SNP Approval Model of Care Training
Elements 1 - 2

Brett Kay, NCQA
Heather Kilbourne, CMS
Sandra Jones, NCQA
Nidhi Dalwadi Mehta, NCQA

January 30, 2018 2:00 – 3:30 pm
<table>
<thead>
<tr>
<th>Table of contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENDA</td>
</tr>
<tr>
<td>OBJECTIVES OF THE SNP MODEL OF CARE (MOC)</td>
</tr>
<tr>
<td>MOC ELEMENTS - OVERVIEW</td>
</tr>
<tr>
<td>SCORING THE MOC</td>
</tr>
<tr>
<td>PROJECT TIMELINE</td>
</tr>
<tr>
<td>REMINDERS</td>
</tr>
<tr>
<td>MOC 1 &amp; 2 WITH EXAMPLES AND Q &amp; A</td>
</tr>
<tr>
<td>HPMS REVIEW</td>
</tr>
<tr>
<td>TECHNICAL ASSISTANCE FOR CURE SUBMISSIONS</td>
</tr>
<tr>
<td>HIGHLIGHT TRAININGS</td>
</tr>
<tr>
<td>IDENTIFY CONTACTS &amp; RESOURCES</td>
</tr>
</tbody>
</table>
Objectives of Special Needs Plans

Compliance
Comply with statutory requirements of ACA

Defines Health Care Delivery
Ensure SNPs have a robust Model of Care

Approval Periods
Establish frequency for approval review cycle (1-3 years)
# Model of Care Elements

<table>
<thead>
<tr>
<th>MOC 1</th>
<th>MOC 2</th>
<th>MOC 3</th>
<th>MOC 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Care Coordination</td>
<td>Provider Network</td>
<td>Quality Measurement</td>
</tr>
</tbody>
</table>
How will NCQA Score the MOC?

The methodology behind the process

MOC elements worth 0-4 points, based on # of factors met

Total of 60 points (15 elements) converted to percentage scores
E.g., 50 points = 83.33% or a 2-year approval:

- 85%+ --3-year approval
- 75-84%--2-year approval
- 70-74%--1-year approval.
- Plans scoring <70% after the initial review will have one Cure process.

Plans that undergo the Cure, will only receive a 1-year approval, regardless of their final score
Project Time Line

- **Annual Submission**: February 14
- **March 27**: Results to CMS
- **April 26**: Cure Submission
- **May 10**: Cure results to CMS
- **April 19**: Technical Assistance call prior to Cure submission
- **June 4**: Bids due to CMS

TA Calls
Reminders for this Review Period

Important information you need to know

• MOC must address the regulatory language in specific elements

• Looking for process details and descriptions
  o Must address the Who, What, Where and How
  o Provide oversight where applicable

• Reviewers will score your MOC narrative based on the Guidelines

• Specific regulations are highlighted within the elements and we will emphasize each as we walk through applicable elements/factors

• General process statements are not acceptable and will be scored down
Keep in Mind

SNPs must identify all H-numbers that follow similar processes under a single MOC on the Matrix Upload document.

- **You must describe the Target population in your service area**
- Data and analysis must be relevant to specific population in each service area (not as described in national statistics)
- Expectation is for SNPs to submit a new MOC each renewal period with process updates and changes (e.g., changes to goals as a result of analysis of outcomes or process improvements), and not the same MOC previously approved
  - An opportunity to think through and improve processes
  - Address all requirements in the elements and factors
  - Check the explanation for clarification
- MOC’s will be reviewed and scored based upon current assessment of the requirements
Description of SNP Population

MOC 1

NIDHI DALWADI MEHTA
MOC 1 Element A: Overall SNP Population

Factor level details

Intent: Identify and describe the target population, including health and social factors, and unique characteristics of each SNP type

• Focus is on a description that:
  - Provides a foundation upon which the remaining measures build a complete continuum of care (e.g., end-of-life & special considerations) for current and potential members the plan intends to serve

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

• Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population

• Identify and describe the medical and health conditions impacting SNP beneficiaries

• Define the unique characteristics of the SNP population served
MOC 1: Description of SNP Population

All about our SNP and a word about national statistics

While national statistics provide some idea of the chronic diseases and comorbidities certain populations face, the description must speak specifically to each SNP’s target population for that service area.
MOC 1 Element A Example - factor 1 (handout)

Determining, verifying, & tracking beneficiary eligibility

SmartHealth 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.

How the plan works to maintain or prevent loss of eligibility:

• On a monthly basis, all SNP members’ Medicaid eligibility is verified with the state agency by the data analyst
• Members identified as not meeting the SNP eligibility requirements are notified and instructed on how to prevent loss 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

“Must address the who, what, how and when, if applicable.”
MOC 1 Element A Example- factor 3 (handout)

Identify and describe the medical and health conditions impacting SNP beneficiaries

Our C-SNP (Diabetes Mellitus) notes: 20% of the population is diagnosed with DM. While CVD, CHF and decreased kidney function diagnoses are often correlated, members in our target population also note these comorbid conditions to include neurological disorders (2%), musculoskeletal disease (2%), pulmonary disease (5%), kidney disease (30%) and psychiatric disorders (25%)…

Tell us about your SNP’s service area data, – not national statistics about chronic conditions

- What are your experiences with the population e.g. average age, cultural or religious beliefs; how do they impact healthcare or needed services (part of the benefit plan or an exception through care management)
- Medical and cognitive factors or comorbidities; barriers e.g. education, language spoken or cultural issues

“Includes specific information on beneficiaries’ current health status and characteristics that may impact status.”
MOC 1 Element B: Most Vulnerable Beneficiaries

How we address the sickest of the sick

Intent: Describe the most vulnerable beneficiaries and how their medical/social factors affect health outcomes and what services/resources the SNP provides to address these factors

- Focus:
  - Important to note that the focus is on population-level, not individual members
  - Simply put, what makes them “different from the general population”? 
  - Includes specially tailored services for members considered “most vulnerable” (e.g. multiple hospital admissions or excessive spending on medications above set limits)
  - Goes above and beyond those service provided to the general population
MOC 1 Element B: Most Vulnerable Beneficiaries Cont.

Factor specific elements

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

2. Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries

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

4. Identifies and describes established relationships with partners in the community to provide needed resources
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 new plan in a nearby location, we expect to see some common characteristics noted in our plan’s 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.

To emphasize the sickest of the sick – most vulnerable, the description must also include the average age, gender ethnicity language barriers, health literacy deficits, and socio-economic status

- Detail how the most-vulnerable beneficiaries demographic characteristics affect
  - Health status
  - (out-of-the-box) Clinical interventions
  - Needed resources
  - Community partnerships
  - Outcomes

“Provide details on special services and programs above and beyond provisions to the general SNP population.”
MOC 1 Element B Example- factor 4 (handout)

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

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.

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

MOC 2
MOC 2 Element A: SNP Staff Structure

Intent: Describe administrative/clinical staff roles and responsibilities

• Focus:
  o How care coordination (e.g., health care needs, preferences and sharing information across health care staff and facilities) occurs
  o All elements must address the SNP’s care coordination activities in detail
MOC 2 Element A: SNP Staff Structure

1. Describe the administrative staff’s roles and responsibilities, including oversight functions
2. Describe the clinical staff’s roles and responsibilities, including oversight functions
3. Describe how staff responsibilities coordinate with the job title
4. Describe contingency plans used to address ongoing continuity of critical staff functions
5. Describe how the organization conducts initial and annual MOC training for its employed and contracted staff
6. Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training
7. Describe actions the organization takes if staff do not complete the required MOC training
MOC 2 Element A Example - factor 3

You must include your organization chart
Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.

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.

Attendance is tracked via sign-in/log-in sheets. Staff responsible for oversight follow-up with those not attending. Corrective actions such as written warnings up to and including termination can occur.

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

The MOC must describe training strategies and content. If the plan is not yet operational, a description (not simply the Table of Contents) must be provided.

Responses for this factor must include:

- Frequency/Timeframe for training (initial & annual)
- Staff responsible for training & development
- Venue of trainings
- Documentation of training & record keeping
- Actions to ensure participation in trainings

SmartHealth MOC Training

“Include slide deck or detailed description of content offered.”
MOC 2 Element B: Health Risk Assessment Tool (HRAT)

Intent: Describe how the HRAT collects and uses data to assess medical, functional, cognitive, psychosocial and mental health needs of members.

Focus:

• How the HRAT is used to develop the Individual Care Plan (ICP)
• Dissemination of information to Interdisciplinary Care Team (ICT)
• Process for conducting the initial and annual assessments
• Methodology used to review, analyze and stratify HRA results
MOC 2 Element B: HRAT

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

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

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

4. The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results
CMS Regulation - MOC 2 Element B

All beneficiaries must have an HRA

Regulations at 42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP. The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP beneficiary.
### IADL Status:

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Minimal Supervision</th>
<th>Needs Assistance</th>
<th>Totally Dependent</th>
<th>Assistive Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housework</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessing Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEENT:

- **Cataracts?**
  - Yes
  - No

- **Laser eye surgery?**
  - Yes
  - No

- **Do you wear eye glasses?**
  - Yes
  - No

- **Do you use a hearing aid?**
  - Yes
  - No

### Chest:

- **Do you have asthma?**
  - Yes
  - No

- **Do you have emphysema?**
  - Yes
  - No

- **Do you have COPD?**
  - Yes
  - No

- **Have you had or do you have wheezing?**
  - Yes
  - No

- **Do you use home oxygen?**
  - Yes
  - No

- **Have you ever smoked tobacco products?**
  - Yes
  - No

### Suicide/Homicidal Assessment:

- Suicidal thoughts
- Homicidal thoughts
- Denies suicidal/homicidal thoughts

### Social History:

**Tobacco Use:**

- **Do you currently smoke tobacco products?**
  - Yes
  - No

- **How many packs per day did you / do you smoke?**
  - <1
  - 1
  - 2
  - >2

- **At what age did you start?**
- **At what age did you stop?**

- **Offered smoking cessation?**
  - Yes
  - No

### Respiration:

- **Do you cough every morning or nearly every morning?**
  - Yes
  - No

- **Are you short of breath at rest?**
  - Yes
  - No

- **Are you short of breath with exertion?**
  - Yes
  - No

- **Have you discussed your shortness of breath with your doctor?**
  - Yes
  - No

  **When?**

- **Spirometry?**
  - Yes
  - No

  **When?**
MOC 2 Element B Example- factor 1 (handout)

How the organization uses the HRAT to develop and update the Individualized Care plan (ICP) for each beneficiary

“Must describe how the HRAT is used, developed, updated into the ICP and how information is disseminated.”

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.

Regulations require an HRA for each beneficiary and MOC language must include this verbiage and provisions for unreachable members.

The assessment includes at a minimum (and this list is not all inclusive):

- 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
- Assessment of 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 detailed plan and rationale for reviewing, analyzing and stratifying (if applicable) the HRA results

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 member’s of the 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 2 Element C: Individualized Care Plan (ICP)

Intent: Describe how the ICP is developed and communicated

Focus

• Describing the essential elements of the ICP
• Detail the process for development/modification
• Identify staff responsible
• How updates to the ICP are:
  • Documented
  • Maintained; and
  • Communicated
MOC 2 Element C: ICP

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

All beneficiaries must have an Individualized Care Plan (ICP)

Regulations at 42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP.
The MOC must describe the process for developing the ICP as well as the staff responsible i.e. roles, functions, professional requirements and credentials. 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 changing 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
  - hospitalization
  - new onset of chronic condition
  - change in psycho-social function
- Included in the ICP revision is an evaluation of the identified goals and whether they are met.

“The MOC details how the beneficiary/caregiver is involved in the ICP development.”
How the ICP is documented, updated and where it is maintained

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.

All members of the ICT have the opportunity to review and provide comments on the ICP.

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.

The PCP is faxed a copy which he/she is asked to sign as evidence of collaboration.

“Describe steps taken to create an ICP for hard to reach members.”
MOC 2 Element D: Interdisciplinary Care Team (ICT)

Intent: Describe the key components of the ICT

Focus:
• Key members of ICT
• Roles/responsibilities
• How the ICT contributes to improving beneficiary health status
• Communications within the ICT
MOC 2 Element D ICT Cont.

1. How the organization determines the composition of ICT membership

2. How the roles and responsibilities of the ICT members (including beneficiaries and/or caregivers) contribute to the development and implementation of an effective interdisciplinary care process

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

4. How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange
CMS Regulation - MOC 2 Element D

All beneficiaries must have an Interdisciplinary Care Team (ICT)

Regulations at 42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv) require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP.
MOC 2 Element D factor 1 example (handout)
How the organization determines the composition of ICT membership

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 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.

“\[In your description of the ICT, you must include rationale for selection of specific team members.\]“
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

“When describing the roles and responsibilities of the ICT team members, detail how they use their expertise to provide needed resources to beneficiaries.”
MOC 2 Element E: Care Transition Protocols

Intent: Describe the SNP’s processes to coordinate care transitions and facilitate timely communications across settings and providers.

Focus:

• Describe the type of healthcare settings and personnel responsible for care transitions
• Describe how elements of the member’s ICP are shared between settings and who has access
• Describe how member’s and/or caregivers are educated for self-management activities
• Describe the point of contact throughout the transition process
MOC 2 Element E: Care Transition Protocols Cont.

1. The process for coordinating transitions
2. Personnel responsible for coordination efforts
3. Description of coordination between settings during a care transition
4. How beneficiaries have access to personal health information to facilitate communication with providers
5. Education provided to members/caregivers to manage conditions and avoid transitions
6. Process used to notify members/caregivers of staff assigned to support member through transitions
CMS Regulation - MOC 2 Element E
All Beneficiaries must have an Individualized Care Plan (ICP)

Regulations at 42 CFR §422.101(f)(2)(iii-v); 42 CFR §422.152(g)(2)(vii-x) require all SNPs to coordinate the delivery of care.
MOC 2 Element E factor 2 example

The personnel responsible for coordinating the care transition process

Health Services Specialists

• have a high school diploma

• 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 licensed practical (LPN’s or registered nurses (RN’s)

• typically on-site at select hospitals

• they conduct medical necessity and discharge planning reviews for members who are admitted

• provide information to the member and the member’s family on what to expect upon discharge

• 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

• is a nurse or social worker with a Bachelor’s degree or LCSW

• who follows patients across care settings after leaving the hospital as part of the Care Transitions Coaching program.

• adopts the strategies to ensure proper follow up and case management after a hospital stay…
MOC 2 Element E factor 4 example
How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.

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

The use of SmartHealth’s online portal will allow both beneficiaries 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.
Questions?
HPMS Review

How to upload via HPMS

HEATHER KILBOURNE, COR, CMS
The Model of Care (MOC) module supports the electronic submission of Model of Care (MOC) documents for off-cycle submissions, renewal proposals, and initial applications.
HPMS Review – Select an MOC to Upload

Renewal Submission - Upload

Select a MOC to Upload

Please select a contract and then select a MOC. To see all MOC uploads that have been submitted, you can select the Submission History link on the right navigation bar.

Please Note:
- File names cannot contain the following characters: "|<>:/*?#%+$&
- File names cannot contain two consecutive periods.
- File names cannot exceed 150 characters.
- Upload non-password protected .zip files only. Files with password protection or extensions other than .zip will not be accepted.
- Within the zipped file, only files with a .doc, .docx, .xls, .xlsx, .txt, or .pdf will be accepted.

MOC Matrix Template for MA renewal submissions

Select a Contract:

| Z0001 - EXAMPLE CONTRACT 1 |
| Z0002 - EXAMPLE CONTRACT 2 |
| Z0003 - EXAMPLE CONTRACT 3 |
| Z0004 - EXAMPLE CONTRACT 4 |
| Z0005 - EXAMPLE CONTRACT 5 |

Select a MOC:

Institutional-Institutional (Facility)
Renewal Submission - Upload

Select a MOC to Upload

Please select a contract and then select a MOC. To see all MOC uploads that have been submitted, you can select the Submission History link on the right navigation bar.

Please Note:
- File names cannot contain the following characters: "";:\*?\#%\+,\&
- File names cannot contain two consecutive periods.
- File names cannot exceed 150 characters.
- Upload non-password protected .zip files only. Files with password protection or extensions other than .zip will not be accepted.
- Within the zipped file, only files with a .doc, .docx, .xls, .xlsx, .txt, or .pdf will be accepted.

MOC Matrix Template for MA renewal submissions

Select a Contract:
- Z0001 - EXAMPLE CONTRACT 1
- Z0002 - EXAMPLE CONTRACT 2
- Z0003 - EXAMPLE CONTRACT 3
- Z0004 - EXAMPLE CONTRACT 4
- Z0005 - EXAMPLE CONTRACT 5

Select MOC file for upload: Browse...
Renewal Submission - Upload

System notification:
- The MOC file has been successfully uploaded.

Confirmation - Z0001

If you are ready to submit your Renewal MOC, please read the attestation below and if you agree click on the checkbox and select the Submit button.

Note: If you choose not to submit your Renewal MOC at this time, you will need to upload another MOC file. Once you have submitted, you may not upload again until NCQA is finished with their review or the Renewal MOC gates have been opened.

<table>
<thead>
<tr>
<th>MOC Type</th>
<th>File Name</th>
<th>Upload Date</th>
<th>Upload User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
<td>TESTFILE1.zip</td>
<td>1/4/2016 3:53 PM</td>
<td>TEST USER</td>
</tr>
</tbody>
</table>

I attest that I am ready to submit this Renewal MOC and I understand that I will be unable to submit again unless CMS opens the gate.

[Submit]
# HPMS Review – Submission Renewal

## Renewal Submission - Submission History

### Uploads for Z0001

<table>
<thead>
<tr>
<th>MOC Type</th>
<th>Latest Submission</th>
<th>Communication History</th>
<th>Contract Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISNP-Institutional (Facility)</td>
<td>TESTFILE1.zip</td>
<td></td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>1/4/2016 3:53:22 PM</td>
<td>TEST USER</td>
<td></td>
</tr>
</tbody>
</table>

[Back](#)
<table>
<thead>
<tr>
<th>MOC Element</th>
<th>MOC Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a Description of the SNP Population</td>
<td>While the organization has provided a description regarding how staff determines, verifies and tracks eligibility for its SNP beneficiaries, the organization provided overall descriptions of the Institutional populations for the organization at the corporate level rather than at the contract level for factors 2-4.</td>
</tr>
<tr>
<td>1.b Subpopulation: Most Vulnerable Beneficiaries</td>
<td>As stated in Element A, the organization did not provide contract level details therefore, it did not describe the most vulnerable beneficiaries in order to provide specially tailored services and to be able to illustrate the correlation between the demographic characteristics to the members unique clinical requirements.</td>
</tr>
<tr>
<td>2. Care Coordination</td>
<td>N/A</td>
</tr>
<tr>
<td>2.a SNP Staff Structure</td>
<td>3 While the organization provided clinical staff's role and responsibilities, it did not describe the oversight for license and competency verification. In addition, challenges associated with employed and contracted staff for completing the MOC training were not discussed.</td>
</tr>
<tr>
<td>2.b Health Risk Assessment Tool</td>
<td>3 The SNP provided a detailed description of how it utilizes its HRAT in order to develop and update ICPs through identifying the most appropriate programs and stratification level for members and sharing this information with the ICT. However, in describing its process for conducting the initial and annual reassessments (the SNP actually performs quarterly reassessments) for members the SNP did not also include a provision to reassess members, if warranted by a health status change or care transition.</td>
</tr>
<tr>
<td>2.c Individualized Care Plan</td>
<td>4</td>
</tr>
<tr>
<td>2.d Interdisciplinary Care Team</td>
<td>4</td>
</tr>
<tr>
<td>2.e Care Transition Protocols</td>
<td>4</td>
</tr>
<tr>
<td>2.f Staff Structure &amp; Care</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Initial and Cure Submissions

How do I submit?
Submission Instructions

How do I submit?

What -
SNP’s submit 2 documents:
• MOC narrative
• Matrix

Where -
Upload via HPMS by the date & time provided

How -
Formatting
• Supporting documentation may be included at the end of the MOC as an appendix
• May be referenced within the text

Using Links*
• Ensure that all links are operational
  ○ Check before submission

*Non-functional links or embedded documents may prevent reviewers from seeing your document and result in a decrease in scores assessed without an opportunity to Cure.
Technical Assistance for Cure
For Plans scoring less than 70% only

Previous instructions apply!

What –
- Must include MOC & Matrix

Where -
Upload via HPMS by the date & time provided

How -
Formatting
- Must redline changes
  - Strikethrough text no longer applicable and replace in colored font
- Address all factor requirements
- May reference documents placed in appendix
- Check links
MOC 1 & 2 Recap

One more time...
MOC 1A
Description of SNP Population

DO

• Refer to the Matrix, regulations and MOC Scoring Guidelines
• Review the factor explanations
• Detail your SNP Target Population

DON’T

• Attach extra documents
• Forget to detail member tracking, verification & process for preventing loss of membership to the extent possible
  o Rely on national statistics to meet requirements. Please provide data specific to each plan’s target population
MOC 1B
Sub-Population: Most Vulnerable Beneficiaries

Do

- Describe methodology used to identify most vulnerable members
- Describe member characteristics
- Provide impact to health outcomes
- Detail how community partners are used

Don’t

- Use the same resources provided to general membership
MOC 2A Care Coordination

SNP Staff Structure

Do

- Describe admin & clinical staff roles and responsibilities
- Detail training, education and/or credentials
- Describe actions for not participating in trainings
- Provide Org chart(s)

Don’t forget

- To describe training materials and detail content
- To detail contingency plans
- To include the process for initial and annual trainings
- To include information for maintaining training records
Do
• Include the process for completing the HRAT:
  o Use & dissemination
  o Describe Initial & Annual trainings
  o Methodology
  o Plan & rationale

Don’t
• Forget to detail the process for conducting an assessment for each beneficiary
• Forget to ensure that text is clearly written
MOC 2C
Individualized Care Plan (ICP)

**Do**
- Include the essential elements
- Describe the process and responsible staff
- Detail how ICP is documented and maintained
- Describe how updates and modifications occur

**Don’t**
- Forget to include regulatory language regarding ICP’s for each beneficiary
- Leave out details on:
  - Goals & objectives
  - Beneficiary & family/caregiver involvement
  - Beneficiary preferences
MOC 2D
Interdisciplinary Care Team (ICT)

Do

• Describe how outcomes are used to evaluate processes
• Detail the communication plan
• Provide details on how the SNP verifies communications with:
  o Each team member
  o Beneficiaries/
  o Caregiver
  o Stakeholders/others
• Describe barriers to communicating

Don’t

• Forget to detail the composition of the ICT
• Forget to detail participation of team members
• Forget to describe how the team works to promote participation of beneficiaries and caregivers
**Do**
- Identify members at risk for transitions
- Include Staff responsible for transitions
- Describe how elements of the ICP are transferred
- Describe how beneficiary’s health info is communicated
- Describe how self management activities are provided
- Detail how POC is identified

**Don’t**
- Forget to detail the process from planning, preparation, and follow up
Make this a simple process for you and the reviewer. Ensure that you address the requirements of all elements and factors.

– THE SNP TEAM
Training & Education

Sessions focus on MOC Requirements & Technical Assistance

-- MOC Elements 1 & 2 (1 training)
  o January 30, 2018, 2:00-3:30pm EST

-- MOC Elements 3 & 4 (1 training)
  o February 1, 2018, 2:00-3:30pm EST

-- Technical Assistance Calls  2:00–3:00pm EST for SNPs scoring <70%
  o April 19, 2018

Recordings and slides will be available on NCQA SNP Approval website (www.snpmoc.org) within one week of training.
For technical inquiries related to the MOC program plan requirements or regulation issues, please contact CMS at: https://dpap.imi.org. In the subject line enter: SNP MOC Inquiry

SNP application inquiries via the CMS SNP mailbox: type https://dmao.imi.org; then select the SNP mailbox. Subject line: SNP Application Inquiry

CMS MMP mailbox: mmcocapsmodel@cms.hhs.gov
Subject line: MMP MOC Inquiry

Training recordings and slides: Please visit the NCQA SNP Approval Website at: https://www.snpmoc.org