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2023

Model of Care Scoring Guidelines for Contract Year 2023

FOR PLANS SUBMITTING IN FEBRUARY 2022 WITH IMPLEMENTATION ON JANUARY 1, 2023

NOVEMBER 2021;Revised: December 2021

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Introduction

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

Clarification to HRA Requirements*

CMS and NCQA received a few questions regarding HRA policies and reporting practices based on MOC training sessions 1 & 2 on November 30, 2021. MA organizations offering Special Needs Plans (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 Special Needs Plans (SNPs) are required under 42 CFR 422.152(g)(2)(iv) to submit health risk assessment (HRA) completion data as a part of 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 the Tech Specs, 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.

*Corrections to statements during trainings regarding the HRA requirements were deleted in the recordings and notification placed on the SNP MOC website as well as noted here within the Scoring Guidelines.

Changes and Points of Emphasis for CY 2023

- In this release and consistent with the January 2021 Final Rule (CMS–4190–F2), CMS is implementing the BBA 2018 Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101) regulations effective for January 1, 2023. These regulatory changes are noted in each applicable element.
- In addition to the requirement that plans meet an overall scoring benchmark, plans must also obtain a minimum score of 50 percent 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.
- Factors whose explanations were previously grouped together (e.g., Factors 1-4) are now identified and explained individually (e.g., Factor 1, Factor 2, Factor 3, Factor 4)

- PowerPoint slides are located on the SNP Approval website here: **https://snpmoc.ncqa.org** and include examples of table templates that may be used to detail plan goals and benchmarks as required by MOC Element 4A and MOC Element 4B.
- **Keep in mind that data included for each submission must be current and relevant to the target population. Using data that predates more than three years from the current submission date is not acceptable.**

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Model of Care

MOC 1: Description of SNP Population (General Population)

The identification and a comprehensive description of the SNP-specific population are integral components of the model of care (MOC). All elements in this standard depend on a complete population description that addresses the full continuum of care of current and potential SNP enrollees, including end-of-life needs and considerations (if relevant). The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient.

MOC 1 Element A: Description of Overall SNP Population

The organization's MOC description of its target SNP population must include, but is not limited, to the following:

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

Summary of changes

- Clarified that verification and tracking membership goes beyond the initial application.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Element stem: Target population characteristics***

The MOC must describe how it identifies its members and must describe the target population that includes specific information on the characteristics of the population it intends to serve. This information must include components that characterize its enrollees, such as average age, gender and ethnicity profiles, the incidence and prevalence of major diseases, chronic conditions and other significant barriers faced by the target population. Information about national population statistics without drawing a correlation to your SNP's target population 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 target population if the plan does not have members, or it must provide details compiled from the intended plan service area.

Factor 1: Determine, verify and track eligibility

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

Factor 2: Identify health conditions

The MOC must include specific information on the current health status of its SNP enrollees. Factor 2 should include descriptions of social, cognitive and environmental aspects, as well as the living conditions and comorbidities associated with the SNP population in the plan's geographic service area.

Factor 3: Other health conditions

The organization should identify and describe other conditions that potentially affect health, including population demographics (e.g., average age, gender, ethnicity) and other health disparities (e.g., access to and availability of medical facilities and services, variations in disease occurrences, mortality, language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs or barriers that may interfere with conventional provision of health care or services, caregiver considerations or other concerns).

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

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

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

MOC 1 Element B: Subpopulation—Most Vulnerable Enrollees

The organization must include a complete description of the specially tailored services for enrollees considered especially vulnerable using specific terms and details. The description must differentiate between the general SNP population and the most vulnerable enrollees, as well as detail additional benefits above and beyond those available to general SNP enrollees. Other information specific to the description of the most vulnerable enrollees must include, but not be limited to, the following:

1. **Define and identify the most vulnerable enrollees within the SNP population, detailing the process for identification.**
2. **Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable enrollees.**
3. **Illustrate the relationship between the demographic characteristics of the most vulnerable enrollees and their unique clinical requirements.**
4. **Identify and describe established relationships with partners in the community to provide needed resources and provide a complete description of the process for supporting continuity of community partnerships and facilitating access to these specially tailored community services by the most vulnerable enrollees and/or their caregiver(s).**

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Factor 1: Define most vulnerable enrollees***

Although the definition of "SNP enrollee" typically implies members requiring additional care and services, the description focuses on the sickest or most vulnerable SNP members. This description differentiates the general population from the most vulnerable.

The MOC must include a robust and comprehensive definition that describes who these members are (i.e., what sets them apart from the overall SNP population), the methodology used to identify them (e.g., data collected on multiple hospital admissions within a specified time frame; high pharmacy utilization; high risk and resultant costs; specific diagnoses and subsequent treatment; medical, psychosocial, cognitive or functional challenges) and specially tailored services for which these enrollees are eligible. The

organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient unless it is used to draw a correlation to the current or proposed population.

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

Factor 2: Demographic characteristics of the most vulnerable enrollees

The MOC definition of its most vulnerable enrollees must describe the demographic characteristics of this population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factors). Explain how these characteristics affect the health outcomes of the most vulnerable enrollees.

Factor 3: Correlation between demographic characteristics and clinical requirements

Specify how these characteristics affect the need for unique clinical interventions.

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

Factor 4: Establish relationships with community partners

The MOC must describe its process for partnering with providers within the community to deliver needed services to its most vulnerable members, and how the organization works with its partners to support continuity of community partnerships and facilitate access to community services by the most vulnerable enrollees and/or their caregiver and maintain continuity of services.

MOC 2: Care Coordination

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

MOC 2 Element A: SNP Staff Structure

The organization's MOC must fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of SNP enrollees. This includes, but is not limited to, identification and detailed explanation of:

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

Summary of changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets no factors

Data source Documented process, Model of Care

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

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

The MOC must identify and describe the specific employed and contracted staff responsible for performing administrative functions, including but not limited to:

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

Factor 2: Clinical staff roles and responsibilities

The organization must identify and describe the employed and contracted staff that perform clinical functions, including but not limited to:

- Verification of applicable license and other credentials required for the staff or contracted position*
- Clinical oversight.
- Care coordination.
- Direct enrollee care and education on self-management techniques.
- Pharmacy consultation.
- Behavioral health counseling.

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

Factor 3: Coordination of responsibilities and job title

To show how staff responsibilities identified in the MOC are coordinated with job title, the organization must:

- Provide a copy of its organization chart and,
- If applicable, include a description of instances when a change to staff title/position or level of accountability is required to accommodate operational changes in the SNP.

Factor 4: Contingency plan

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

Factors 5: Initial and annual MOC training

The organization must conduct initial and annual MOC training for its employed and contracted staff*. The MOC must:

- Specifically indicate employed and contracted* staff.
- Describe the training strategies and content. Documentation must include a complete description of the types of trainings and specific examples of slides or training materials or at a minimum, a detailed list of the training content.
- May also include but is not limited to printed instructional materials, face-to-face training, web-based instruction and audio/video-conferencing.
- Descriptions may also include results of MOC competency testing. If the training plan is not currently operational, the organization's MOC must provide a complete description of the plan's training contents.

*Contracted staff do not include physicians or other providers that the organization contracts with as part of the provider network.

Factor 6: Maintaining training records

The organization must provide the methodology it uses to document and maintain training records as evidence that staff have completed MOC training such as examples of dated attendee lists, web-based attendance confirmation and electronic training record. This includes tracking and storage of documentation.

Factor 7: Actions if training is not completed

The MOC must explain challenges associated with employed and contracted staff completing training and must describe the specific actions the organization will take when the required MOC training has not been completed or has been found to be deficient. Actions taken goes beyond a statement that notes "appropriate actions will be taken." All applicable actions must be detailed.

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

Regulations at 42 CFR § 422.101(f)(1)(i); 42 CFR § 422.152(g)(2)(iv) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP. The organization's MOC includes a clear and detailed description of the policies and procedures for completing the HRAT.

1. **Describe the process (policies and procedures [P&P's]) for completing the HRAT and how the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each enrollee (Element 2D).**
2. **Provide a detailed description of how the organization conducts the initial HRAT and annual reassessment for each enrollee.**
3. **Explain how the organization then disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and subsequently how the ICT uses that information (Element 2E).**
4. **Describe the detailed plan and rationale for reviewing, analyzing and stratifying (if applicable) the HRA results, including how the results are communicated back to the ICT, PCP and other applicable providers.**

Summary of changes

- Clarified the amended requirement in 42 CFR § 422.101(f)(1)(i) for updating the HRA and incorporating changes into the ICP in a timely manner.

Scoring

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

Data source Documented process, Model of Care

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

Factor 1: Use and dissemination of HRAT information

The organization must include a description of the process (P&P) it uses to develop and update, in a timely manner, the ICP (MOC Element 2D) for each enrollee and how the HRAT information is disseminated to and used by the ICT (MOC Element 2E).

Factor 2: Initial and annual HRA reassessment

The organization must complete the HRAT for each enrollee, for an initial assessment. At a minimum, the organization must conduct the initial assessment within 90 days of enrollment including detailed information of the data collected and how it is collected. The organization must conduct the annual reassessment within one year of the initial assessment.

- For factor 2, the description must include the methodology used to coordinate the initial and annual HRAT for each enrollee (e.g., mailed questionnaire, in-person assessment, phone interview) and the timing of the assessments.

Factor 3: Dissemination of HRAT information

As part of the model of care under the BBA 2018, the results of the initial assessment and annual reassessment of each individual enrolled in the plan must be addressed in the ICP and the results of each subsequent assessment must be incorporated into the enrollees' ICP plan. The plan must detail its process for disseminating all HRAT (i.e., initial, reassessment) information to the ICT and subsequently detail how the ICT uses this information during care coordination.

- There must be a provision to reassess enrollees, if warranted by a health status change or care transition (e.g., hospitalization, change in medication, multiple falls).
- The organization must describe its process for attempting to contact enrollees to complete their HRAT, including provisions for enrollees that cannot or do not want to be contacted or complete the HRAT*.

*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 the Tech Specs, only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements.

Factor 4: Methodology and communication plan

The MOC must explain the rationale for reviewing, analyzing and stratifying (if applicable) HRAT results and describe the SNP's communication plan. It must include the mechanisms for communicating information to the ICT, provider network, enrollees and/or their caregiver(s) and other SNP personnel involved with overseeing the plan of care. If stratified results are used, the MOC must explain how the SNP uses the stratified results to improve the care coordination process.

MOC 2 Element C: Face-to-Face Encounter

Regulations at 42 CFR § 422.101(f)(1)(iv) require that all SNPs must provide for face-to-face encounters for the delivery of health care, care management or care coordination services. Face-to-face encounters must occur, as feasible and with the individual's consent, on at least an annual basis beginning within the first 12 months of enrollment. The face-to-face encounter must be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy, and as a result, the MOC must:

1. **Describe in detail the process, including policies, procedures, purpose and intended outcomes of the face-to-face encounter.**
2. **For instances in which the SNP is providing the encounter, include staff (employed and/or contracted) who may conduct the face-to-face encounter.**
3. **Describe how the SNP will verify through data collection that the enrollee has participated in a qualifying face-to-face encounter.**
4. **Explain what types of clinical functions, assessments and/or services may be conducted during the face-to-face encounter.**
5. **Provide a detailed description of how health concerns and/or active or potential health issues will be addressed during the face-to-face encounter.**
6. **Describe how the SNP will conduct care coordination activities through appropriate follow-up, referrals and scheduling as necessary.**

Summary of changes

- This is a new element.

Scoring

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

Data source Documented process, Model of Care

Explanation This element describes the mandatory face-to-face encounter that serves a clinical or care coordination/care management purpose. The face-to-face encounter should pertain to the individual's health care and is a way of ensuring that the goals of a SNP are met.

Factor 1: Face-to-face essentials

The description must detail the process including, but not limited to the following:

- How it obtains the enrollee's consent for virtual encounters.
- How it ensures that encounters occur within the first 12 months of enrollment and at least annually thereafter.
- P&Ps, objectives and expected outcomes for the delivery of healthcare during the encounter.

CMS recognizes that a SNP may not be able to comply with the rule's mandate of an annual face-to-face encounter and intends the ''as feasible'' standard in the regulation to address such situations. If the enrollee refuses an annual face-to-face encounter or if the SNP was unable to reach the enrollee after a reasonable number of attempts, the plan would be considered to have complied with the requirement despite the lack of a qualified encounter. However, plans should document the basis or reason that a face-to-face encounter is not feasible in order to demonstrate that, where there are no face-to-face encounters in the year, the failure is not a violation of the regulation. Note that the provision of reasonable accommodations by the SNP to enable the enrollee to participate in the encounter (e.g., interpreter services) is not considered a feasibility barrier.

Factors 2: Identifying appropriate personnel

The organization must describe who is qualified (employed and/or contracted staff) to deliver needed services to the enrollee. The organization's process must, at a minimum, include who is qualified to deliver the care (employed or contracted staff), and specify what qualifies as a face-to-face visit:

- In person
- Real time
- Visual/Interactive

Qualified staff include an enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan healthcare providers, including: 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 Support (MLTSS) plan staff or related MLTSS health care provider. These providers must be: 1) a member of the enrollee's interdisciplinary team; 2) part of the plan's case management and coordination staff; or 3) contracted plan healthcare providers.

Face-to-face encounters are restricted to those that are in-person or a visual*, real-time, interactive telehealth encounter.

*SNPs conducting the virtual face-to-face encounters must ensure that the platforms used meet health information and personally identifiable information

of Medicare enrollees under requirements at 42 CFR 422.118 and 422.504.

Factor 3: Verification of qualifying encounter

The organization must describe how the SNP will verify via data collection (e.g., claims data) that the enrollee has participated in a qualifying face-to-face encounter in circumstances that require external or contracted providers to render treatment or services on behalf of the SNP.

Factor 4*: *Types of clinical functions

The MOC must detail the types of clinical functions and assessments that may be performed during encounters. Examples of the necessary services or engagement during the required encounter include but are not limited to:

- Engaging with the enrollee to manage, treat and oversee (or coordinate) their health care (such as furnishing preventive care included in the individualized care plan (ICP)).
- Annual wellness visits and/or physicals.
- Completion of a health risk assessment (HRA), such as the one annually required for all SNPs under the current regulation at § 422.101(f)(1).
- Care plan review or other similar care coordination activities.
- Health related education whereby the enrollee receives information or instructions critical to the maintenance of their health or implementing processes for maintaining the enrollee's health, such as the administration of a medication.

Factor 5: Addressing identified health concerns

The MOC must detail the process for how health concerns identified during encounters are addressed and how enrollees or their caregivers are educated about potential issues that may develop.

Factor 6: Care coordination activities

The MOC must describe how it will conduct care coordination activities necessary to follow-up on needed care or services (e.g., handling referrals, scheduling procedures or tests).

MOC 2 Element D: Individualized Care Plan (ICP)

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

1. **Detail the essential components of the ICP.**
2. **Describe the process to develop the ICP, including applicable staff involved, how often the ICP is modified as enrollees' health care needs change.**
3. **Identify the personnel responsible for development of the ICP, including how enrollees and/or caregivers are involved.**
4. **Detail how the ICP is documented and updated, and where it is maintained.**
5. **Describe how updates and modifications to the ICP are communicated to the enrollee and other stakeholders.**

Summary of changes

- Reformatted this element to accommodate the new MOC Element 2C.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Factor 1: ICP essential components***

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

- The enrollee's self-management goals and objectives.
- The enrollee's personal healthcare preferences.
- A description of services specifically tailored to the enrollee's needs.
- Role of the enrollee's caregiver(s).
- Identification of goals (met or not met).
- If the enrollee's goals are not met, the MOC must describe the organization's process for reassessing the current ICP and determining the appropriate alternative actions as well as providing the update(s).

Factors 2: ICP development process

The MOC must, at a minimum, describe the process for developing the ICP and detail how the results of the initial assessment and annual re-assessment and are included in the ICP. The MOC must also include a description of how it determines the frequency for review and modification, as appropriate, as the enrollee's health care needs change. If a stratification model is used for determining SNP enrollees' health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each member's ICP. Additionally, the organization must describe how the enrollee or their caregiver/representative is involved in the ICP development process.

Factor 3*: *Personnel responsible

The MOC must detail the personnel responsible for developing the ICP. The description of responsible staff must include roles and functions, professional requirements and credentials necessary to perform these tasks.

Factor 4: ICP documentation and maintenance

The MOC must describe how the ICP is documented and updated with information collected from a more recent HRAT and where the documentation is maintained so it is accessible to the ICT, provider network and enrollees and/or their caregivers.

Factor 5: Updates and modifications

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

MOC 2 Element E: Interdisciplinary Care Team (ICT)

Regulations at 42 CFR § 422.101(f)(1)(iii); 42 CFR § 422.152(g)(2)(iv) require all SNPs to use an ICT that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the SNP. The organization's MOC must describe the critical components of the ICT as addressed in factors 1-4.

1. **Provide a comprehensive description of how the organization determines the composition of ICT membership, including addition of team members to address the unique needs of enrollees.**
2. **Describe the roles and responsibilities of the ICT members (including enrollees and/or caregivers) and how each contributes to the development and implementation of an effective interdisciplinary care process.**
3. **Detail how ICT members use the outcomes to evaluate, contribute and continually manage and improve the health status of SNP enrollees.**
4. **Describe how the SNP's communication plan to exchange enrollee information occurs regularly within the ICT, including evidence of ongoing information exchange.**

Summary of changes

- Reformatted this element to accommodate the new MOC Element 2C.
- Changes to this element emphasize that SNPs must have an ICT trained and credentialed to address the health needs of its target population.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Factor 1: ICT membership***

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

Factor 2: ICT facilitation of enrollees

The organization must:

- Explain how the SNP facilitates the participation of enrollees and their caregiver(s) as members of the ICT.
- Describe how the enrollee's HRAT (MOC Element 2B) and ICP (MOC Element 2D) are used to determine the composition of the ICT, including where additional team members are needed to meet the developing needs of an enrollee. If a stratification model is used for determining SNP enrollees' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.
- Explain how the ICT uses health care outcomes to evaluate processes established to manage changes or adjustments to the enrollee's health care needs on a continuous basis.

Factor 3: Use of clinical managers

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

Factor 4: Communication plan

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

- Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC.
- How the SNP maintains effective and ongoing communication among SNP personnel, the ICT, enrollees and/or their caregivers, community organizations and other stakeholders.
- The types of evidence used to verify that communications have taken place (e.g., written ICT meeting minutes, documentation in the ICP).
- How communication is conducted with enrollees who have hearing impairments, language barriers and cognitive deficiencies.

MOC 2 Element F: Care Transition Protocols

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

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

Summary of changes

- Reformatted this element to accommodate the new MOC Element 2C.
- The changes clarify that transitions of care and transfer of elements of the care plan must be conducted for all transitions, for both in-network and out-of-network providers.

Scoring

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

Data source Documented process, Model of Care

Explanation **Definitions**

- **Health care setting:** The provider from whom or setting where a member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for a member's medical care.
  - Settings include home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility and outpatient/ambulatory care/surgery centers.

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

Factor 1: Continuity of care

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

Factor 2: Care transition personnel

The organization must identify and describe the personnel (e.g., case manager) responsible for coordinating the care transition process and for ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.

Factor 3: Applicable transitions

The organization must ensure that elements of the enrollee's ICP are transferred between health care settings when an applicable transition in care occurs. The MOC must describe the steps that take place before, during and after a transition in care.

Factor 4: Enrollee personal health information

Enrollees and/or their caregivers need access to enrollees' personal health information to communicate about care with healthcare providers in other health care settings and/or health specialists outside their primary care network. The organization must describe the process for ensuring that SNP enrollees and/or their caregiver(s) have access to and can adequately utilize the enrollees' personal health information to facilitate communication between the SNP enrollee and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.

Factor 5: Self-management activities

The MOC must describe how enrollees and/or their caregivers will be educated about indicators that their condition has improved or worsened; how they will demonstrate understanding of changes in their condition and use of appropriate self-management activities. For example, they should be educated about signs

and symptoms signaling a change in their condition and how to respond to such changes. Self-management activities can include regular assessment of progress, goal setting and problem-solving support to reduce crises and improve health outcomes.

Factor 6: Notification of point of contact

The organization must describe the process it uses to inform enrollees and/or their caregivers of the personnel responsible (point of contact) for supporting them through transitions between any two care settings.

MOC 3: Provider Network

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP enrollees. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population as identified in MOC 1 and provide oversight information for all its network types. SNPs must ensure that their MOC identifies, fully describes and implements the following elements for their SNP provider networks.

MOC 3 Element A: Specialized Expertise

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

1. **Provide a complete and detailed description of the specialized expertise that corresponds to the target population identified in MOC 1.**
2. **Explain how the SNP oversees its provider network facilities and oversees that its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP enrollees.**
3. **Describe how the SNP documents, updates and maintains accurate provider information.**
4. **Describe how providers collaborate with the ICT and contribute to an enrollee's ICP to provide necessary specialized services.**

Summary of changes

- The MOC must include evidence that the SNP provides each enrollee with an ICT that includes specialized provider expertise and training.

Scoring

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

Data source Documented process, Model of Care

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

Factor 1: Specialized network

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

Factor 2: Evidence of provider expertise

The organization must include evidence of how it provides each enrollee with an ICT that includes providers with demonstrated experience and training in areas applicable to treating individuals in its target population. This includes applicable training, expertise in specialty areas and applicable licensure. The organization must describe how it determines that its providers and network facilities have and maintain active licenses and are competent to provide specialized health care services to SNP enrollees (e.g., process for verification of licensure and confirmation of applicable board certification).

Factor 3: Updating provider information

The MOC should describe how it maintains current information on providers, including updates to ensure an accurate provider network directory.

Factor 4: Collaboration with the ICT

The MOC must describe how providers in the network collaborate with members of the ICT (MOC Element 2E) to ensure that specialized services are delivered to the SNP enrollee in a timely and effective way. The MOC must describe how providers communicate enrollee's care needs to the ICT and other stakeholders, how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

MOC 3 Element B: Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CPTs)

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

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

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Factor 1: Utilization of guidelines and protocols***

Evidence-based clinical guidelines and protocols promote the use of nationally recognized and accepted practices for providing the right care at the right time. The organization must monitor how network providers utilize these guidelines, when appropriate. The organization may use electronic databases, web technology, manual medical record review or other methods to oversee use of clinical practice guidelines.

Factor 2: Challenges and exceptions to guidelines

Certain clinical practice guidelines and protocols may not always be appropriate for some patients with complex health care needs. In these cases, the organization must include their process to identify challenges to using clinical practice guidelines and nationally recognized protocols for certain enrollees with complex health care needs.

Factor 3: Decision to modify

Provide details of how the decision to modify or ignore such guidelines are made, incorporated into the patient's ICP (MOC Element 2D), communicated with the ICT (MOC Element 2E) and acted on by the enrollee's ICT or by other providers.

Factor 4: Care transition protocols

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

MOC 3 Element C: MOC Training for the Provider Network

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

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

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

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

The MOC must describe the process for how the organization provides initial and annual training for network providers and any out-of-network providers seen by enrollees on a routine basis; and must detail training documents and materials, including how training is conducted (e.g., printed instructional materials, in-person meetings, web-based training, audio/video-conferencing, availability of instructional materials via the SNP's website), how often training occurs and examples of detailed training content beyond a table of contents. For initial submissions, the description may detail the content of the training materials or provide slide examples. For renewal submissions, the description must include a sampling of actual slides or written materials used for training for providers. Plans must ensure inclusion of in-network and out-of-network providers used on a regular basis in its description.

Factor 2: Evidence of training

The MOC must describe how the organization documents and maintains records (e.g., copies of dated attendee lists, web-based training confirmation, electronic training records, physician attestation) as evidence that it makes training on the MOC available and offers it to all in-network and out-of-network providers used on a regular basis in its description.

Factor 3: Deficient or incomplete training

The MOC must describe specific actions taken by the organization if providers do not receive the required training and must explain challenges (e.g., geographically distant network, very large number of providers in network) associated with completion of the MOC trainings for network providers as well as any out-of-network providers used on a consistent basis.

Factor 4: Actions taken for deficient training

The MOC must also describe actions the organization takes to address deficient training (e.g., incentives or other best practices to encourage provider training participation and compliance). The SNP must describe what corrective action it will take to address non-compliant providers beyond notification that the training is incomplete. Stating that “appropriate action will be taken” in the absence of further details is insufficient and will not meet the requirement of this factor.

MOC 4: MOC Quality Measurement and Performance Improvement

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

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

The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified, based on performance results.

MOC 4 Element A: MOC Quality Performance Improvement Plan

The organization must develop a MOC quality performance improvement plan that focuses on overall plan enrollee's health and includes but is not limited to the details described in factors 1-4.

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

Summary of changes

- This element requires the inclusion of benchmarks, goals, time frames and data sources, preferably in a table or bullet points.
- Goals must be focused on overall plan improvements and emphasize what the plan hopes to achieve.
- The SNP must report whether the goals of the previous MOC submission were met and, if not, must also detail how it intends to address these unmet goals going forward.

Scoring

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

Data source Documented process, Model of Care

Explanation Definition

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

Factor 1: QI process

The organization's MOC must include the complete process and describe how the quality performance improvement plan specific to the MOC is designed to detect whether the overall MOC structure effectively accommodates enrollees' unique health care needs by using specified data sources, performance and outcomes measures.

Factor 2: QI data collection

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

Factor 3: QI staff and oversight

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

Factor 4: Plan integration and determination of goals met/not met

The organization must specify data used for analyses and must identify clear measures to determine if stated goals or outcomes are achieved. Measures must have specific benchmarks and time frames for achieving outcomes. The description must specify the process for assessing if goals are met as well as a remeasurement plan for goals not achieved. This factor requires bullet points, a table or other means to identify overall plan goals and other specific details for demonstrating MOC improvement.

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

The organization must identify and clearly define measurable goals and health outcomes for the MOC. The organization's MOC must include but is not limited to:

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

Summary of changes

- This element focuses on improvements to overall plan members' health.
- This element requires an analysis of the previous MOC goals, a determination of whether goals were met/fulfilled and a plan to address improvements needed when goals are not met.
- Detail goals for HRA, ICP and ICT.

Scoring

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

Data source Documented process, Model of Care

Explanation ***Factor 1: Identify goals***

A description of the specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC 1.

Detail measurable goals in a table or bullet points. They must include benchmarks, data sources, specific time frames and how goal achievement will be determined. Responses should include, but are not limited to:

- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT. The use of Medicare Stars as a goal is only appropriate if the goal is set at 5 Stars (i.e., equivalent to 100%). Anything less than 5 Stars does not meet the requirement.
- Enhanced care transitions across all health care settings and providers for all SNP enrollees.

- Ensuring appropriate utilization of services for preventive health and chronic conditions.

Factor 2: Identify health outcome measures

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

Factors 3: Track and assess goals

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

Factor 4: Determine if goals are met

For factor 4, the MOC must describe how it determines if the goals described in factor 1 are met.

- SNPs submitting an initial MOC need to provide relevant information pertaining to the MOC's goals for review and approval.
- SNPs submitting a renewal MOC must provide the determination of *'met'* or *'not met'* resulting from the previously approved MOC.

Factor 5: Steps taken if goals not met

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

- If the MOC did not fulfill the previous MOC's goals, indicate in the MOC submission how the SNP will achieve or revise the goals for the next MOC.

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

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

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

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

Explanation The MOC must describe the specific survey tool it uses to measure SNP enrollee satisfaction.

Factor 1: Description of the survey tool

The MOC must describe the types of surveys used to assess SNP member experience.

Factor 2: Rationale for survey tool selection

The organization's description must include the rationale for the selection of its chosen tool.

Factor 3: Process for assessing member feedback

Member feedback must include information about the overall SNP program or program staff (e.g., ICT or case managers), the usefulness of the information disseminated by the organization and the member's ability to adhere to recommendations. Feedback must be specific to the experience with the SNP's overall programs being evaluated and how results are integrated into the overall performance improvement plan.

Methodology. The organization must describe how it proactively solicits feedback from a broad sample of members, not only those members who contact the organization to share their feedback. Member feedback may be obtained by conducting focus groups or through member experience surveys representational of members throughout the plan. The organization must be able to describe the methodology it uses to collect patient experience surveys, including the sample size used.

Factor 4: Addressing identified issues

The organization must describe how it analyzes feedback to identify issues. The MOC should explain how the results of SNP enrollee satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.

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

The organization's MOC description must include the process for continuous monitoring and evaluation of its performance as described factors 1-4.

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

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

Explanation

Factor 1: Ongoing improvements

The organization must provide a written description of how quality will be continuously assessed and evaluated to support the ongoing improvement of the MOC.

Factor 2: Incorporate results

This process must describe how the organization will use the results to assess and evaluate its quality performance indicators and measures on a continual basis.

Factor 3: Assess ability to improve

The organization's process must include the steps it will take including how the organization will improve its ongoing performance by incorporating lessons learned through the MOC performance evaluation process.

Factor 4: Documentation and communication of lessons learned

The organization must describe how the performance improvement evaluation of the MOC (lessons learned) is documented and communicated to key stakeholders.

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

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

1. **Describe how performance results and other pertinent information is shared with multiple stakeholders.**
2. **State the scheduled frequency of communications with stakeholders.**
3. **Describe the methods for ad hoc communication with stakeholders.**
4. **Identify the individuals responsible for communicating performance updates in a timely manner.**

Summary of changes

- No changes to this element.

Scoring

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

Data source Documented process, Model of Care

Explanation

The organization's plan to disseminate information must include individuals responsible for providing communication (roles and responsibilities) as described in MOC Element 2A. The MOC must describe methods for communication (regular and ad hoc) with stakeholders and time frame for communication with stakeholders.

Factor 1: Process for communicating results of performance evaluation

The organization describes how quality performance results are routinely shared with stakeholders which may include, but are not limited to:

- SNP leadership.
- SNP management groups.
- SNP board of directors.
- SNP personnel and staff.
- SNP provider networks.
- SNP enrollees and caregivers.
- General public.
- Regulatory agencies.

Factor 2: Time frame/Schedule for routine communication

The organization must detail the frequency of routine communications.

Factor 3: Ad hoc communications process

The description must detail and specify what constitutes ad hoc and other unplanned communications, how they are disseminated (method and frequency) and the individual(s) responsible for dissemination.

Factor 4: Staff responsible for communication of performance results

The organization's description must identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A and the individual(s) who provide oversight for this task.