the Part C reporting requirements. SNPs should take this into consideration when reviewing their MOC HRA processes and incorporate appropriate enrollee refusal or "unable to reach" policies into their MOC HRA policies.

General Information

1. **Where can I find the recordings for the CY 2023 trainings?**

   The recordings for the CY 2023 trainings are available here on the NCQA SNP Approval website.

2. **Where can I locate the SNP MOC Matrix?**

   The matrix along with the CY 2023 MA and Part D applications will be posted on CMS websites in January 2022; however, you can also review the CY 2023 MOC Scoring Guidelines for details related to the MOC content. The CY 2023 MOC Scoring Guidelines are available here.

[1] https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare

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3. Has NCQA incorporated the changes mandated by the Bipartisan Budget Act of 2018 (BBA of 2018) and as codified in the January 2021 Part C/D final rule, into the CY 2023 MOC matrix and scoring guidelines?

Yes, the CY 2023 MOC matrix and scoring guidelines include changes from the BBA 2018. These regulatory changes are noted in each applicable element, and include:

- Codification of existing guidance in Chapter 5 of the Medicare Managed Care Manual under 422.101(f)(1)(iii) whereby SNPs are required to provide an interdisciplinary team that includes providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the plan for all SNPs.
- Incorporation of a new requirement at 42 CFR 422.101(f)(1)(iv) whereby SNPs are required to provide annual face-to-face encounters between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan healthcare providers.
- Incorporation of an amendment to 42 CFR 422.101(f)(1)(i) whereby SNPs are required to ensure that the results of the initial assessment and annual reassessment required for each enrollee be addressed in the individual's individualized care plan.
- Incorporation of a new requirement at 42 CFR 422.101(f)(3)(ii) that the evaluation and approval of the MOC take into account whether the plan fulfilled the previous MOC's goals.
- Incorporation of a new requirement at 42 CFR 422.101(f)(3)(iii) whereby each element of the MOC must meet a minimum benchmark score of 50 percent, and a plan's MOC will only be approved if each element meets the minimum benchmark.

4. Should SNPs with existing approved MOCs submit off-cycle revisions to capture changes resulting from the January 2021 Part C and D final Rule (86 FR 5864)?

No. New regulatory guidance issued in January 2021 Parts C and D Final Rule applies to initial and renewal MOC submissions beginning CY 2023. CMS is expecting SNPs to meet these new requirements on a rolling basis as current MOCs expire.

- C-SNPs must submit MOCs annually for review and approval [§ 1859(f)(5)(B)(iv) of the Act]. Therefore, all C-SNPs are expected to incorporate the final rule requirements in their CY 2023 MOC submissions due February 16, 2022.
- All D-SNPs and I-SNPs submitting initial and renewal MOCs for CY 2023 are expected to incorporate the final rule requirements in their submissions due February 16, 2022.
- For I-SNPs and D-SNPs with MOCs that are not up for renewal for CY 2023 (i.e., their MOCs are set to expire in CY 2024 and CY 2025), plans are expected to meet the new requirements set in the final rule upon the start date of their next MOC (and based on approval by NCQA). I-SNPs and D-SNPs are **not** required to submit off-cycle MOC submissions in order to meet the final rule requirements.

5. **If the MOC has an overall submission score of 75% or greater but the MOC has a deficiency in scoring at least 50% on each element, will plans have the ability to resubmit the MOC so that it can be approved for multiple years?**

   No. Plans must meet an overall scoring benchmark in addition to a minimum score of 50% for each element to obtain approval, regardless of the final overall score [42 CFR § 422.101(f)(3)(iii)]. Plans that do not meet this minimum threshold for each element are required to Cure, and will only receive a one-year approval, regardless of the final overall score.

6. **For plans submitting a CY 2023 MOC, can they also submit an off-cycle MOC if changes are made prior to the effective date?**

   No. Plans cannot submit an off-cycle submission for a MOC that has yet to go into effect. That is, plans cannot submit an off-cycle submission for their CY 2023 approved MOC until the MOC is active starting January 1, 2023. Plans that wish to modify their current MOC should be aware that the HPMS MOC Off-Cycle Submission window is only available from June 1, 2023 through November 30, 2023.

7. **For a renewal MOC submission, should plans include changes over the previous MOC submission in strikethrough text?**

   No. Plans submitting a renewal MOC should not include changes from the previous MOC submission in strikethrough text. Note, however, that strikethrough text is required to highlight changes when submitting an off-cycle or Cure submission.

8. **Where should plans include additional documents (if applicable) that detail processes in the MOC?**

   It is not acceptable to upload additional documents or attachments to your MOC. All required information must be included directly in the MOC document itself. Appendices, such as training slides and/or other materials, may be included at the end of the MOC; however, ideally this information would be embedded under the appropriate factor within the MOC. SNPs should indicate at the end of a factor if NCQA should review the appendix for additional material (e.g., "see Appendix for additional information").

9. **How much detail regarding policies and procedures are SNPs expected to provide in the MOC to meet the intent of the factors? For example, do we need to include specific details or are general statements adequate?**

   We are not prescriptive in the level of detail that should be provided in the MOC to meet the intent of factors that require information on policies and procedures; however, for these types of factors, the MOC should clearly describe a clear and holistic process that someone outside of the SNP can understand and evaluate. This goal can generally be accomplished by addressing the who, what, where, when and how for that particular policy/procedure.

10. **If plans are doing a Service Area Expansion (SAE) into a new state, but under an H contract with an existing and approved MOC, do plans need to submit an entirely new MOC for the new state?**

    SAEs no longer require a MOC submission; however, plans should include this information within the population description upon resubmission. Upon renewal, the MOC should provide a description of the target population of the new plan and discuss any differences in MOC processes based on any relevant

individual state requirement(s). Please reach out to the CMS Division of Policy, Analysis, and Planning (DPAP) mailbox at https://dpap.lmi.org/dpapmailbox/mailbox to address any questions regarding SAEs.

MOC 1: Description of SNP Population

11. We understand population data should be from 2018 or newer; however, can we utilize information and/or data that are prior to 2018? (MOC 1)

No, data prior to 2018 is not considered adequate or sufficient enough to determine current resource needs or to consider changes in treatment.

12. Can plans select a different target population (TP) for their 2023 MOC submission? (MOC 1A)

Since the TP is determined by SNP type, a different population or SNP type would require its own submission. That is, the use of a different population would entail an additional MOC unless this is an SAE.

13. What is considered the minimum threshold of membership for describing the TP? (MOC 1A)

Plans should be able to provide some demographic information regardless of size of the expected enrollment level.

- The organization must provide information about its local TP in the service areas covered under the contract. Information about national population statistics is insufficient.
- The MOC must describe how the plan identifies its members and include specific information on the characteristics of the TP population it intends to serve. This information must include components that characterize its enrollees (e.g., average age, gender and ethnicity profiles, incidence and prevalence of major diseases, chronic conditions and other significant barriers faced by the target population). Information about national population statistics without drawing a correlation to the SNP's TP is insufficient.
- The organization may use enrollee information from other product lines (e.g., Medicare Advantage or Medicaid plans) as an example of the intended TP if the plan does not have members, or it must provide details compiled from the intended plan service area.

14. For MOC 1, we currently have less than 10 members and therefore it is difficult to complete a robust description of the current population. Given this, can we also include a description of our TP based on our much larger Medicare Advantage Part D (MAPD) plans in the same service area? (MOC 1A)

The organization may either use enrollee information from other product lines (e.g., Medicare Advantage or Medicaid plans) as an example of the intended TP if the plan does not have members or has very low enrollment, or it must provide details compiled from the intended plan service area. Please specify that you are using this data due to low membership and will update when information regarding your TP becomes available. Please include a description of your expected TP.

15. Are C-SNPs required to verify eligibility beyond the initial enrollment period for MOC 1A, Factor 1? (MOC 1A)

NCQA provides guidelines related to the determination, verification, and tracking of SNP enrollee eligibility under MOC 1A Factor 1 as part of the MOC Scoring Guidelines for Contract Year 2023. NCQA recognizes that there may be circumstances when the annual verification for some C-SNP chronic conditions could be considered unnecessary. Based on this consideration, NCQA will review MOC 1A Factor 1 with this knowledge and score accordingly.

16. Are there suggestions or guidance you can provide on how to define the most vulnerable? (MOC 1B)

Plans must provide a description of how its most vulnerable individuals are identified and differentiate between the general TP and the most vulnerable population. It is suggested that plans determine what makes the SNP enrollees higher risk by looking at the presence of comorbidities, service utilization, demographics, etc. The description must include the demographic characteristics of this population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factors).

MOC 2: Care Coordination

17. How do you define "contracted staff" in MOC 2? Is it the same as delegated staff, or can this also include temporary staff and/or contractors, etc.? (MOC 2A)

"Contracted staff" refers to contracted health care providers within the SNP's network.

18. Is there a minimum MOC training completion threshold for providers/physicians? (MOC 2A)

No, there is no minimum threshold percentage for MOC training completion by providers. Please note, SNPs are required to have appropriate staff (employed, contracted, or non-contracted) trained on the SNP plan MOC to coordinate and/or deliver all services and benefits under 42 CFR 422.101(f)(2)(ii). However, the expectation is that plans have a process that maximizes provider participation. Therefore, we are focused on the procedures SNPs have in place to maximize provider completion.

19. Is there a requirement that the Health Risk Assessment Tool (HRAT) be limited to a single tool per plan, or can we use multiple types of assessment tools under different circumstances that will adhere to all requirements? In other words, do we need to use the same HRAT for initial and reassessments, or can we use different tools? (MOC 2B)

CMS does not require the use of a single tool.

20. Based on MOC 2B, are SNPs required to complete a new HRA when an enrollee's health status changes or there is a care transition? If yes, can a SNP use a more targeted assessment? (MOC 2B)

CMS does not currently require SNPs to provide a new HRA when an enrollee has a health status update or care transition, although SNPs may establish this process under their approved MOC to further support their care transition protocols, as needed, or to further support care coordination activities, as appropriate. Under Title XVIII, section 1859(f)(5)(A)(ii)(I) of the Social Security Act, each SNP is required to conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional

needs. We also say under 42 CFR 422.101(f)(1)(i) that SNPs conducting this process must do so using a comprehensive risk assessment tool that CMS may review during oversight activities, and ensure that results from the initial assessment and annual reassessment conducted for each individual enrolled in the plan are addressed in the individual's individualized care plan as required under 42 CFR 422.101(f)(1)(ii).

21. Can you provide specific timeframes for ICP updates following the completion of an HRA? (MOC 2B)

CMS does not currently require SNPs to follow specific timeframes for updating member ICPs. Under Title XVIII, section 1859(f)(5)(A)(ii)(II) of the Social Security Act, each SNP is required develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided. As we note in Attachment A of the MOC protocols as part of PRA package CMS-10565 (OMB 0938-1296), SNPs should explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. Any timeframe the SNP may enact should be consistent with the requirements in 1859(f)(5)(A)(ii)(II) and with the plan's approved MOC.

22. For unable to reach members or members who refuse to complete the HRA, are we required to complete "administrative HRAs" for these members using claims or other data? (MOC 2B)

Medicare Advantage organizations offering SNPs must conduct initial and annual HRAs of individuals' physical, psychosocial, and functional needs, using a comprehensive risk assessment tool that CMS may review during oversight activities [see Social Security Act, § 1859(f)(5)(A)(ii)(I) and 42 CFR § 422.101(f)(1)(i)].

In addition, Medicare Advantage SNPs are required under 42 CFR 422.152(g)(2)(iv) to submit HRA completion data as a part of the CMS Part C Plan Reporting process. CMS provides further guidance to plans in the Part C Plan Reporting Technical Specifications found here: https://www.cms.gov/files/document/cy2021-part-c-technical-specifications.pdf. As noted in these Technical Specifications, only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. This means, for example, that HRAs completed only using claims and/or other administrative data would not be acceptable for the purposes of meeting the Part C reporting requirements. SNPs should take this into consideration when reviewing their MOC HRA processes and incorporate appropriate enrollee refusal or "unable to reach" policies into their MOC HRA policies. Plans must provide a detailed approach for attempting to contact members, including the number of attempts, as well as assurance that efforts are documented.

23. How much detail on HRAT policies and procedures in terms of how the ICP is developed/updated and how HRAT information is disseminated to and used by the ICT are SNPs expected to provide in the MOC to meet the intent of MOC 2B, Factor 1? Do we need to reference specific details, or are general statements adequate? (MOC 2B)

We are not prescriptive in the level of detail that needs to be provided in the MOC to meet the intent of this factor in terms of the information requested regarding policies and procedures; however, the MOC should clearly describe a clear and holistic process that someone outside of the SNP can understand and evaluate. This goal can generally be accomplished by addressing the who, what, where, when and how of the process for that particular policy/procedure.

24. Does any face-to-face visit with a primary care provider (PCP) qualify towards satisfying the requirements of the new Face-to-Face Encounter element? (MOC 2C)

A qualifying Face-to-Face Encounter can be held by a member of the enrollee's Interdisciplinary Care Team (ICT), the plan's case management and coordination staff, or contracted plan healthcare providers. This includes: the enrollee's regular primary care physician, a specialist related to the enrollee's chronic condition, a behavioral health provider, health educator, social worker, and Managed Long-Term Services and Supports (MLTSS) plan staff or related MLTSS health care providers provided that such providers are: (i) a member of the enrollee's interdisciplinary team; (ii) part of the plan's case management and coordination staff; or (iii) contracted plan healthcare providers performing services on behalf of the plan.

25. For MOC 2C, can the member's consent for the Face-to-Face Encounter be obtained in advance? For example, can the face-to-face encounter requirement be explained (and the member's consent obtained) at the time of the HRA? If the member refuses at that time, will documentation of such refusal be adequate? (MOC 2C)

Providing an explanation in advance of what is considered a face-to-face encounter followed by obtaining consent would be sufficient. A reminder at the time of scheduling may be beneficial.

26. Since the Individualized Care Plan (ICP) is supposed to be member-directed (or at least member-involved), what do we do if the member refuses to have any communication or involvement with the care coordination process? (MOC 2D)

CMS firmly believes that the ICP is an essential tool for managing care for all SNP beneficiaries, regardless of whether they complete an HRA. Additionally, MA regulations at 42 C.F.R. 422.152(g)(v) require that as part of a SNPs' quality improvement program, it must implement an ICP for each beneficiary. Although we recognize that the information collected during an HRA along with involvement of the beneficiary and/or his/her caregiver/representative is valuable in developing an ICP, we expect that SNPs will formulate an ICP based on information gathered from assessments, medical records, or other available data.

27. Can plans use data obtained through interoperability disclosures from prior plans when developing an ICP, or just what the current plan has found? (MOC 2D)

Interoperability disclosures from prior plans could be a means of obtaining information to support the development of an ICP. Otherwise, plans will need to seek other methods for gathering the info such as claims data, PCP notes (if accessible), pharmacy data, or Heath Information Exchanges, to name just a few examples.

28. If transitions of care are provided only to those enrollees determined to be high-risk members, does this meet the requirements included in MOC 2F? (MOC 2F)

No, there are no exceptions when it comes to transitions of care. Regulations at 42 CFR § 422.101(f)(2)(iii)-(v) and 42 CFR § 422.152(g)(2)(vii)-(x) require all SNPs to coordinate the delivery of care. It is the SNP's responsibility to ensure that treatment protocols and needed resources related to transitions of care across healthcare setting and providers are delivered to all enrollees.

CY2023 SNP Model of Care Training FAQs

As of January 26, 2022

MOC 3: Provider Network

29. What is the difference between the ICT provider training and credentialing/verification requirements included for MOC 2E, Factor 1, versus the information requested for MOC 3A, Factor 2? (MOC 3A)

MOC 2E, Factor 1 requires a comprehensive description of how the organization determines the composition of ICT membership to address the unique needs of enrollees. We want to understand how these needs correlate with the expertise of the providers included in the ICT.

In MOC 3A, Factor 2, we want plans to explain how the SNP oversees its provider network and facilities and ensures that its providers are actively licensed and competent to provide these specialized healthcare services to SNP enrollees. Plans should detail how they credential, track and monitor the providers that comprise the ICT.

The overall similarity across these two factors is that plans need to describe how they confirm that everyone on the ICT team and within the network are adequately skilled and able to accommodate the unique needs of the SNP enrollees.

30. Our MOC training is under development. If the staff training and provider training content is similar/identical, are we expected to duplicate the description under MOC 2A (staff training) for MOC 3C (provider training)? (MOC 3C)

While there will be similarities between the general staff MOC training and the provider MOC training, the provider training should include specific information for practitioners/clinicians.

31. Is there a threshold for when an out-of-network provider would need to participate in MOC training? (MOC 3C)

CMS does not set a threshold to determine when a SNP must offer training to out-of-network (OON) providers. MA organizations offering SNPs must have appropriate staff (employed, contracted, or non-contracted) trained on the SNP's MOC to coordinate and/or deliver all services and benefits as part of their MOC under 42 CFR 422.101(f)(2)(ii). Since the regulation stipulates that training must be offered to OON providers, SNPs must describe the process for how the organization provides initial and annual training and provide evidence that it makes training on the MOC available to all applicable OON providers. CMS recognizes that offering training to an OON provider based on a one-time encounter with a member may create an administrative burden, and plans should establish policies that meet the regulation without jeopardizing the SNP's ability to reach OON providers that members may see on a more frequent basis.

32. Tracking provider compliance for MOC provider training is extremely difficult, can NCQA provide suggestions on how provider training should be monitored? (MOC 3C)

We are not prescriptive in how SNPs should track provider compliance related to MOC training completion. CMS believes that plans are in the best position to determine how to best track training compliance.

33. The CY 2023 standards for Element 3C, Factor 4 indicate that a "training incomplete" reminder notice is an insufficient corrective action step for providers who are deficient. If a reminder notice is not sufficient, what specifically is required for plans to comply? Are plans expected to take corrective or disciplinary action related to training non-compliance with non-contracted providers? (MOC 3C)

We want to understand the extent of the actions taken by plans beyond notification of the deficiency to the provider when it is determined that training is incomplete or deficient. Plans may want to consider using incentives to encourage and/or ensure completion.

MOC 4: MOC Quality Measurement and Performance Improvement

34. MOC goals are formally evaluated annually. For MOC renewal submissions with a 2-or 3-year approval, is it your expectation that we call out each element that is used in MOC 4 that did not meet the goal, or just identify the process of how the plan will work towards attainment of the goal?

The objective is to provide a brief overview/description of unmet goals, the expected and actual outcomes, and a plan of action to be taken towards improvement and included in the next or subsequent MOC submission due for approval.

35. Do plans need to keep all current MOC outcome measures and/or goal targets for their new MOC, or can they modify them as needed for MOC 4A and MOC 4B? If so, in what part of the MOC should this be documented? (MOC 4A, MOC 4B)

SNPs should modify goals as needed to meet the needs of their population and to affect improvement. Please describe any changes to previously established goals along with the rationale for these changes in MOC 4A or MOC 4B, as applicable. Regulations at 42 CFR 422.101(f)(3)(ii) require SNPs to provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment the previous MOC's goals. For MOC 4A and 4B, SNPs should provide a review of actions taken for improvement as well as the rationale for doing so.

36. For MOC 4A and MOC 4B, are plans only required to indicate whether goals are "met" or "not met" rather than provide the actual quantified results? (MOC 4A, MOC 4B)

Plans should include benchmarks, goals, timeframes and data sources related to their goals. In addition, plans should provide a synopsis of whether goals were met or unmet as well as any action plans for improvement (if goals were not met) along with the rationale for said improvements. NCQA reviewers are looking for a brief overview of whether goals are met/unmet. This information can be provided in the table depicting your goals or in a statement. While we cannot be certain as to the significance of this information as reviewed by CMS auditors, NCQA will not validate the data specifically as we do not have actual evidence to compare against, but will instead evaluate the summary of results.

37. Where should plans add the results of goals from prior years? Should this be included as part of the MOC goals chart for MOC 4B? If a plan identified 10 goals in a prior renewal, is the plan expected to provide data related to each goal as to whether the goal was met and, if not, how the plan is going to address this in the future? (MOC 4A, MOC 4B)

Plans may add a column to their table denoting met/not met. However, as stated above, NCQA reviewers are looking for a brief overview of whether goals are met/unmet. This can be provided in the table depicting your goals or in a statement. As previously stated, while we cannot be certain as to the significance of this information as reviewed by CMS auditors, NCQA does not review the data specifically as we do not have any actual evidence to compare against, but rather only your overview summary.

38. Are measurable goals related to the SNP population, or are they more granular (i.e., goals of the ICP)? (MOC 4A, MOC 4B)

MOC 4A goals focus on the improvement of overall plan operations while MOC 4B objectives focus on health-related improvements for the overall SNP population (not for individual member health).

39. Given that our plan has an effective start date of January 1, 2022, we will not have sufficient data to report outcome measures related to the achievement of goals for the CY 2023 MOC submission. Is it acceptable to note in the MOC that we have insufficient data available to measure goal achievement? (MOC 4A)

No. As required under 42 CFR 422.101(f)(3)(ii)(B), plans submitting an initial MOC must provide relevant information pertaining to the MOC's goals for review and approval. As we noted in the January 2021 Parts C/D final rule, for SNPs submitting a MOC renewal after one year (because an annual review and approval is necessary), preliminary data from the immediately prior year can provide evidence to the level of fulfillment of the previous MOC's goals.

Further, for goals that are tied to building on prior performance or making incremental progress in the same or similar area each year, information about performance in more than one prior year may be relevant and pertinent to show how the SNP is fulfilling the MOC's goals. Under MOC 4, Element B of the MOC, SNPs must currently provide a description of the processes and procedures the plan will use to determine if health outcome goals are met. By sharing the findings from these processes, SNPs can outline achievable steps toward long term goals so that small steps using limited data year to year can be evaluated. Therefore, we believe that SNPs can effectively demonstrate progress to meet the requirements of § 422.101(f)(3)(ii).

40. For MOC 4B, we equate health outcome measures to Health Outcomes Survey (HOS) measures; however, it appears that the term is being used more broadly. Please clarify how we should interpret the term "health outcomes"? (MOC 4B)

You are correct. However, for the purposes of the MOC, the use of the term health outcome measures is not limited to HOS measures, and meant to capture changes to specific health related measures of the plan population that is attributable to an intervention or series of interventions.

41. Are plans required to include HRAT, ICP and ICT goals in MOC 4B? What is the numeric value or benchmark for HRA completion? Does the benchmark include those that refuse or are unable to be reached? (MOC 4B)

Yes. This is a new requirement for CY 2023 and is a means for ensuring that plans attempt to meet the requirement. The goal must be set at 100% because these activities are a regulatory requirement. Per the CY 2023 MOC Scoring Guidelines, the MOC must detail goals for the HRA, ICP and ICT. CMS understands that it is the expectation of the requirement and not necessarily the realized results, as there are challenges that may impact the desired outcome (e.g., enrollees unable to be reached).

The regulations state that all SNP enrollees must have an HRA, ICP and ICT, therefore, completion goals should be set at 100%. However, CMS and NCQA understand that this is not always possible, as enrollees cannot be compelled to respond.

42. If we set the HRA completion goal to 100%, can we include enrollees who refused and those unable to be contacted when determining the completion rate? (MOC 4B)

No. The HRA goal must be set at 100%, regardless of the fact that some enrollees will not complete an HRA. We understand that there will be enrollees who refuse to complete or cannot be reached to complete an HRA despite your best efforts. We are looking for plans to explain the actions taken in an attempt to reach these enrollees. Enrollee non-compliance can certainly be cited as a perennial barrier to achieving 100% HRA completion.

Resources

Technical Assistance Resources

- For technical inquiries related to the MOC program plan requirements or regulation questions, please contact the CMS Division of Policy, Analysis, and Planning (DPAP) mailbox.

  CMS DPAP Mailbox
  https://dpap.lmi.org
  Subject: SNP MOC Inquiry

- For SNP application inquiries, please submit questions via the SNP mailbox on the Division of Medicare Advantage Operations (DMAO) website.

  CMS SNP Mailbox
  https://dmao.lmi.org
  Subject: SNP Application Inquiry

Additional Resources

- NCQA SNP Approval Website
- CY2023 MOC Scoring Guidelines
- Training Slides and Recordings