
CMS Manual System

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SUBJECT: Chapter 16B. Medicare Managed Care Special Needs Plans chapter.

I. SUMMARY OF CHANGES: Chapter 16b is a new chapter in the *Medicare Managed Care Manual* that provides guidance specific to Medicare Advantage (MA) special needs plans (SNPs). We issued a draft of Chapter 16b for public comment on March 3, 2011, considered those comments carefully as we finalized Chapter 16b. Chapter 16b also incorporates guidance from the Contract Year 2012 Rate Announcement and Final Call Letter, as well as the Contract Year Parts C and D final rule (76 FR 21432 - 21577) issued in April 2011.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: May 20, 2011

IMPLEMENTATION DATE: May 20, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	16B/Entire Chapter

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

*Unless otherwise specified, the effective date is the date of service.

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10—INTRODUCTION

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

10.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

This chapter reflects the Centers for Medicare & Medicaid Services' (CMS) current interpretation of statute and regulation that pertains to Medicare Advantage (MA) coordinated care plans (CCPs) for special needs individuals. This manual chapter is a subchapter of Chapter 16, which categorizes guidance that pertains to specific types of MA plans, such as private-fee-for service (PFFS) plans, into distinct subchapters. The contents of this chapter are generally limited to the statutory framework set forth in sections 1851-1859 of the *Social Security Act* (the Act), and are governed by regulations set forth in Chapter 42 of the *Code of Federal Regulations*, Part 422, (42 CFR 422.1 et seq.). This chapter additionally references enrollment, benefits, marketing, and payment guidance that pertains to special needs individuals in the *Medicare Managed Care Manual*.

To assist MA organizations in distinguishing the requirements that apply to the types of CCPs for special needs individuals, Table 1 below provides information on the applicability of sections of this chapter to chronic, dual-eligible, and institutional special needs plans (SNPs), as described in section 20 of this chapter.

Table 1: Chapter Sections Applicable to Certain SNP Types

Type of Special Needs Plan	Applicable Sections
Chronic	20.1; 30.3; 40.6; 50.2.1
Dual eligible	20.2; 30.2; 40.4.1; 40.5.1; 40.5.2; 40.5.3; 40.7; 40.8; 50.6; 60.3; 70.2; 80.4;
Institutional	20.3; 40.4.2; 50.2.2; 50.7; 70.3; 80.4.3; 90.13

10.2 Statutory and Regulatory History

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

The Medicare Modernization Act of 2003 (MMA) established an MA CCP that was specifically designed to provide targeted care to individuals with special needs. In the MMA, Congress identified "special needs individuals" as: 1) institutionalized beneficiaries; 2) dual eligibles; and/or 3) individuals with severe or disabling chronic conditions as specified by CMS. MA CCPs that are set up to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs. 42 CFR § 422.2 additionally defines special needs individuals and specialized MA plans for special needs individuals. The MMA gave the SNP program the authority to operate until December 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 subsequently extended the SNP program from December 31, 2008 to December 31, 2009, but placed a moratorium that prevented CMS from approving new SNPs or re-designating MA plans as SNPs after January 1, 2008. Accordingly, CMS did not accept SNP applications in 2008 for the 2009 contract year.

In July 2008, *The Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) lifted the *Medicare, Medicaid, and SCHIP Extension Act of 2007* moratorium on approving or re-designating new SNPs. By amending section 1859(f) of the Act, MIPPA extended the SNP program through December 31, 2010, thereby allowing CMS to accept MA applicants' proposals for new SNPs and SNP expansions until calendar year (CY) 2010. CMS accepted SNP proposals from MA applicants for creating new SNPs and expanding existing CMS approved SNPs for all three types of specialized SNPs (dual-eligible SNPs (D-SNPs), institutional SNPs (I-SNPs), and chronic condition SNPs (C-SNPs)) in accordance with additional SNP program requirements specified in MIPPA. However, CMS did not permit other non-SNP MA plans to convert to or consolidate into a SNP. CMS regulations that implement and further detail MIPPA conversion and expansion requirements for SNPs are located at 42 CFR §422.501- 422.504.

Effective immediately upon its enactment, *the Patient Protection and Affordable Care Act* (the ACA) extended the SNP program through December 31, 2013, and mandated further SNP program changes. Section 3205(e) of the ACA amends section 1859(f) of the Act to:

- Require all SNPs to comply with an approval process that will be based on CMS standards and executed by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012 (see §40.2 of this chapter);
- Permit existing D-SNPs to continue operating through 2012 without a State Medicaid contract in their current service areas (see §40.5.1 of this chapter);
- Authorize CMS to pay a frailty adjustor payment to fully integrated dual eligible SNPs (FIDE SNPs) (see §20.2.5 and §30.2 of this chapter);
- Establish new cost-sharing requirements for SNPs (see §40.5 and §80.4.2 of this chapter); and
- Require CMS to implement new quality-based payment procedures for all MA plans by 2012.

20—DESCRIPTION OF SNP TYPES

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.2; 42 CFR §422.52

SNPs may be any type of MA CCP, including either a local or regional preferred provider organization (PPO) plan, which are MA CCP types described in Chapter 1, §30.2, of the *Medicare Managed Care Manual*. This section describes the 3 types of SNPs (i.e., chronic, dual, and institutional) in further detail.

20.1 Chronic Condition SNPs (C-SNPs)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

20.1.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions defined in 42 CFR §422.2. Approximately two-thirds of Medicare beneficiaries have multiple chronic conditions requiring coordination of care among primary providers, medical and mental health specialists, inpatient and outpatient facilities, and extensive ancillary services related to diagnostic testing and therapeutic management. C-SNPs are designed to narrowly target enrollment to Medicare beneficiaries who have severe or disabling chronic conditions.

20.1.2 List of Chronic Conditions

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Section 1859(b)(6)(B)(iii) of the Act and 42 CFR §422.2 define special needs individuals with severe or disabling chronic conditions as special needs individuals “who have one or more co-morbid and medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care.” As required under section 1859(b)(6)(B)(iii) of the Act, CMS solicited public comments on chronic conditions meeting the clarified definition and convened the SNP Chronic Condition Panel in the fall of 2008. Panelists included six clinical experts on chronic condition management from three Federal agencies – the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and CMS. After discussing public comment on a proposed list of SNP-specific chronic conditions, the panelists recommended, and CMS subsequently approved, the fifteen SNP-specific chronic conditions listed in the November 12, 2008, *Special Needs Plan Chronic Condition Panel Final Report*, available at <http://www.cms.gov/SpecialNeedsPlans>.

The fifteen conditions currently approved for C-SNPs are listed below:

- (1) Chronic alcohol and other drug dependence;
- (2) Autoimmune disorders limited to:
 - Polyarteritis nodosa;
 - Polymyalgia rheumatica;
 - Polymyositis;
 - Rheumatoid arthritis;
 - Systemic lupus erythematosus.
- (3) Cancer excluding pre-cancer conditions or in-situ status;
- (4) Cardiovascular disorders limited to:
 - Cardiac arrhythmias;
 - Coronary artery disease;
 - Peripheral vascular disease;
 - Chronic venous thromboembolic disorder.

- (5) Chronic heart failure;
- (6) Dementia;
- (7) Diabetes mellitus;
- (8) End-stage liver disease;
- (9) End-stage renal disease requiring dialysis;
- (10) Severe hematologic disorders:
 - Aplastic anemia;
 - Hemophilia;
 - Immune thrombocytopenic purpura;
 - Myelodysplastic syndrome;
 - Sickle-cell disease (excluding sickle-cell trait); and
 - Chronic venous thromboembolic disorder.
- (11) HIV/AIDS;
- (12) Chronic lung disorders Asthma:
 - Chronic bronchitis;
 - Emphysema;
 - Pulmonary fibrosis; and
 - Pulmonary hypertension.
- (13) Chronic and disabling mental health conditions:
 - Bipolar disorders;
 - Major depressive disorders;
 - Paranoid disorder;
 - Schizophrenia; and
 - Schizoaffective disorder.
- (14) Neurologic disorders:
 - Amyotrophic lateral sclerosis (ALS);
 - Epilepsy;
 - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia);
 - Huntington's disease;
 - Multiple sclerosis;
 - Parkinson's disease;
 - Polyneuropathy;
 - Spinal stenosis; and
 - Stroke-related neurologic deficit.
- (15) Stroke.

The list of SNP-specific chronic conditions is not intended for purposes other than clarifying eligibility for the C-SNP CCP benefit package. CMS will periodically re-evaluate the fifteen chronic conditions as it gathers evidence on the effectiveness of care coordination through the SNP product, and as health care research demonstrates advancements in chronic condition management.

20.2 Dual Eligible SNPs (D-SNPs)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

20.2.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §400.202; 42 CFR §400.203; 42 CFR §423.772

D-SNPs enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). These Medicaid eligibility categories encompass all categories of Medicaid eligibility including – Qualified Medicare Beneficiary without other Medicaid (QMB only); QMB+; Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only); SLMB+; Qualifying Individual (QI); other full benefit dual eligible (FBDE); and Qualified Disabled and Working Individual (QDWI).

Definitions of these categories are listed below

(Note: The “+” refers to the full State Medicaid benefit):

- Qualified Medicare Beneficiary without other Medicaid (QMB only): An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits (QMB+): An individual entitled to Medicare Part A, with income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level^{1 2}. Medicaid does not pay towards the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only): An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less

¹ The “medically needy” program allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

² When “spending down”, an individual(s) reaches Medicaid eligibility by incurring medical and/or remedial care expenses to offset his/her excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan.

than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

- **Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+)**: An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. The individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Qualifying Individual (QI)**: An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Qualified Disabled and Working Individual (QDWI)**: An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Other Full Benefit Dual Eligible (FBDE)**: An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Table 2 below summarizes Medicaid coverage of Medicare benefits by category of dual eligibility. Although Medicaid does not pay Part D premiums or Part D cost-sharing for dual eligible individuals, QMBs, SLMBs, and QIs are automatically enrolled in Medicare's low income subsidy (LIS) program, which provides assistance with Part D prescription drug costs. More information about the LIS program is available at <http://www.cms.gov/limitedincomeandresources/> and in Chapter 13 of the *Medicare Prescription Drug Benefit Manual*.

Table 2: Medicaid Benefits by Medicaid Eligibility Category

Dual Eligible Category	Full Medicaid	Medicaid coverage of Medicare Premiums and Cost-Sharing				Medicaid coverage of Medicare Part C Premiums and Cost-Sharing		
		Part A Premium	Part B Premium	Part D Premium ³	OOP Cost-Sharing	Premium		OOP Cost-Sharing
						Part A, Part B & Mandatory Supplemental	Optional Supplemental	Required
QMB	No	Yes	Yes	No	Yes	Optional	Not Permitted	Required
QMB+	Yes	Yes	Yes	No	Yes	Optional	Optional	Required
SLMB	No	No	Yes	No	No	Not Permitted	Not Permitted	Not Permitted
SLMB +	Yes	No	Yes	No	No	Not Permitted	Optional	Conditional
QI	No	No	Yes	No	No	Not Permitted	Not Permitted	Not Permitted
QDWI	No	Yes	No	No	No	Not Permitted	Not Permitted	Not Permitted
FBDE	Yes	No	No	No	No	Not Permitted	Optional	Conditional

CMS divides D-SNPs into the following five categories, according to the types of beneficiaries that the SNP enrolls. The five CMS-approved enrollment categories for D-SNPs are:

- All-Dual D-SNPs;
- Full-Benefit D-SNPs;
- Medicare Zero-Cost-sharing D-SNPs;
- FIDE SNPs; and
- Dual eligible subset D-SNPs.

We describe each of these D-SNP types in detail in the following subsections. Table 3 summarizes the Medicaid eligibility category that each of these D-SNP types may enroll. Note that a dual eligible subset D-SNP may choose to enroll any category or combination of Medicaid eligibility categories, as long as CMS approves the subset and the D-SNP’s enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program in the State in which the D-SNP operates.

Table 3: Medicaid Eligibility Categories Permitted to Enroll in D-SNP Types

³ QMBs, SLMBs, and QIs are automatically enrolled in the low-income subsidy program and are, therefore, not subject to the Medicare Part D premium.

D-SNP Type	Category of Medicaid Eligibility						
	QMB	QMB+	SLMB	SLMB+	QI	QDWI	FBDE
All-Dual	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Full-Benefit	No	Yes	No	Yes	No	No	Yes
Medicare Zero Cost-Sharing	Yes	Yes	No	No	No	No	No
FIDE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dual Eligible Subset	Yes	Yes	Yes	Yes	Yes	Yes	Yes

20.2.2 All-Dual D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §400.202; 42 CFR §400.203

An all-dual D-SNP enrolls beneficiaries who are MA eligible and who are entitled to medical assistance under a State/Territorial plan under Title XIX of the Act. An all-dual D-SNP must enroll all categories of dual eligible individuals, including those with comprehensive Medicaid benefits as well as those with more limited cost-sharing such as QMBs, SLMBs, and QIs.

20.2.3 Full-Benefit D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §400.202; 42 CFR §400.203; 42 CFR §423.34

A full-benefit D-SNP enrolls individuals who are eligible for:

- (1) Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act; or
- (2) Medical assistance under section 1902(a)(10)(C) of the Act (Medically Needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

Sections 1902(a), 1902(f), 1902(p), 1905, and 1935(c)(6) of the Act describe categories of individuals who are entitled to full Medicaid benefits. This includes QMB+ individuals, SLMB+ individuals, and other FBDEs. The full-benefit is usually referred to by the “+”.

20.2.4 Medicare Zero-cost-sharing D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §400.202; 42 CFR §400.203

This type of D-SNP limits enrollment to QMBs only and QMBs with comprehensive Medicaid benefits (QMB+)—the two categories of dual eligible beneficiaries who are not financially

responsible for cost-sharing for Medicare Parts A or B. Because QMB-only individuals are not entitled to full Medicaid benefits, there may be Medicaid cost-sharing required.

20.2.5 Fully Integrated Dual Eligible (FIDE) SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

FIDE SNPs are described in section 1853(a)(1)(B)(iv) of the Act and at 42 CFR §422.2. FIDE SNPs are CMS-approved SNPs that:

- (1) Enroll special needs individuals entitled to medical assistance under a Medicaid State plan, as defined in section 1859(b)(6)(B)(ii) of the Act and 42 CFR §422.2;
- (2) Provide dually eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO);
- (3) Have a contract with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;
- (4) Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
- (5) Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

20.2.6 Dual Eligible Subset D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations that offer D-SNPs may exclude specific groups of dual eligibles based on the MA organization's coordination efforts with State Medicaid agencies. CMS reviews and approves requests for coverage of dual eligible subsets on a case-by-case basis. To the extent a State Medicaid agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements, those same groups may also be excluded from enrollment in the SNP, provided that the enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program. Enrollment coordination with State Medicaid agencies is described in detail in §50.6.2 of this chapter.

20.3 Institutional SNPs (I-SNPs)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

20.3.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.2

I-SNPs are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for

the mentally retarded (ICF/MR), or an inpatient psychiatric facility. A complete list of acceptable types of institutions can be found in Chapter 2 of the Medicare Managed Care Manual.

When an I-SNP opts to enroll individuals prior to having at least 90-days of institutional level care, a CMS-approved needs-assessment must show that the individual's condition makes it likely that either the length-of-stay or the need for an institutional level-of-care will be at least 90 days.

I-SNPs may also restrict enrollment to individuals that reside in a contracted Assisted Living Facility (ALF) since this may be necessary to ensure uniform delivery of specialized care. In this case, enrollees must agree to reside in ALF, and the SNP must demonstrate the need for the enrollment limitation, including how community resources will be organized.

20.3.2 Institutional Equivalent SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.2

A SNP that enrolls MA eligible individuals living in the community, but requiring an institutional level of care, must meet both of the following eligibility requirements:

- (1) Determination of institutional level of care (LOC) must be based on the use of a State assessment tool. The assessment tool used for persons living in the community must be the same LOC tool used for individuals residing in an institution. In States and territories without a specific tool, SNPs must use the same LOC determination methodology used in the respective State or territory in which the SNP is authorized to enroll eligible beneficiaries.
- (2) The MA organization must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective MA organization) with the requisite professional knowledge to accurately identify institutional LOC. The entity cannot be owned or controlled by the MA organization.

30— GENERAL REQUIREMENTS AND SNP PAYMENT PROCEDURES

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

30.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

SNPs are expected to follow existing MA program rules, including MA regulations at 42 CFR Part 422, as modified by guidance with regard to Medicare-covered services and the Prescription Drug program (PDP) rules. SNPs should assume that, if no modification is contained in these guidelines, existing MA and PDP rules apply. Additional requirements for SNP plans can be found in the *Medicare Managed Care Manual* and the *Prescription Drug Benefit Manual*.

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including:

- State licensure as a risk-bearing entity;
- MA reporting requirements that are applicable depending on plan size (e.g., Health Effectiveness Data and Information Set (HEDIS)®, CAHPS, HOS), except for I-SNPs, which use Minimum Data Set (MDS)-like reporting measures; and
- Part D prescription drug benefit requirements.

Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. SNPs must prepare and submit a bid like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and risk adjustment payment methodology. Guidance on payment to MA organizations is available in Chapter 8 of the *Medicare Managed Care Manual*. We post current MA payment rates online in the “Ratebooks and supporting Data” section at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>.

30.2 Application of Frailty Adjustment for Certain SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Section 1853(a)(1)(B) of the Act gives the Secretary the authority to apply a frailty payment under Program of All-Inclusive Care for the Elderly (PACE) payment rules for certain individuals under FIDE SNPs described in section 1853(a)(1)(B)(iv) of the Act. CMS will announce its methodology for determining whether a FIDE SNP “has a similar average level of frailty ... as the PACE program” in the *CY 2012 Rate Announcement*. We will also notify FIDE SNPs of their frailty score and how they compare to the PACE average. In accordance with the statutory requirement, we also intend to add a definition of FIDE SNPs at 42 CFR §422.2.

30.3 Hierarchical Condition Categories (HCC) Risk Adjustment for C-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

CMS uses a risk score that reflects the known underlying risk profile and chronic health status of similar individuals for purposes of hierarchical condition categories (HCC) risk adjustment described under section 1853(a)(1)(C)(i) of the Act. The Act requires CMS to use such risk score in place of the default risk score that is otherwise used to determine payment for new enrollees in MA plans. Refer to our annual Rate Announcements for a description of any evaluation conducted during the preceding year and any revisions made under section 1853(b) of the Act.

40—APPLICATION AND APPROVAL REQUIREMENTS

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.501-422.504; §423.502-504

40.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

The SNP proposal is part of the MA application process. Applicants that do not have a CMS contract and are requesting to offer a SNP must complete the MA application, including the SNP proposal. The timeline for submitting the SNP proposal is the same as the MA application timeline. Both the MA application and the SNP proposal for the current contract year are available at <http://www.cms.hhs.gov/MedicareAdvantageApps/>.

The SNP proposal contains a list of questions and attestations requiring a “yes” or “no” response and requires the applicant to upload documentation in support of responses to the questions and attestations. This is similar to the format of the MA application. All SNP proposals must be submitted electronically through the Health Plan Management System (HPMS) to CMS by the MA application due date. CMS will not accept a SNP proposal submitted on paper.

Every applicant that proposes to offer a SNP must obtain additional CMS approval as a Medicare Advantage Prescription Drug (MA-PD) plan. A CMS MA-PD contract that is offering a new SNP, or that is expanding the service area of a CMS-approved SNP, needs to complete only the SNP proposal portion of the MA application if CMS has already approved the service area for the MA contract. Otherwise, if the MA organization is planning to expand its contract service area, it must complete both a SNP proposal and an MA Service Area Expansion (SAE) application for the approval of the MA service area. We provide further guidance on SAE procedures in §40.4 of this chapter.

40.2 National Committee for Quality Assurance (NCQA) Approval

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

As provided under section 1859(f)(7) of the Act, SNPs must be approved by the NCQA as of January 1, 2012. The statute gives the Secretary authority to establish standards for the approval process. The SNP approval process will provide a foundation for selecting MA organizations that comprehend the unique requirements of the SNP program and that are capable of implementing these requirements. The NCQA SNP approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC in the SNP proposal.

The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factor. These components of the SNP approval methodology are defined below:

- (1) Standard: The standard is defined as each SNP that is approved to operate in contract 2012 must have a MOC that has achieved a score of 70 percent or greater based on the scoring methodology as described in this section;
- (2) Element: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
 - Description of the SNP-specific Target Population;
 - Measurable Goals;
 - Staff Structure and Care Management Goals;
 - Interdisciplinary Care Team;
 - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
 - Model of Care Training for Personnel and Provider Network;
 - Health Risk Assessment;
 - Individualized Care Plan;
 - Integrated Communication Network;
 - Care Management for the Most Vulnerable Subpopulations; and

- Performance and Health Outcomes Measurement.

Each element is comprised of multiple factors that NCQA will evaluate and score on a scale of 0 to 4, where 4 is the highest score for a factor. Plans are required to provide a response that addresses every factor within each of the eleven (11) elements. Responses should be detailed and provide specific multiple examples and/or case studies. A passing score is seventy (70) percent. Refer to Appendix 1 at the end of this chapter for a summary description of MOC evaluation criteria for SNP approval in CY 2012.

(3) Factor: Each element is comprised of multiple factors that are outlined in the SNP proposal on the MOC upload matrix in HPMS. The factors for each element are scored using a system from 0 to 4, where 4 is the highest score for a factor. The scores for each factor within a specific element are totaled to provide the overall score for that element. There is a total of 160 possible points. SNPs must achieve a minimum score of 70 percent to meet the NCQA approval standard. Refer to Appendix 1 of this chapter for a summary of the SNP approval process scoring criteria for CY 2012.

For the purposes of NCQA approval, ALL SNPs were required to complete the ENTIRE SNP proposal for the 2012 MA application cycle and every additional time they need to be re-approved by NCQA. SNPs will be given two opportunities to cure deficiencies in the SNP proposal that they submit for NCQA review.

We are implementing a multi-year approval process that will allow plans to be granted a longer approval period based on higher MOC scores.

The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher on NCQA's evaluation of their MOC are granted SNP approval for three (3) years.
- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range on NCQA's evaluation of their MOC will be granted SNP approval for two (2) years.
- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range on NCQA's evaluation of their MOC will be granted SNP approval for one (1) year.

To minimize the burden of implementing the SNP application process, we incorporated the SNP approval process into the general MA application process. By including the SNP approval process in the application cycle, SNPs will have the ability to cure their MOCs. SNPs will have two opportunities to cure their MOCs in parallel with the overall MA application process.

During the first cure opportunity, deficient SNPs (all those with MOCs scoring below 85 percent) are provided an opportunity to improve their scores. All such SNPs receive feedback on the elements and factors that need additional work via an email. Plans with questions about their deficiency notices or scores should send an email to SNP_mail@cms.hhs.gov.

The second and final opportunity to cure the MOC occurs when the notices of intent to deny are sent to plans. Once again, any SNP that has not achieved a score of 85 percent or more will receive notification and will have a chance to improve its score by submitting its revised MOC by the deadline specified for that contract year.

After this final round of curing, SNPs with MOCs below the minimum score of 70 will be scored as unmet and will not be approved. All other SNPs will receive a conditional approval per the application procedures until the remaining CMS requirements have been completed.

40.3 New and Existing SNP Proposals

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations applying to contract with CMS and existing MA organizations applying for an SAE, must submit a SNP proposal for the current contract year if they wish to offer a SNP targeting special needs individuals. A SNP must also submit its SNP proposal for each additional time that it requires re-approval by the NCQA. As noted above in Section 40.2 of this chapter, all SNPs were required to complete the entire SNP proposal for CY 2012; however, those SNPs gaining a multi-year approval by the NCQA will not be required to submit the entire SNP proposal for the contract year (or years) following their multi-year approval.

For years in which a SNP is operating under NCQA approval continuing from a prior year, the SNP must submit a new SNP proposal only if it falls in one of the following categories:

- Any new SNP (Chronic, Dual Eligible, or Institutional). New D-SNPs must be classified as either “Medicaid subset \$0 cost share” or “Medicaid subset Non-\$0 cost share”;
- An existing D-SNP that anticipates contracting with a State Medicaid Agency to provide services for a subset of the dual eligible population it currently serves; or
- Any existing C-SNP or I-SNP seeking to expand its service area (Note: SNPs seeking to expand their service area must complete both a SNP proposal and a MA SAE application. Refer to §40.4 of this chapter for additional guidance on the MA SAE application).

A SNP operating under NCQA approval from a prior year is not required to submit a new proposal if it falls in any one of the following categories:

- An existing C-SNP or I-SNP that is not expanding its service area;
- An existing D-SNP that continue to serve its current CMS-approved population under a contract with the State Medicaid Agency with significant change, and whose contract includes all CMS-required contract elements; or
- A non-renewing SNP plan.

CMS will not allow applicants to offer any new disproportionate share SNP⁴.

40.4 Service Area Expansion (SAE)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

In general, an MA organization may continue to offer the same local MA plan benefit package (PBP) and add one or more new service areas (i.e., counties) to the plan's service area in the following CY. If an MA organization is interested in expanding its service area and adding a SNP in the expanded service area, it must complete the MA SAE application and an SAE application for Part D. If the MA organization does not have Part D coverage in the service area in which it is seeking to offer a SNP, it must file a Part D application in addition to the MA SAE application. The Part D application for MA-PD plans is posted at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra>.

The service area of the proposed SNP cannot exceed the existing or pending service area for the MA contract. Refer to §40.4.1 of this chapter for additional guidance regarding SAE application requirements for D-SNPs.

40.4.1 Initial Application and SAE Requirements for D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.501-504

All applicants that request to operate in a new service area or to expand a service area of an existing D-SNP must have a contract with State Medicaid Agency(ies) in the State(s) in which the D-SNP plan operates. Applicants should note that the service area(s) must match those in their State Medicaid contract. MA organizations seeking a SAE for an CMS-approved D-SNP must provide CMS with a copy of the State Medicaid contract and related information in their SNP proposal through the plan creation module in HPMS. Refer to annual guidance for the SNP proposal submission deadline for the current CY.

40.4.2 Service Area Requirements for I-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

CMS may allow an I-SNP that operates either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents. As with all MA plans, CMS will monitor the plan's marketing/enrollment practices and long-term care facility contracts to confirm that there is no discriminatory impact in terms of excluding either "sicker," lower-income or minority beneficiaries in its service area.

40.5 Contracting Requirements

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

⁴ Prior to January 1, 2010, SNPs were permitted to enroll persons who were not special needs individuals, as long as the SNP enrolled a greater proportion of the targeted special needs population than occurred nationally in general Medicare population. Effective January 1, 2010, SNPs may enroll only individuals who meet the specific eligibility criteria of the SNP.

40.5.1 State Contract Requirements for D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.107

As provided under section §164(c)(2) of MIPPA, and as amended by section 3205(d) of the ACA, D-SNPs that continue to operate in their existing service areas are not required to have a contract with the State Medicaid Agencies in the States in which the D-SNP plan operates until January 1, 2013. Note that the requirement for a State contract and the requirement for NCQA approval discussed in §40.2 of this chapter are separate requirements, and that D-SNPs must meet both requirements in order to operate. Note that the requirement for a contract with the State Medicaid Agency and the requirement for NCQA approval discussed in §40.2 of this chapter are separate requirements and D-SNPs must meet both requirements in order to operate.

The SNP proposal application, which is available through HPMS, provides further information on how and when D-SNPs must submit their State Medicaid agency contracts and related information to CMS. Plans should refer to the State Medicaid Agency Contract Upload Document and other documents included in the application packet.

The State Medicaid Agency contract must document each entity's role and responsibility with regard to dual-eligible individuals, and must cover the minimum regulatory requirements below:

(1) The MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits.

Meeting this contracting element requires that the process by which the State Medicaid agency provides and arranges for Medicaid benefits must be clearly outlined in the contract by and between the State Medicaid agency and the entity. All contracts must specify how the Medicare and Medicaid benefits are integrated and/or coordinated.

(2) The category(ies) of eligibility for dual eligible beneficiaries to be enrolled under the SNP, including the targeting of specific subsets.

Meeting this contracting element requires that the contract clearly identify the dual population eligible to enroll in the D-SNP. Any enrollment limitations for Medicare beneficiaries under this SNP must parallel any enrollment limitations under the Medicaid program. For example, if a State Medicaid agency contracts with a plan for a Medicaid wrap-a-round package for certain dual-eligibles (e.g., those aged 65 and above), an MA organization may establish a SNP that limits enrollment to that same subset of dual-eligibles. For those organizations whose contract with the State is for Medicaid managed care, enrollment in the D-SNP must be limited to Medicaid dual-eligibles permitted to enroll in that organization's Medicaid managed care contract.

The MA contract with the State Medicaid agency may cover certain category(ies) of dual-eligible individuals and does not need to cover all categories of dual-eligible individuals or

target a subset of dual-eligible individuals, such as a frail, elderly population. Any such subset must be specified in the State Medicaid agency contract.

(3) The Medicaid benefits covered under the SNP.

This contractual element requires information be included on benefit design and administration as well as assigning plan responsibility to provide or arrange for this benefit. Meeting this contracting element requires that the information provided in the contract include the benefit design, how it will be administered and that it is the plan's responsibility to provide or arrange for this benefit. The contract should specify the benefits offered in the State plan as well as benefits that go beyond Original Medicare parameters that the SNP will offer. If the list of services is an attachment to the contract, the SNP must reference the list in the body of the contract.

(4) The cost-sharing protections covered under the SNP.

MA organizations offering D-SNPs must enforce limits on the OOP costs for dual-eligibles. Meeting this contracting element requires that D-SNPs not impose cost-sharing requirements on specified dual-eligible individuals (i.e., FIDE individuals, QMBs, or any other population designated by the State) that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP.

(5) The identification and sharing of information on Medicaid provider participation.

Meeting this contracting element requires that the information provided include a process for the State to identify and share information on providers contracted with the State Medicaid agency for inclusion in the SNP provider directory. Although CMS does not require all providers to accept both Medicare and Medicaid, the D-SNP's Medicare and Medicaid networks should meet the needs of the dual-eligible population served.

(6) The verification process of an enrollee's eligibility for both Medicare and Medicaid.

Meeting this contracting element requires the State Medicaid agency to provide MA organizations with access to real time information verifying eligibility of enrolled dual-eligible members. The agreed upon eligibility verification process must be described in detail.

(7) The service area covered under the SNP.

Meeting this contracting element requires that the contract clearly identify the covered service area(s) in which the State has agreed the MA organization may market and enroll. The SNP service area(s) must be consistent with the State Medicaid Agency contract approved service area(s).

(8) The contracting period.

Meeting this contracting element requires a period of performance between the State Medicaid agency and the D-SNP of at least January 1 through December 31 of the year following the due date of the contract. Contracts may also be drafted as multi-year or evergreen contracts (i.e., continuously valid until a change is made in the contract) so that the entire calendar year is covered. In this case, the plan may indicate the evergreen clause within the contract and provide an explanation of when the State issues an update.

40.5.2 Relationship to State Medicaid Agencies

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Pursuant to section 1859 of the Act, State Medicaid agencies are not required to enter into contracts with MA organizations with respect to a SNP. The submission of the State Medicaid agency contract to CMS does not relieve the MA applicant of the pre-existing MA application requirement to secure a license and certification from the State Department of Insurance to offer a MA product in the State.

Pursuant to the regulations at 42 CFR Part 438, Subparts D and E, the State must include a written strategy for assessing and improving the quality of managed care services as part of its contract with a D-SNP. Refer to the regulations at 42 CFR Part 438, Subparts D and E, for further information on State requirements for contracted MCOs serving dually eligible individuals.

40.5.3 Limiting Enrollment to Dual Eligible Subsets under a State Contract

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

A D-SNP may target a population that is narrower than the populations of CMS's defined D-SNP categories (i.e., Full Dual D-SNPs and Zero Cost-share D-SNPs) in order to coordinate services between the Medicare and Medicaid programs.

Any enrollment limitations for Medicare beneficiaries under this type of limited enrollment D-SNP must parallel any enrollment limitations under the Medicaid program, including the Medicaid program's structure and care delivery patterns. For example, if a State Medicaid Agency contracts with a plan for a Medicaid wraparound package for certain dual eligibles (e.g., individuals aged 65 and above), an MA organization may establish a SNP that limits enrollment to that same subset of dual eligibles.

Further, the SNP must provide documentation to CMS regarding their contract and/or agreement with the State Medicaid agency. If applicable, this would include verification that the subset of enrolled dual-eligible beneficiaries will have zero-cost-sharing for Medicare Part A, Part B, or Part D.

If an MA organization has been approved to offer a D-SNP for a subset population that is identified in the State contract, then, in order for the MA organization to continue offering the subsetted plan, it must have a signed State Medicaid agency contract that is effective for the following year. The contract must be in place before the contract year begins, and must either overlap the entire CMS MA contract year, or contain an evergreen clause in the current contract that extends the contract.

40.5.4 Long-term Care (LTC) Facility Contract Requirements for I-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

I-SNPs that serve residents of long-term care (LTC) facilities must own, operate, or have a contractual arrangement with the LTC facility that includes delivery of its SNP MOC. Contract requirements are described below:

(1) Facilities in a chain organization must be contracted to deliver the SNP MOC.

If the MA organization's contract is with a chain organization, the chain organization and the applicant agree that the facilities listed will deliver the SNP MOC.

(2) Facilities must provide access to SNP clinical staff.

The facility must agree to provide the SNP enrollees residing in the MA organization's contracted facilities with appropriate access to the applicant's SNP clinical staff including physicians, nurses, nurse practitioners and care coordinators, in accordance with the SNP protocols for operation.

(3) Facilities must provide protocols for the SNP MOC.

The MA organization must agree to provide protocols to the facility for serving the beneficiaries enrolled in the SNP in accordance with the SNP MOC. These protocols must be referenced in the SNP's contract with the facility.

(4) Delineation of services provided by the SNP staff and the LTC facility staff must be specified.

A delineation of the specific services provided by the MA organization's SNP staff and the facility staff to the SNP enrollees in accordance with the protocols and payment for the services provided by the facility.

(5) Training plan for LTC facility staff to understand the MOC must be included.

A training plan to ensure that LTC facility staff understand their responsibilities in accordance with the SNP MOC, protocols and contract. If the training plan is a separate document it should be referenced in the contract.

(6) Procedures must be developed and in place for facilities to maintain a list of credentialed SNP clinical staff.

Procedures should ensure cooperation between the SNP and the facility in maintaining a list of credentialed SNP clinical staff in accordance with the facility's responsibilities under Medicare conditions of participation.

(7) Contract year for SNP must be specified.

The contract must include the full CMS contract cycle, which begins on January 1 and ends on December 31. The MA organization may also contract with additional LTC facilities throughout the CMS contract cycle.

(8) Grounds for early termination and transition plan for beneficiaries enrolled in SNP must be specified.

Termination clause must clearly state any grounds for early termination of the contract. The contract must include a clear plan for transitioning the beneficiary should the MA organization's contract with the LTC facility terminate.

40.6 C-SNP Plan Benefit Packages (PBPs)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

40.6.1 Targeted Plan Benefit Packages (PBPs)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

A C-SNP should have specific attributes beyond that of a standard MA CCP, in order to receive the special designation and marketing and enrollment accommodations. C-SNPs are expected to have specially designed PBPs that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all CCPs.

These specially designed PBPs should include, but not be limited to:

- (1) Supplemental health benefits specific to the designated chronic condition (e.g., diabetic testing supplies);
- (2) Specialized provider networks (e.g., physicians, home health, hospitals, etc.) specific to the designated chronic conditions); and
- (3) Appropriate enrollee cost-sharing structured around the designated chronic conditions and co-morbidities for all Medicare-covered and supplemental benefits.

40.6.2 Grouping Chronic Conditions in PBPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

CMS has revised the automated SNP proposal section of the MA application to expand options at the point of application. When completing the SNP proposal application, MA organizations can choose to offer a C-SNP that targets any one of the groups below:

- (1) A single CMS-approved chronic condition;
- (2) A CMS-approved group of multiple chronic conditions; or
- (3) An MA organization-customized grouping of multiple chronic conditions selected from the 15 CMS-approved SNP-specific chronic conditions.

A C-SNP cannot be structured around multiple common co-morbid conditions that are not clinically linked in their treatment because this arrangement, by its very nature, leads to a general market product rather than a product tailored for a particular population. However, we recognize that certain chronic conditions are commonly co-morbid and clinically linked. We also know that some MA organizations presently operating a C-SNP serving multiple chronic conditions, in the interest of maintaining continuity for beneficiaries and their own operations, wish to maintain these multi-condition C-SNPs.

Therefore, CMS allows C-SNPs to target a group of multiple chronic conditions under two scenarios:

- (1) A CMS-designated grouping of commonly co-morbid and clinically linked conditions; or
- (2) An MA organization -customized multiple-conditions option.

We describe both of these types of multiple-condition grouping scenarios in §40.6.2.1 and §40.6.2.2 of this chapter.

40.6.2.1 Commonly Co-morbid and Clinically-Linked Conditions

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

C-SNPs will be permitted to target a group of multiple chronic conditions in cases where the conditions are commonly co-morbid and clinically linked, based on the determination criteria below:

- The conditions in question are, based upon CMS’s data analysis, determined to be commonly co-morbid; and
- The conditions in question are, based upon recognized national guidelines such as those listed in the Guidelines Clearinghouse maintained by AHRQ, clinically linked in their treatment.

Based on an analysis of commonly co-existing chronic conditions in the current Medicare population, CMS will accept proposals with the following multi-condition groupings:

Group 1: Diabetes mellitus and chronic heart failure;

Group 2: Chronic heart failure and cardiovascular disorders;

Group 3: Diabetes mellitus and cardiovascular disorders;

Group 4: Diabetes mellitus, chronic heart failure, and cardiovascular disorders; and

Group 5: Stroke and cardiovascular disorders.

For MA organizations that are approved to offer a C-SNP targeting one of the above-listed groups, beneficiaries need only to have one of the qualifying conditions for enrollment. CMS will review the MOC, provider network, and benefits package specified on the application for the multi-condition SNP to determine adequacy in terms of creating a specialized product for the chronic conditions it serves.

40.6.2.2 Beneficiaries with All Qualifying Conditions

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations may develop their own multi-condition SNP combinations for enrollees with all of the qualifying chronic conditions in the combination. MA organizations that pursue this customized option must verify that enrollees have all of the qualifying conditions in the combination. MA organizations interested in pursuing this option for multi-condition C-SNPs are

limited to groupings of the same 15 conditions selected by the panel of clinical advisors that other C-SNPs must select. As with SNPs pursuing the Commonly Co-Morbid and Clinically-Linked Option described in section §40.6.2.1, CMS will carefully assess the prospective multi-condition SNP proposal to determine the adequacy of its care management system for each condition in the combination.

40.7 Procedures to Convert to another D-SNP Type

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

CMS will allow existing All Dual, Full Dual, Medicaid Subset, Zero-Cost Share and Non-Zero Cost Share D-SNPs to convert to another D-SNP type. Plans must request the conversion during the application period as part of a new SNP proposal. Submission of a new MA application is not required.

For these purposes, the following documents are required as part of the SNP proposal:

- (1) Completed State Medicaid Agency contract for implementation in the following contract year; and
- (2) Contracting Review Matrix with the “Page Number(s)” and “Section Number” columns completed.

The contracting review matrix and the guidance attached to the matrix must include instructions to ensure that the target population for the SNP matches that in the State Medicaid contract.

An MAO currently offering a D-SNP PBP that has requested conversion to a different D-SNP type under the same MAO contract may transition current eligible enrollees into its newly created D-SNP PBP of the new SNP type. If the new D-SNP type has less restrictive eligibility requirements than the original D-SNP, the MAO may retain current eligible enrollees in the newly designated D-SNP PBP because all current enrollees will remain eligible for the new D-SNP with the new designation.

40.8 Technical Assistance for States

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

CMS provides resources to assist States with coordination of Federal and State-based SNP policy in the following areas:

- Researching issues raised by States;
- Addressing State inquiries regarding State and Federal policy coordination;
- Soliciting and cataloguing relevant State materials; and
- Creating communication forums for States to exchange ideas.

CMS has established a State Resource Center to provide States with helpful information as they engage in contract negotiations with MA organizations seeking to offer new or expanded D-SNPs pursuant to the State contract requirement established at 42 CFR §422.107. The State Resource Center facilitates integration and coordination of benefits, policies, and day-to-day business processes between State Medicaid Agencies and D-SNPs. It supports State Medicaid agencies' efforts to improve Medicare-Medicaid benefit integration for their dual eligible

populations, and provides a forum for States to make inquiries and share knowledge about the coordination of State and Federal policies pertaining to SNPs.

Plans may e-mail questions and information related to this topic to:

State_Resource_Center@cms.hhs.gov. The State Resource Center may be accessed on the Internet at http://www.cms.gov/SpecialNeedsPlans/05_StateResourceCenter.asp#TopOfPage.

50—SNP ENROLLMENT REQUIREMENTS

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.50; 42 CFR §422.52; 42 CFR §422.60; 42 CFR §422.62; 42 CFR §422.2264

50.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

As specified in section 1859(f) of the Act, SNPs may only enroll individuals who meet the plan's specific eligibility criteria and enrollment requirements; a provision in the MMA that previously permitted SNPs to enroll and serve a "disproportionate share" of individuals who do not meet the targeted criteria or condition has been repealed. For example, a SNP that is approved to serve only a "full dual eligible" population cannot enroll an individual who is qualified for a different category of Medicaid or an individual who has no Medicaid entitlement. A SNP approved to serve a population with diabetes cannot enroll individuals who do not have the diabetic condition. However, beneficiaries who are dual eligible and who also qualify for a C-SNP can choose either plan. They are not required to choose plan over the other. A non-qualifying individual that disenrolls from a SNP may re-enroll in the same SNP if the individual once again meets the specific qualifying characteristic(s) of the SNP.

SNPs must include elements on the enrollment request mechanism that correspond to the special needs focus of the particular SNP. Refer to policy regarding enrollment request mechanisms, including special guidance for C-SNPs, in Chapter 2 of the *Medicare Managed Care Manual*.

Although MA organizations must accept enrollment through the Online Enrollment Center (OEC), SNPs may choose whether they wish to enroll beneficiaries through the OEC. Additional guidance on enrollment processes is available in Chapter 2 of the *Medicare Managed Care Manual*. Refer to §50.2.1 of this chapter and Chapter 2 of the *Medicare Managed Care Manual* for more information about C-SNP eligibility verification processes.

50.2 Verification of Eligibility

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.52(b); 42 CFR §422.52(f)

All SNPs are required to verify the applicant's special needs status according to the requirements outlined in Chapter 2 of the *Medicare Managed Care Manual*. *C-SNPs have the option of completing this verification process prior to submitting the enrollment to CMS or, as described below, conducting a pre-enrollment assessment and then completing the verification during the first month of enrollment.*

50.2.1 Special Procedure for Verifying C-SNP Eligibility

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

To determine eligibility for a special needs individual having one or more severe or disabling chronic conditions to enroll in a C-SNP, CMS requires that the C-SNP contact the applicant's existing provider or provider's office to verify the enrollee has the targeted condition. Not only does contact with the existing provider permit confirmation of the condition(s), but it also affords the opportunity to initiate the exchange of health information and facilitate the smooth transition of care to the C-SNP.

C-SNPs must reconfirm a beneficiary's eligibility at least annually.

50.2.1.1 Pre-enrollment Qualification Assessment Tool

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

An MA organization may be approved to use a Pre-enrollment Qualification Assessment tool and attempt to complete the verification process during the first month of enrollment. CMS will approve the use of a Pre-enrollment Qualification Assessment tool under the following conditions:

- (1) The Pre-enrollment Qualification Tool provides a clinically appropriate set of questions relevant to the specific condition(s) for each applicable condition that cover the potential enrollee's past medical history, current signs and/or symptoms, and medication that provides reliable evidence that the beneficiary has the condition.
- (2) The MA organization maintains a record of the results of the Qualification Tool to include the date and time of the verification.
- (3) The MA organization conducts a post-enrollment confirmation of each enrollee's information and eligibility using medical information provided by the enrollee's physician or other provider.
- (4) The MA organization ensures that any payment or compensation associated with enrollments will be forfeited if the condition cannot be confirmed.
- (5) A C-SNP using a Pre-enrollment Qualification Assessment Tool that is unable to verify the qualifying condition during the first month of enrollment must notify the beneficiary within the first seven calendar days of the following month that s/he will be disenrolled at the end of the second month of enrollment.
- (6) The MA organization tracks the total number of enrollees and the number and percent by condition whose post enrollment verification matches the pre-enrollment verification. Data and supporting documentation to be available upon request by CMS.
- (7) All information gathered in the Qualification Tool will be held confidential and in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy provisions.

A request for approval to use a Pre-enrollment Qualification Assessment Tool must be submitted by mail to:

Centers for Medicare & Medicaid Services
Medicare Drug & Health Plan Contract Administration Group
ATTN: Prequalification Assessment Tool
7500 Security Blvd.
Mail Stop C4-22-04
Baltimore, MD 21244

50.2.1.2 Alternative Verification Methodology

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Notwithstanding standard eligibility verification tools, C-SNPs have historically reported that it is sometimes difficult to obtain verification from provider offices in a timely manner. To address this issue, CMS implemented an alternative methodology to verify the targeted chronic condition.

The alternative methodology is outlined below:

- (1) For each applicable condition, the C-SNP develops a Pre-enrollment Qualification Assessment Tool – a clinically appropriate set of questions presumptive for the target chronic condition (i.e., past medical history, current signs and/or symptoms, and medication regimen that provide reliable indicators that the beneficiary has the condition).
- (2) The Pre-enrollment Qualification Assessment Tool and a signed attestation that the MA organization will comply with CMS conditions for use of the alternative methodology are mailed to the address provided in section 50.2.1.1 above.
- (3) CMS reviews the submitted materials and contacts the MA organizations approved to implement the alternative methodology. Only MA organizations having CMS Central Office approval may use the Pre-enrollment Qualification Assessment Tool.
- (4) The MA organization maintains a record of the use of the Tool such as retention of the completed Tool and documentation of the call if plan personnel administer the Tool on the phone. This record must include a date and time that establishes when the verification occurred.
- (5) The MA organization conducts a post-enrollment confirmation of each enrollee's information and eligibility based on medical information provided by the enrollee's physician or other provider. The MA organization has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP. If the MA organization cannot confirm that the enrollee has the qualifying condition within that time, the organization has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the beneficiary notice of disenrollment for not

having the qualifying condition. Refer to §60 of this chapter for more details on the disenrollment process for SNPs.

- (6) The MA organization must ensure that, for all enrollments conducted by an agent or broker, if applicable, any compensation associated with that enrollment will be forfeited in the event the condition cannot be confirmed post-enrollment.
- (7) The MA organization tracks the total number of enrollees, including the number and percent by condition, whose post-enrollment verification matches the pre-enrollment verification. The data and supporting documentation must be made available upon request by CMS and will be audited.
- (8) All information gathered in the Pre-enrollment Qualification Assessment Tool will be held confidential in accordance with the privacy provisions of the HIPAA. This requirement applies to plan employees as well as the plan's business associates.

50.2.1.3 Expanded Alternative Verification Methodology

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations that have experienced and documented an inordinate delay in getting a timely response from beneficiaries' existing providers and that have a CMS-approved Pre-enrollment Qualification Assessment Tool may develop and submit an expanded alternative verification methodology that meets CMS recommended practices for CMS approval. We reiterate our preference that C-SNPs contact enrollees' existing providers and obtain confirmation of the targeted chronic condition prior to enrollment. However, plans documenting a pattern of delayed response from providers and that have CMS approval to use their Pre-enrollment Qualification Assessment Tool may submit an expanded alternative verification methodology to the CMS mailing address provided in section 50.2.1.1 above.

CMS will review and approve proposals contingent on the following:

- (1) The C-SNP uses the CMS-approved Pre-enrollment Qualification Assessment Tool, described in section 50.2.1.1, to identify and enroll beneficiaries reporting the target chronic condition(s), and obtains confirmation that the enrollees have the qualifying condition from their existing providers (licensed physicians, nurse practitioners, psychiatrists, or clinical psychologists authorized to diagnose per State law) within the first month of enrollment.
- (2) If the C-SNP is unsuccessful in obtaining confirmation from the existing provider within the first month of enrollment, the C-SNP notifies the enrollees within the first seven days of the second month of enrollment that disenrollment will occur at the end of the second month if the target condition is not confirmed. During this time, the C-SNP must continue to attempt to contact the enrollees' existing providers, but may simultaneously use any of the following alternatives to confirm the chronic condition:

- a) Schedule and complete a visit with a new provider (licensed physicians, nurse practitioners, psychiatrists, clinical psychologists authorized to diagnose per State law) from the plan's provider network.
- b) Obtain and review a copy of a diagnostic lab or radiology report authenticated by a provider licensed by the respective State to interpret the test that documents the chronic condition or is uniquely diagnostic for the condition.
- c) Obtain and review a copy of an active prescription label or prescription receipt displaying the enrollee's identifying information, the medication name, and its indication for use, which must exactly match the enrollees' qualifying condition.
- d) Obtain and review a copy of a medical or pharmacy claim displaying the enrollee's identifying information that specifies the ICD-9 or CPT code exactly matching the enrollees' qualifying condition and authenticated by a State-licensed provider.
- e) For those beneficiaries who have been Medicare-eligible for a minimum of 12 months, obtain and review a copy of a monthly risk adjustment model output report indicating the enrollee has a designated HCC score that exactly matches the qualifying condition.

50.2.2 Level of Care (LOC) Assessment for Institutional Equivalent SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Pursuant to Section 1859(f)(2) of the Act, I-SNPs that are designated for individuals living in the community and requiring an institutional LOC may only enroll individuals who have been determined to need an institutional LOC. CMS permits I-SNPs serving individuals living in the community who require an institutional LOC to restrict enrollment to those individuals that reside in, or agree to reside in, a contracted ALF or continuing care community, as this may be necessary to ensure uniform delivery of specialized care.

Use of an ALF is optional. If a community-based I-SNP is limited to specific ALFs, a potential enrollee must either reside or agree to reside in the MA organization's contracted ALF in order to enroll in the SNP. The SNP must demonstrate the need for the limitation, and must describe how community resources will be organized and provided.

MA applicants requesting to offer a new or expand an existing I-SNP(s) for individuals living in the community and requiring an institutional LOC must submit to CMS information via HPMS that pertains to:

- (1) The State assessment tool; and
- (2) The entity performing the assessment

The assessment must be performed by an entity unrelated to the MA organization. This independent party cannot be an employee of the MA organization or its parent organization, and should be an independent contractor or grantee. In addition, the independent party should not

receive any kind of bonus or differential payment for qualifying members for the SNP.

MA organizations must submit this required information as a part of their SNP proposal application. Proposals for this type of I-SNP are reviewed on a case-by-case basis for approval during the annual MA application cycle. Refer to §40.3 of this chapter for further information regarding the SNP proposal submission.

50.3 Waiver to Enroll Individuals with ESRD

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.50(a)(2)(ii); 42 CFR §422.52(c)

A SNP may enroll individuals with End-Stage Renal Disease (ESRD) if it has obtained a waiver to be open for enrollment to individuals with ESRD. This waiver should be requested as part of the SNP application, and is available to all types of SNPs, not only C-SNPs. CMS's decision to grant an ESRD waiver is conditional upon SNPs arranging access to services specifically targeted to individuals living with ESRD (e.g., nephrologists, hemodialysis centers, and renal transplant centers).

SNPs that did not initially elect to enroll ESRD beneficiaries at the time of application must submit a new SNP proposal if they decide to begin enrolling ESRD beneficiaries. Refer to section 40 of this chapter for further guidance on the SNP application process. Once a waiver is approved, the SNP must allow all eligible ESRD beneficiaries—and only these beneficiaries—to enroll in accordance with the guidance outlined in Chapter 2, §20.2.2, of the *Medicare Managed Care Manual*.

50.4 Continued Eligibility Requirements

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.52(d)

An MA organization sponsoring a SNP must continue to provide care for at least one full calendar month for a member who no longer has special needs status if the individual can reasonably be expected to again meet SNP eligibility criteria within a 6-month period. If an individual cannot be reasonably expected to regain the appropriate special needs status required for SNP enrollment, the individual must be disenrolled from the SNP as per the guidance in Chapter 2 of the *Medicare Managed Care Manual*.

The MA SNP may choose any length of time from one month to 6 months for deeming continued eligibility as long as the plan provides appropriate care, applies the criteria consistently among all members and fully informs members of its policy. Refer to Chapter 2 of the *Medicare Managed Care Manual* for more information about deeming continued eligibility.

50.5 Special Enrollment Period (SEP) for Individuals Losing Special Needs Status to Disenroll from SNP

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.60(g)(3); 42 CFR §422.62(b)

CMS provides a SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. SNPs must send out the notices explaining the disenrollment to the beneficiary. Refer to Chapter 2 of the *Medicare Managed Care Manual* for additional guidance on SEPs for these individuals.

50.6 Auto and Facilitated Enrollment for Low Income Subsidy (LIS) and Certain Dual Eligible Individuals

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §423.34

To ensure no gap in prescription drug coverage between the end of the Medicaid coverage and the beginning of eligibility for Medicare Part D prescription drug coverage, full-benefit dual eligible individuals who are enrolled in a MA-only plan without Medicare prescription drug benefits are auto-enrolled into an MA-PD plan in the same organization. CMS delegates the auto-enrollment of this population to MA organizations. Additional guidance on auto-enrollment is provided in Chapter 2 of the *Medicare Managed Care Manual*.

Enrollment of other LIS eligible individuals enrolled in MA-only plans is facilitated into an MA-PD plan in the same organization. The process is similar to the auto-enrollment process for full-benefit dual eligible individuals, and is discussed further in Chapter 2 of the *Medicare Managed Care Manual*.

50.7 Open Enrollment Period for Institutionalized Individuals

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.62; 42 CFR §422.68

An open enrollment period for institutionalized individuals (OEPI) is available for individuals who meet the definition of “institutionalized individual” to enroll in or disenroll from an I-SNP. Refer to Chapter 2 of the *Medicare Managed Care Manual* for further information about the OEPI.

50.8 Seamless Conversion Enrollment Option for Newly Medicare Advantage Eligible Individuals

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly MA eligible individuals who are currently enrolled in other health plans offered by the MA organization, such as commercial or Medicaid plans, at the time of their conversion to Medicare. For example, an MA organization may request to enroll a current Medicaid member in a D-SNP. CMS will review an organization’s proposal and must approve it before use. MA organizations using the seamless enrollment option must provide the individual with clear instructions on how to opt-out, or decline, the seamless conversion enrollment. Additional guidance on seamless enrollment is provided in Chapter 2 of the *Medicare Managed Care Manual*.

60—DISENROLLMENT

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

60.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

SNP enrollees who lose special needs status must be notified and disenrolled from the SNP, if necessary, in accordance with the requirements described in Chapter 2 of the *Medicare Managed Care Manual*.

60.2 Involuntary Disenrollment of Ineligible or Disproportionate Share SNP Enrollees

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Effective CY 2012, SNPs that include members who:

- (1) enrolled prior to January 1, 2010 under the disproportionate share policy (i.e., the members did not meet the special needs criteria at the time of enrollment); or
- (2) were enrolled in a C-SNP as of January 1, 2010, but did not meet the revised special needs criteria as of that date;

must disenroll those individuals from the plans they are in if the individuals do not request enrollment in a different plan prior to January 1, 2012. However, MAOs must retain any of these enrollees whose circumstances change and who regain special needs status prior to January 1, 2012.

Section 1859(f)(6) of the Act requires CMS to develop a transition process for those SNP enrollees who are ineligible to remain enrolled in SNPs as of January 1, 2010. Refer to our 2012 Call Letter to Medicare Advantage Organizations, available at:

http://www.cms.gov/HealthPlansGenInfo/02_WhatsNew.asp#TopOfPage

for further guidance on this transition process for these ineligible or disproportionate share SNP enrollees. We will disseminate additional guidance on the disenrollment process for these SNP enrollees via HPMS memoranda.

60.3 Transitioning Enrollees from Renewing and Non-Renewing D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

Table 4 below provides an overview of CMS policy for D-SNP renewals and non-renewals in several exceptional circumstances. Refer to our 2012 Call Letter to Medicare Advantage Organizations, available at:

http://www.cms.gov/HealthPlansGenInfo/02_WhatsNew.asp#TopOfPage

for detailed guidance regarding the plan renewal and non-renewal options available to D-SNPs.

Table 4: Guidance for D-SNP Renewals/Non-Renewals

Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
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<p>D-SNP with no State contract consolidating with a D-SNP with a State contract, so that, effectively, an entire D-SNP is transferred into another D-SNP with a State contract and the D-SNP without a State contract no longer exists</p>	<p>For D-SNPs only: An MAO offering a CY 2011 D-SNP PBP with no State contract may consolidate with a CY 2012 D-SNP, offered under the same contract, which has a contract with the State.</p>	<p>HPMS Plan Crosswalk Definition: Two or more whole 2011 D-SNP plans (PBPs) that consolidate into one 2012 plan. The 2012 plan ID must be D-SNP with the State contract.</p> <p>HPMS Plan Crosswalk Designation: Consolidated Renewal Plan</p>	<p>The MAO does not send enrollment transactions for current enrollees who will remain enrolled in the 2012 PBP.</p> <p>The MAO must submit disenrollment transactions for current enrollees who are ineligible for the renewal PBP.</p>	<p>No enrollment request is required for current eligible enrollees to remain enrolled in the renewal PBP in 2012.</p> <p>New enrollees must complete enrollment requests.</p>	<p>Current enrollees eligible to remain enrolled in the renewal plan receive a standard ANOC.</p> <p>The MAO sends a CMS model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.</p>
<p>Renewing D-SNPs that also creates new Medicaid subset D-SNP and transitions eligible enrollees into the new Medicaid subset D-SNP</p>	<p>For D-SNPs only: An MAO renewing a D-SNP plan for 2012 and also creating a new Medicaid subset D-SNP for 2012. A subset of current enrollees under the renewing D-SNP is eligible to be enrolled in the new Medicaid subset D-SNP. The organization must submit enrollment transactions to move the eligible D-SNP enrollees into the new Medicaid subset D-SNP.</p>	<p>Exceptions Crosswalk Request: Organizations cannot complete the transition of current eligible enrollees to the new Medicaid subset D-SNP via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions.</p> <p>HPMS Plan Crosswalk Definition: A 2012 D-SNP that links to a 2011 D-SNP and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011 plan. In addition, a new Medicaid subset plan is added for 2012 that is not linked to a 2011 plan.</p> <p>HPMS Plan</p>	<p>The renewal PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID.</p> <p>The MAO must submit enrollment transactions to transition eligible current enrollees into the new Medicaid subset D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012.</p> <p>New enrollees must complete enrollment request.</p>	<p>Current enrollees transitioned to the renewal plan receive a standard ANOC. Current enrollees who are transitioned to the new Medicaid subset PBP receive a standard ANOC.</p>

		<p>Crosswalk Designation: Renewal Plan (renewing D-SNP designation) AND New Plan (new Medicaid subset D-SNP designation)</p>			
<p>Renewing D-SNP in a multi-State service area with a SAR to accommodate State contracting efforts in portions of that service area</p>	<p>For D-SNPs only: An MAO reduces the service area of a CY 2011 D-SNP PBP to accommodate State contracting efforts in a multi-State service area. Current enrollees in the reduced portion of the service area are transitioned to one or more new or renewing CY 2012 D-SNP PBPs. The organization must submit enrollment transactions to move current enrollees in the reduced portion of the CY 2011 D-SNP PBP into the new or renewing CY 2012 D-SNP PBPs.</p>	<p>Exceptions Crosswalk Request: Organizations cannot complete the transition of current enrollees to one or more new or renewing CY 2012 D-SNP PBPs via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. HPMS Plan Crosswalk Definition: A 2012 plan that links to a 2011 plan and only retains a portion of its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. In addition, a new plan(s) is added for 2012 that is not linked to a 2011 plan(s), or a 2011 plan is renewed in 2012. HPMS Plan Crosswalk Designation: Renewal Plan with a SAR AND/OR New Plan AND/OR Renewal Plan</p>	<p>The renewal PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID. The MAO must submit enrollment transactions to transition current enrollees in the reduced portion of the service area into a new or renewing D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.</p>	<p>No enrollment request is required for current enrollees in the remaining portion of the service area to remain enrolled in the renewal PBP in CY 2012. New enrollees must complete enrollment request.</p>	<p>Current enrollees in the renewal portion of the service area receive the standard ANOC. Current enrollees in the reduced portion of the service area who are transitioned to a new or renewal D-SNP PBP receive the standard ANOC.</p>

<p>D-SNP that transitions current enrollees to a new D-SNP with a different designation and less restrictive eligibility requirements.</p>	<p>For D-SNPs only: An MAO offering a CY 2011 D-SNP PBP that requests conversion to a different D-SNP type for CY 2012. The new D-SNP has less restrictive eligibility and all current enrollees remain eligible for the new D-SNP with the new designation.</p>	<p>Exceptions Crosswalk Request: Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. HPMS Plan Crosswalk Definition: The 2011 D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new 2012D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.</p>	<p>The MAO does not submit enrollment transactions for current enrollees.</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.</p>	<p>Current enrollees are sent a standard ANOC.</p>
<p>D-SNP that transitions some current enrollees to a new D-SNP with a different designation and more restrictive eligibility requirements consistent with the new D-SNP’s State contract.</p>	<p>For D-SNPs only: An MAO offering a CY 2011 D-SNP PBP that requests conversion to a different D-SNP type for CY 2012. The new D-SNP has more restrictive eligibility criteria. A subset of current enrollees is eligible to remain enrolled in the new 2012 D-SNP.</p>	<p>Exceptions Crosswalk Request: Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. HPMS Plan Crosswalk Definition: The 2011 D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new 2012 D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.</p>	<p>The MAO does not submit enrollment transactions for current enrollees who will be transitioned to the new D-SNP. The MAO submits disenrollment transactions for current enrollees who are ineligible for the new D-SNP.</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the new PBP in 2012. New enrollees must complete enrollment requests.</p>	<p>Current enrollees who remain eligible for the renewing plan receive a standard ANOC. The MAO sends a CMS model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.</p>
<p>Renewing SNP with ineligible, or “disproportionate share” enrollees.</p>	<p>An MAO renewing a SNP that includes a subset of current enrollees who do not meet the eligibility criteria for enrollment in the SNP (“disproportionate share” enrollees or</p>	<p>HPMS Plan Crosswalk Definition: A 2012 plan that links to a 2011 plan and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011</p>	<p>The MAO does not submit enrollment transactions for current enrollees who meet the SNP eligibility criteria for enrollment and will remain enrolled in the 2012 PBP. Plans must submit</p>	<p>No enrollment request is required for enrollees eligible to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment</p>	<p>Enrollees who remain eligible for the renewing plan receive a standard ANOC. The MAO sends a CMS model disenrollment notice to ineligible current enrollees</p>

	enrollees affected by change in scope of C-SNP).	plan HPMS Plan Crosswalk Designation: Renewal Plan	disenrollment transactions for current enrollees who were enrolled as of January 1, 2010 and continue to not meet the eligibility criteria for enrollment in the SNP.	requests.	who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.
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70—MARKETING

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.4; 42 CFR §422.111; 42 CFR §422.2; 42 CFR §422.2264; 42 CFR §423.2264; 42 CFR §423.2268; 42 CFR §423.128

70.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

As with any MA organization, MA SNPs must market to all individuals eligible for the plan. For example, if an MA SNP is developed for institutionalized beneficiaries at select skilled nursing facilities (SNFs), the MA SNP must market to all Medicare Part A and/or Part B beneficiaries residing in those SNFs. D-SNPs may wish to work with their respective States to identify an acceptable method of targeting dual eligible beneficiaries. CMS will also work with States to coordinate language for explanatory marketing materials such as the summary of benefits (SB).

There are certain marketing provisions specifically related to providers, such as allowing providers to feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement with a SNP by placing the SNP affiliations at the beginning of the announcement and may include specific information about the SNP (e.g., special plan features, the population the SNP serves, specific benefits for each SNP). This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated. Refer to Chapter 3 of *The Medicare Managed Care Manual* for further information on marketing requirements for SNPs.

70.2 Comprehensive Written Statement for D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.2, 422.4(a)(1)(iv), §422.111(b)(2)(iii), §422.2264, §423.2264

Pursuant to section 1859(f)(3)(C) of the Act, plan sponsors offering D-SNPs must provide each prospective enrollee, prior to enrollment, with a comprehensive written SB that includes a comparison of cost-sharing protections between the SNP and the relevant State Medicaid plan.

The comprehensive written statement must include the elements described below:

- The benefits that the individual is entitled to under Title XIX (Medicaid);

- The cost-sharing protections that the individual is entitled to under Title XIX (Medicaid); and
- A description of the benefits and cost-sharing protections that are covered under the D-SNP for dual-eligible individuals.

Further guidance on submission of the comprehensive written statement is available in §60.1, Chapter 3, of the *Medicare Managed Care Manual*.

70.3 Special Requirements for I-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.2268(k), §423.2268(k)

Marketing materials and outreach for new enrollment must clearly indicate that enrollment is limited to the targeted population and to those beneficiaries who live in, or are willing to move to, contracted LTC facilities. Further guidance on marketing within a health care setting and other I-SNP marketing policies is available in Chapter 3, §70.8.2, of the *Medicare Managed Care Manual*.

80—COVERED BENEFITS

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.100

80.1 Part D Coverage Requirement

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §423.104(f)(3)

All SNPs must include required Part D prescription drug coverage, regardless of whether the MA organization offers a CCP in the area with Part D benefits. Refer to Chapter 5, §20.4.4, of the *Prescription Drug Benefit Manual* for more information about this requirement.

80.2 SNP-Specific PBPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.100(f); 42 CFR §422.111(b)

CMS expects MA organizations offering SNPs to begin with a well-developed MOC, structure their service delivery system to support this model, and design their PBP to address the specialized needs of the targeted beneficiaries. In addition, SNP-specific PBPs should incorporate some or all benefits that exceed the basic required Medicare A and B benefits offered by other MA products available in the same service area.

The following are examples of benefits that exceed basic Medicare Parts A and B benefits:

- | | |
|-------------------------------------------|----------------|
| • beneficiary cost-sharing | No or lower |
| • coverage periods for inpatient services | Longer benefit |

- coverage periods for specialty medical services Longer benefit
- between medical and mental health benefits and services Parity (equity)
- preventive health benefits (e.g., dental screening, vision screening, hearing screening, age-appropriate cancer screening, risk-based cardiac screening,) Additional
- (e.g., connection to community resources for economic assistance) Social services
- services Transportation
- programs to prevent the progression of chronic conditions. Wellness

Plans should note that some social-support services (e.g., in-home support services) may not be approved in bids as Medicare supplemental benefits by our Medicare bid reviewers, and proposed supplemental benefits must be consistent with our guidance in Chapter 4, §30, of the *Medicare Managed Care Manual*. Refer to §40.6 of this chapter for further guidance specific to C-SNP PBPs.

CMS will continue to analyze the SNP PBPs to identify best practices and recommendations for designing PBPs that demonstrate recognition of the specialized needs of target populations. If we believe that benefits could be more robust, we may provide targeted guidance to MA organizations before approving SNP PBPs.

80.3 Meaningful Difference in Plan Benefits

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.112; §422.254

To determine whether SNPs satisfy the meaningful difference requirement outlined in Chapter 4, §160, of the *Medicare Managed Care Manual*, we separate SNP plans into groups representing the various allowed SNP plan types (i.e., C-SNP, I-SNP, D-SNP). SNPs are further separated into narrower groups and evaluated on the meaningful difference criteria as follows:

- C-SNPs: Separated by the chronic disease served;
- I-SNPs: Separated into the categories of either Institutional (Facility), Institutional Equivalent (Living in the Community), or a combination of Institutional and Institutional Equivalent; and
- D-SNPs: Excluded from the meaningful difference evaluation.

CMS evaluates meaningful differences among plans offered in the same county by a parent organization. Each year, CMS calculates the combined Part C and Part D (if applicable) out-of-pocket cost (OOPC) estimate for each PBP within the plan-type groups, and determines a total OOPC difference that plans must have in order to be considered meaningfully different. The calculation includes Parts A, B, and D services and mandatory supplemental benefits, but not

optional supplemental benefits. For purposes of evaluating meaningful differences among MA plans, CMS does not consider premiums, current enrollment, or risk scores when calculating the OOPC. We release the OOPC amount through guidance each year before plans submit their bids for the following contract year.

Plan bids that do not meet these meaningful difference requirements and those outlined in Chapter 4, §160, of the *Medicare Managed Care Manual* will not be approved by CMS. Although CMS will not prescribe how plans should redesign their benefits packages to achieve the differences, we expect plans to submit bids that meet the meaningful difference requirements, and may not permit revised submissions if a plan's initial bid does not comply with meaningful difference requirements. Refer to and the renewal/non-renewal guidance in our annual Call Letter to MA organizations and §60.3 of this chapter for guidance on how plans may consolidate with other plans.

80.4 Special Requirements for D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

80.4.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

MA organizations offering D-SNPs may provide Medicaid benefits directly, or under contract with another entity, but must retain responsibility for the benefits. States and MA organizations may identify the package of Medicaid benefits included in the D-SNP through their contract negotiations. The contract should include the limitation on OOP costs for full benefit dual-eligible individuals or qualified Medicare beneficiaries when these dual-eligible categories are covered in its plan. We encourage States and MA organizations to move towards more complete integration of Medicare and Medicaid benefits for dual-eligible individuals in SNP products.

80.4.2 Cost-Sharing Requirements for D-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

43 CFR §422.504(g)(1)

MA organizations offering D-SNPs must enforce limits on OOP costs for dual-eligibles. Pursuant to §1852(a)(7) of the Act and 43 CFR §422.504(g)(1), D-SNPs cannot impose cost-sharing requirements on specified dual-eligible individuals (FBDEs, QMBs or any other population designated by the State) that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP. This category includes QMBs and QMB+, the two categories of dual eligible beneficiaries that have all Medicare Part A and Medicare Part B cost-sharing paid by Medicaid, and may also include other dual eligible beneficiaries that the State holds harmless for Part A, Part B, or Part D cost-sharing.

Like all other local MA plans, D-SNPs must establish a maximum out of pocket (MOOP) limit to provide this enrollee protection even though the State Medicaid program is usually paying those costs on the enrollee's behalf. CMS requires D-SNPs to establish annual MOOP limits because an enrollee's eligibility for Medicaid may change during the year, leaving the enrollee liable for cost sharing. In this circumstance, the State Medicaid program would not be expected to pay more than the MOOP amount it would pay if it were responsible for the enrollee's cost-

sharing. We strongly encourage D-SNPs to establish MOOP amounts that are greater than \$0 to protect the plan from full liability for the cost sharing amounts in the event that an enrollee's Medicaid coverage is discontinued for some period of time. However, we permit plans to adopt a \$0 MOOP.

Although it may be rare that an enrollee of a D-SNP would be responsible for paying any cost sharing because the State Medicaid program is making those payments on his behalf, the PBPs for D-SNPs must reflect the plan's actual out-of-pocket cost sharing charges for covered services as well as a valid MOOP amount. For purposes of tracking out-of-pocket spending relative to its MOOP limit, a plan must count only the actual OOP expenditures for which each enrollee is responsible. Thus, for any dual eligible enrollee, MA plans must count toward the MOOP limit only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost-sharing and not the cost-sharing amounts for services the plan has established in its PBP. Effectively, this means that for those dual eligible enrollees who are not responsible for paying the Medicare Parts A and B cost-sharing, the MOOP limit will rarely be reached. However, plans must still track OOP spending for these enrollees.

Any D-SNP type, other than a zero-cost share D-SNP, must also indicate the cost-sharing range for the plan in the plan's (SB). Refer to our 2012 Call Letter to Medicare Advantage Organizations, available at:

http://www.cms.gov/HealthPlansGenInfo/02_WhatsNew.asp#TopOfPage

for guidance on SB changes reflecting D-SNP cost-sharing requirements.

80.4.3 Cost-sharing for Dual Eligible Beneficiaries Requiring an Institutional Level of Care

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §423.782

As provided under section 1860D-14 of the Act, full-benefit dual eligible institutionalized individuals have no cost-sharing for covered Part D drugs under their PDP or MA-PD plan. Effective January 1, 2012, Section 1860D-14 of the Act also eliminates Part D cost-sharing for full-benefit dual eligible individuals who are receiving home and community-based services (HCBS) either through:

- A home and community-based waiver authorized for a State under §1115 or subsection (c) or (d) of §1915 of the Act
- A State Plan Amendment under §1915(i) of the Act, or
- A Medicaid managed care organization with a contract under §1903(m) or §1932 of the Act.

These services are targeted to frail, elderly individuals who, without the delivery in their home of services such as personal care services, would be at risk of institutionalization. HCBS eligibility is not based on where an individual resides. In other words, sponsors cannot assume that all beneficiaries residing in assisted living facilities receive HCBS and therefore qualify for the \$0 cost sharing. Thus, in order to receive the waiver under Section 3309, a plan sponsor must determine or a beneficiary must demonstrate that s/he is a full-benefit dual-eligible individual

receiving HCBS under Title XIX. Below, we list of acceptable documents that may be used as best available evidence (BAE) for demonstrating receipt of HCBS:

- A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
- A copy of a State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
- A copy of a State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
- Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or
- Acceptable documents listed in Chapter 13, §70.5, of this manual that may be used to demonstrate Medicaid eligibility, if a beneficiary is not already in CMS' data systems as a full-benefit dual-eligible.

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

90—MODEL OF CARE (MOC)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.101; §422.152(g)(2)(ix)

90.1 General

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

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

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

All SNP MOCs must include the following elements:

- (1) Description of SNP-specific Target Population;

- (2) Measurable goals;
- (3) Staff structure and Care Management Roles;
- (4) Interdisciplinary Care Team;
- (5) Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
- (6) MOC Training for Personnel and Provider Network;
- (7) Health Risk Assessment;
- (8) Individualized Care Plan;
- (9) Communication Network;
- (10) Care Management for the Most Vulnerable Subpopulations; and
- (11) Performance and Health Outcome Measurement.

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

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

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

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

CMS examines differences in MOCs by SNP type in order to address potential conflicts between

MOCs established by States and CMS MOC requirements, and to work with States to integrate their measures into ours. We will also review the SNP MOC during audits, which may be part of regularly scheduled MA organization audits.

90.2 Description of SNP Target Population

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.102(f)(2)(i)

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

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

90.3 Measurable Goals

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.101(f)(1)(ii)

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

At a minimum, care management goals must include:

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

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

90.4 Staff Structure and Care Management Roles

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.101(f)(2)(ii)

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

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

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

90.5 Interdisciplinary Care Team (ICT)

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.101(f)(1)(iii)

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

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

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

90.6 Specialized Provider Network

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.101(f)(1)

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

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

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

SNPs must additionally describe how their provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it ensures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, and how services are delivered across care settings

and providers). This element should also describe the procedures that the plan uses to ensure that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, and written protocols providers send to MAO Medical Director for review).

90.7 MOC Training for Personnel and Provider Network

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.102(f)(2)(ii)

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

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

90.8 Health Risk Assessment

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

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

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

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

SNPs are not only required to conduct an initial comprehensive health risk assessment, but also a comprehensive annual reassessment. The health risk assessment includes a medical, psychosocial, cognitive, and functional assessment that guides care management and accounts

for health status changes. We expect the SNP to conduct the initial risk assessment within 90 days of enrollment and the annual risk assessment within 12 months of the last risk assessment, or as often as the health of the enrollee requires.

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

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

90.9 Individualized Care Plan

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

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

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

- Which personnel develop the individualized plan of care and how the beneficiary is involved in its development as feasible;
- The essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, and add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life);
- The personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the ICT, beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified);
- How the plan of care is documented and where the documentation is maintained (e.g., accessible to ICT, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, and secured for privacy and confidentiality);
- How the plan of care and any care plan revisions are communicated to the beneficiary, ICT, MA organization, and pertinent network providers; and
- Essential care management elements, including goals and objectives for each individual in order to measure outcomes and determine if needs have been met, standard and

specialized services and benefits that meet the specialized needs that the SNP identified in the initial and subsequent risk assessments, and measurable outcomes that enable the SNP to determine the effectiveness of the care management plan. (Note: A measurable outcome is the quantification of results from an intervention that demonstrates change from baseline status. The SNP must identify its goal or baseline beneficiary status, the intervention(s) employed, and the results of the intervention(s) in order for CMS to determine a measurable outcome.).

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

90.10 Integrated Communication Network

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

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

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

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

90.11 Care Management for the Most Vulnerable Subpopulations

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.102(f)(2)(iv)

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

90.12 Performance and Health Outcome Measurement

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.102(f)(1)(ii)

This MOC element must include a description of the following:

- How the plan will collect, analyze, report, and evaluate the MOC (e.g., specific data sources, specific performance and outcome measures, etc.);

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

90.13 Change of Residence Requirement for I-SNPs

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

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

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

100—QUALITY IMPROVEMENT

(Rev. 98, Issued: 05-20-11, Effective:05-05-20-11, Implementation: 05-20-11)

42 CFR §422.152, §422.153, and §480.140

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

APPENDIX 1:

Summary of MOC Evaluation Criteria for SNP Approval Process

Score	Description	Examples Review
4	The response is detailed and in depth.	Multiple specific examples for example: three (3) or more or one very detailed case study of an example
3	The response is detailed but is	Limited examples, less

	lacking depth.	specificity. May include one (1) to two (2) examples; no case study.
2	The response provides limited details but does not provide enough information provided to support it.	No examples.
1	The response provides incomplete details or incorrect information or inappropriate material for this element.	No examples. There was an effort but the information provided was not responsive to the factor and element.
0	No details.	No examples.

Model of Care Elements and Standards

1. Description of the SNP-specific Target Population (at a minimum include: Medicaid subset D-SNP, institutional equivalent individuals enrolled in I-SNP, diabetes C-SNP, or chronic heart failure/cardiovascular C-SNP)

4	The response provides a detailed and in depth description of the population being served. The description includes multiple specific examples and/or a case study type of example specific to this factor. The description includes information on the incidence and prevalence of the specific diseases for a chronic condition special needs plan (C-SNP). For a dual-eligible special needs plan (D-SNP) the description includes information on both Medicare and Medicaid characteristics of the population. Further, for an institutional special needs plan (I-SNP) the description includes attributes of a patient and the type of long term care facility where the beneficiary resides.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the target population for the specific SNP type. No case study is provided as an example.
2	The response provides limited information on the description of the target population for the specific SNP type. No examples are included with this description.

1	The response provides incomplete details or incorrect information on the description of the target population for the specific SNP type. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

2. Measurable Goals

2a. Describe the specific care management goals including:

These goals must be stated in measurable terms that indicate how the plan will know whether the goals have been achieved. The care management goals should include at a minimum:

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

4	The response provides a detailed and in depth description of the goals that addresses all seven (7) bullets above. The description provides multiple specific examples and /or a detailed case study. Note all 7 bullets MUST be addressed.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the goals. No case study is included as an example. Only 5 to 6 of the bullets above are addressed.
2	The response provides a limited description of the goals. Only 3 to 4 of the bullets as noted above are included in the response. No examples are provided.
1	The response provides incomplete details or incorrect information on the description of the goals. The description may contain material that is inappropriate or irrelevant for this factor. The response addresses only 1 to 2 of the bullets as noted above. No examples are included.
0	No description/information provided.

2b. Describe the goals as measurable outcomes and indicate how MAO will know when goals are met

4	The response provides a detailed and in depth description of clearly measurable goals to include bench marks for those goals, the specific time frames, and how achieving those goals will be determined. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the goals, the specific time frames, and how achieving those goals will be determined.
2	The response provides limited information on the description of the measureable outcomes. The methods for measuring the benchmarks or determining when the goal has been achieved are not clearly described. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the goals, the specific time frames, and how achieving those goals will be determined. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

2c. Discuss actions MAO will take if goals are not met in the expected time frame

4	The response provides a detailed and in depth description of the internal corrective action plan and time frames that would be implemented by the plan to achieve this goal(s). The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the internal corrective action plan and time frames that would be implemented by the plan to achieve this

	goal(s). No case study is provided as an example.
2	The response provides limited information on the description of the internal corrective action plan and time frames that would be implemented by the plan to achieve this goal(s). No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the internal corrective action plan and time frames that would be implemented by the plan to achieve this goal(s). The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

3. Staff Structure and Care Management Roles

3a. Identify the specific employed or contracted staff to perform administrative functions (at a minimum identify staff who process enrollments, verify eligibility, process claims)

4	The response provides a detailed and in depth description that identifies all staff performing administrative functions. The staff structure and roles includes at a minimum, specific details about the personnel who coordinate benefits, plan information, data collection and analysis for beneficiaries, network providers, and the public. The personnel and the assigned role(s) are specified. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the staff performing administrative functions, the personnel and the assigned role(s) or functions. No case study is provided as an example.
2	The response provides limited information on the description of the staff performing administrative functions, the personnel and the assigned role(s) or functions. No examples are included with this description.

1	The response provides incomplete details or incorrect information on the description of the staff performing administrative functions, the personnel and the assigned role(s) or functions. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

3c. Identify the specific employed or contracted staff to perform administrative and clinical oversight functions (at a minimum verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines)

4	The response provides a detailed and in depth description that identifies all staff performing administrative and clinical oversight functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.) This description specifies the job title and the assigned role or function. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the staff performing administrative and clinical oversight functions. No case study is provided as an example.
2	The response provides limited information on the description of the staff performing administrative and clinical oversight functions. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the staff performing administrative and clinical oversight functions. The description may contain material that is inappropriate or irrelevant for this factor.

0	No description/information provided.
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4. Interdisciplinary Care Team (ICT)

The description must include at a minimum:

- How the SNP will determine the composition of the ICT;
- How the beneficiary will participate in the ICT as feasible;
- How the ICT will operate and communicate; and
- How the activities of the ICT will be documented and maintained.

4a. Describe the composition of the ICT and how the MAO determined the membership

4	The response provides a detailed and in depth description of the composition of the ICT. The description includes multiple specific examples and/or a case study type of example specific to this factor. The response provides a detailed description of the composition and responsibilities of the ICT and how members are selected for the ICT. At a minimum, the description includes details from all four (4) bullets above. The description includes specific examples that are part of a protocol or standard operating procedure (SOP).
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the composition of the ICT. Three (3) of the bullets are addressed. No case study is provided as an example.
2	The response addresses only 1-2 of the bullets as noted above and/or lacks specific examples. No examples are provided.
1	The response provides incomplete details or incorrect information on the description of the ICT. Only 1 of the bullets is addressed and the description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

4b. Describe how the MAO will facilitate the participation of the beneficiary whenever feasible

4	The response provides a detailed and in depth description of the process for facilitating the inclusion of the beneficiary in the meetings with the ICT. The response provides a
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	detailed description of the expectations for beneficiary participation to include: education and outreach efforts, the communication process, resources, and how the beneficiary has ongoing access to the ICT. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the process for facilitating the inclusion of the beneficiary in the meetings with the ICT. No case study is provided as an example.
2	The response provides limited information on the description of the process for facilitating the inclusion of the beneficiary in the meetings with the ICT. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the process for facilitating the inclusion of the beneficiary in the meetings with the ICT. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

4c. Describe how the ICT will operate and communicate (at a minimum includes: frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders)

4	The response provides a detailed and in depth description of the how the ICT will operate and communicate. The response includes a detailed description of how the activities of the ICT will be documented and maintained. This description includes who performs reviews of items such as: communication strategies, frequency of communication, service standards with each member of the ICT, assessments and administrative data. It states when the reviews are performed for different special needs patients. It also states who revises the Plan of Care (POC), if needed. The description also explains how
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	the data/records are being kept so every member of the ICT has secure access to them. Frequency of meetings should also be documented. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the procedures as described above for operating the ICT. No case study is provided as an example.
2	The response provides limited information on the description of the operations of the ICT as outlined above. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of how the ICT operated. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols.

The description must include at a minimum:

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

- How the plan assures that specialized services are delivered to the beneficiary in a timely and quality way;
- How reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan;
- How services are delivered across care settings and providers; and
- How the plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.

5a. Describe the specialized expertise in the MAO’s provider network that corresponds to the target population including facilities and providers (at a minimum includes: medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics)

4	The response provides a detailed and in depth description of the provider network and the details as outlined in the bullets noted above. The response includes a detailed description of the composition and responsibilities of the provider network having specialized expertise for the plans targeted special needs populations. The description must address at least 10-12 of the bullets for this factor. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. The description must address at least 7-9 of the bullets for this factor. Limited examples are provided with less specificity on the description of the provider network and how it operates. No case study is provided as an example.
2	The response provides limited information on the description of the provider network. The description must address at least 3-6 of the bullets for this factor. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the provider network. The description must address at least 1-2 of the bullets for this factor. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

5b. Describe how the MAO determined that its network facilities and providers were actively licensed and competent

4	<p>The response provides a detailed and in depth description of the process for determining licensing and competency of the network facilities and providers. The response includes a detailed description of the credentialing program to include: (a) initial determination/verification of licensure and competency (credentialing program for initial practitioners, initial facilities and ancillary providers); (b) ongoing monitoring of licensure and competency (re-credentialing program for initial practitioners, initial facilities and ancillary providers); and (c) ongoing board certification monitoring. In addition, the description of the credentialing program provides details on how the MAO addresses negative information that must be added to a practitioner's profile between credentialing cycles. The description includes multiple specific examples and/or a case study type of example specific to this factor.</p>
3	<p>The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the process for determining licensing and competency of the network facilities and providers. No case study is provided as an example.</p>
2	<p>The response provides limited information on the description of the process for determining licensing and competency of the network facilities and providers. No examples are included with this description.</p>
1	<p>The response provides incomplete details or incorrect information on the description of the process for determining licensing and competency of the network facilities and providers. The description may contain material that is inappropriate or irrelevant for this factor.</p>

0	No description/information provided.
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5c. Describe who determines which services beneficiaries will receive (at a minimum includes: that is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider)

4	The response provides a detailed and in depth description of the services that the beneficiary will receive and the process on how the beneficiary will have access to the appropriate services. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the services that the beneficiary will receive and the process on how the beneficiary will have access to the appropriate services. No case study is provided as an example.
2	The response provides limited information on the description of the services that the beneficiary will receive and the process on how the beneficiary will have access to the appropriate services. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the services that the beneficiary will receive and the process on how the beneficiary will have access to the appropriate services. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

5d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (at a minimum includes: how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers)

4	The response provides a detailed and in depth description on how the ICT coordinates the delivery of specialized services. This description includes at a minimum: how the ICT assures care is delivered in a timely manner, how quality of care is assessed, how the ICT maintains reports of services delivered and care plan records to show the coordination of care for beneficiaries across all providers and settings. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the how the ICT coordinates the delivery of specialized services. No case study is provided as an example.
2	The response provides limited information on the description of the how the ICT coordinates the delivery of specialized services. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of how the ICT coordinates the delivery of specialized services. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

5e. Describe how the MAO ensures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (at a minimum includes: review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to MAO Medical Director for review)

4	The response provides a detailed and in depth description and specific examples of how it ensures that providers are using evidence-based practice guidelines and nationally recognized protocols. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are

	provided with less specificity on the description of the how it ensures that providers are using evidence-based practice guidelines and nationally recognized protocols. No case study is provided as an example.
2	The response provides limited information on the description of the how it ensures that providers are using evidence-based practice guidelines and nationally recognized protocols. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the how it ensures that providers are using evidence-based practice guidelines and nationally recognized protocols. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

6. Model of Care (MOC) Training for Personnel and Provider Network

6a. Describe how the MAO conducted initial and annual MOC training including training strategies and content (at a minimum includes at least one of the following: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing)

4	The response provides a detailed and in depth description of the initial and annual MOC training. The types of training, number of participants and specific examples of slides or training materials are included. The description includes multiple specific examples and/or a case study type of example specific to this factor
3	The response provides a detailed description but is lacking depth; may have only described the initial or annual training. Limited examples are provided with less specificity on the description of the training. No case study is provided as an example.
2	The response provides limited details and lacks a description of the content and training strategies for the initial and/or annual MOC training. Evidence of specific examples of

	content and training materials is missing.
1	The response provides incomplete details or incorrect information on the description of the how it conducts the MOC training. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

6b. Describe how the MAO assures and documents completion of training by the employed and contracted personnel (at a minimum include attendee lists, and at least one of the following: results of testing, web-based attendance confirmation, electronic training record)

4	The response provides a detailed and in depth description of the methodology for documenting that all personnel have received the training. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the training materials and methods. No case study example is provided.
2	The response provides limited details of the description of the methodology and materials used to document the training. Examples of documentation such as the attendee list and results of training are missing.
1	The response provides incomplete details or incorrect information on the description of the training methods and materials. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information is provided.

6c. Describe who the MAO identified as personnel responsible for oversight of the MOC training

4	The response provides a detailed and in depth description of the personnel who conducted the training, including their qualifications and the method for indentifying those individuals. The description includes multiple specific examples and/or a case study type of example
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	specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided on the qualifications of the personnel conducting the training. No case study is provided as an example.
2	The response lacks details in the description of the personnel conducting the training. No specific examples are provided.
1	The response provides incomplete details or incorrect information on the description of the personnel conducting the training. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

6d. Describe what actions the MAO will take when the required MOC training has not been completed (at a minimum includes: contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion)

4	The response includes a detailed and in depth description of the procedures that are in place to address the situation where the required MOC training has not been completed. This description includes examples of letters to staff, staff performance evaluation criteria and incentives for completing training if applicable. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided on the actions the SNP will take when the training has not been completed. No case study is provided as an example.
2	The response provides a limited description of the procedures that are in place to address the situation where the required MOC training has not been completed. No specific examples are provided.
1	The response provides incomplete details or incorrect information the description of the actions that will be taken when the MOC training has not been completed. The

	description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

7. Health Risk Assessment (HRA)

7a. Describe the HRA tool the MAO uses to identify the specialized needs of its beneficiaries (at a minimum includes: medical, psychosocial, functional, and cognitive needs, medical and mental health history)

4	The response provides a detailed and in depth description of the HRA tool that includes medical and mental health history, psychosocial, functional and cognitive needs assessment at a minimum. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the HRA tool. No case study is provided as an example.
2	The response provides limited information on the description of the HRA tool. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the HRA tool. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

7b. Describe when and how the initial HRA and annual reassessment are conducted for each beneficiary (at a minimum includes: initial assessment within 90 days of enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary)

4	The response provides a detailed and in depth description of the process for conducting the initial and annual HRAs. The response provides a detailed description of the protocol that is used to coordinate the initial and annual HRA for each beneficiary to include at a minimum the timing of initial assessment
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	and the annual reassessments and the methods used. The description also includes details on how the assessments are conducted (e.g. by phone interview, face-to-face, written form completed by beneficiary, etc). The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the process for conducting the initial or annual HRAs. No case study is provided as an example.
2	The response provides limited information on the description of the process for conducting the initial and/or annual health risk assessments. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the process for conducting the initial and annual HRAs. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

7c. Describe the personnel who review, analyze, and stratify health care needs (at a minimum includes: professionally knowledgeable and credentialed personnel such as physicians, nurses, restorative therapists, pharmacists, psychologists)

4	The response provides a detailed and in depth description of the personnel (including title and credentials) who have the responsibility to review, analyze and stratify health care needs. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the characteristics of the

	personnel performing the functions as described above. No case study is provided as an example.
2	The response provides limited information on the description of the characteristics of the personnel performing the functions as described above. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the characteristics of the personnel performing the functions as described above. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

7d. Describe the communication mechanism the MAO institutes to notify the ICT, provider network, beneficiaries, etc. about the HRA and stratification results (at a minimum includes: written notification, secure electronic records)

4	The response provides a detailed and in depth description of the process and communication mechanism used to disseminate the results of the HRA to the ICT, provider network, beneficiaries and others. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the process and communication mechanism used to disseminate the results of the HRA to the ICT, provider network, beneficiaries and others. No case study is provided as an example.
2	The response provides limited information on the description of the process and communication mechanism used to disseminate the results of the HRA to the ICT, provider network, beneficiaries and others. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the

	process and communication mechanism used to disseminate the results of the HRA to the ICT, provider network, beneficiaries and others. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

8. Individualized Care Plan

8a. Describe which personnel develop the individualized plan of care (POC) and how the beneficiary is involved in its development as feasible

4	The response provides a detailed in depth description of the expectations for the beneficiary to include: education and outreach efforts, the communication process, resources, and how the beneficiary is involved and has ongoing access to the ICT. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the personnel involved and how the beneficiary is included in the development of the individualized care plan. No case study example is provided.
2	The response provides limited information on the description of the personnel involved and how the beneficiary is included in the development of the individualized care plan. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the personnel involved and how the beneficiary is included in the development of the individualized care plan. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

8b. Describe the essential elements incorporated in the POC (at a minimum includes: results of health risk assessments, goals/objectives, specific services and benefits, outcome

measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life)

4	The response provides a detailed and in depth description of the essential elements in the POC as outlined above, including add-on benefits and services for vulnerable patients. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the essential elements in the POC as outlined above, including add on benefits and services for vulnerable patients. No case study example is provided.
2	The response provides limited information on the description of the essential elements in the POC as outlined above, including add on benefits and services for vulnerable patients. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the essential elements in the POC as outlined above, including add on benefits and services for vulnerable patients. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

8c. Describe the personnel who review the care plan and how frequently the POC is reviewed and revised (at a minimum includes: POC is developed by the ICT, beneficiary whenever feasible, and other pertinent specialists required by the beneficiary’s health needs; reviewed and revised annually and as a change in health status is identified)

4	The response provides a detailed and in depth description of the personnel who review and revise the care plan, and the frequency of the reviews and revisions of the care plan. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description

	but is lacking depth. Limited examples are provided with less specificity on the description of the personnel who review and revise the care plan, and the frequency of the reviews and revisions of the care plan. No case study example is provided.
2	The response provides limited information on the description of the personnel who review and revise the care plan, and the frequency of the reviews and revisions of the care plan. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the personnel who review and revise the care plan, and the frequency of the reviews and revisions of the care plan. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

8d. Describe how the POC is documented and where the documentation is maintained (at a minimum includes: accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality)

4	The response provides a detailed and in depth description of how the POC documentation is maintained and where it is located. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided on how the POC is documented and how the documentation is maintained. No case study example is provided.
2	The response provides a limited description of how the POC is documented and/or where this document is maintained. No specific examples are included.
1	The response provides incomplete details or incorrect information provided on how the POC is documented and how that

	documentation is maintained. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

8e. Describe how the POC and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers

4	The response provides a detailed and in depth description of the communication process for making revisions to the ICT that will include the beneficiary, ICT, the MAO and other network providers. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided on how the care plan and revisions to this plan are communicated to the beneficiary, ICT, MAO and other network providers. No case study example is provided.
2	The response provides a limited description of the communication process and/or excludes the beneficiary, ICT, MAO and any other pertinent providers in the MAO. No specific examples are included.
1	The response provides incomplete details or incorrect information on the description of the process for how the care plan and revisions to the plan are communicated to the beneficiary, ICT, MAO, and other network providers. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

9. Communication Network

9a. Describe the MAOs structure for a communication network (at a minimum includes at least one of the following: web-based network, audio conferencing, face-to-face meetings)

4	The response provides a detailed and in depth description of the structure of the communication network that outlines the specifics of the network and how it is
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	applicable to each stakeholder group. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the communication network that outlines the specifics of the network and how it is applicable to each stakeholder group. No case study is provided as an example.
2	The response provides limited information on the description of the communication network. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the communication network. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

9b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies

4	The response provides a detailed and in depth description that specifically addresses how the communication network connects all of the stakeholders. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description how the communication network connects all of the stakeholders. No case study is provided as an example.
2	The response provides limited information on the description of how the communication network connects all of the stakeholders. No examples are included with this description.

1	The response provides incomplete details or incorrect information on the description of how the communication network connects all of the stakeholders. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

9c. Describe how the MAO preserves aspects of communication as evidence of care (at a minimum includes at least one of the following: recordings, written minutes, newsletters, interactive websites)

4	The response provides a detailed and in depth description of the mechanism(s) used to preserve aspects of communication as evidence of care. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the mechanism(s) used to preserve aspects of communication as evidence of care. No case study is provided as an example.
2	The response provides limited information on the description of the mechanism(s) used to preserve aspects of communication as evidence of care. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the mechanism(s) used to preserve aspects of communication as evidence of care The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

9d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness

4	The response provides a detailed and in depth description of the personnel having responsibility for monitoring and evaluating communication effectiveness. The description includes specific personnel information
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	including job title, years of experience, licensing and/or certification. The description provides information about the process used to evaluate the effectiveness of the communication network. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description of the personnel having responsibility for monitoring and evaluating communication effectiveness. The description includes specific personnel information including job title, years of experience, licensing and/or certification. The description provides information about the process used to evaluate the effectiveness of the communication network and includes limited examples, less specificity with no case study.
2	The response provides limited information on the description of the personnel having responsibility for monitoring and evaluating communication effectiveness. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the personnel having responsibility for monitoring and evaluating communication effectiveness. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

10. Care Management for the Most Vulnerable Subpopulations

10a. Describe how the MAO identifies its most vulnerable beneficiaries

4	The response provides a detailed and in depth description of the methodology/ies used to identify vulnerable member beneficiaries. The description also includes how the MAO defines “vulnerable” for its enrollment
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	population. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description of the methodology/ies used to identify vulnerable member beneficiaries. The description also includes how the MAO defines “vulnerable” for its enrollment population and provides limited examples. No case study is provided as an example.
2	The response provides limited information on the description of the methodology/ies used to identify vulnerable member beneficiaries. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the methodology/ies used to identify vulnerable member beneficiaries. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

10b. Describe the add-on services and benefits the MAO delivers to its most vulnerable beneficiaries

4	The response provides detailed and in depth information about the types of add-on services, how the beneficiary accesses the services(s), and the anticipated outcomes/benefits from receiving these services. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. The response provides information about the types of add-on services, how the beneficiary accesses the services(s), and the anticipated outcomes/benefits from receiving these services. Limited examples are provided with less specificity. No case study is provided as an example.
2	The response provides limited information on the description of the types of add-on services, how the beneficiary accesses the

	services(s), and the anticipated outcomes/benefits from receiving these services. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the types of add-on services, how the beneficiary accesses the services(s), and the anticipated outcomes/benefits from receiving these services. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

11. Performance and Health Outcome Measurement

11a. Describe how the MAO will collect, analyze, report, and evaluate the MOC (at a minimum include: specific data sources, specific performance and outcome measures)

4	The response provides a detailed and in depth description of the methodologies used to collect, analyze, and act on the results to evaluate the MOC. The description identifies the frequency of collection, analysis, and evaluation, as well as the steps taken to address any identified deficiencies. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the methodologies used to collect, analyze, and act on the results to evaluate the MOC. No case study is provided as an example.
2	The response provides limited information on the description of the methodologies used to collect, analyze, and act on the results to evaluate the MOC. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the methodologies used to collect, analyze, and act on the results to evaluate the MOC. The description may contain material that is

	inappropriate or irrelevant for this factor.
0	No description/information provided.

11b. Describe who will collect, analyze, report, and act on to evaluate the MOC (at a minimum includes: internal quality specialists, contracted consultants)

4	The response includes a detailed and in depth description of the personnel involved in the collection, analysis and reporting and evaluation of the MOC. The description includes specific personnel information including job title, years of experience, licensing and/or certification. The description provides information about the process used to collect, analyze, evaluate and act on the results of the evaluation. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the personnel involved in the collection, analysis and reporting and evaluation of the MOC. No case study is provided as an example.
2	The response provides limited information on the description of the personnel involved in the collection, analysis and reporting and evaluation of the MOC. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the personnel involved in the collection, analysis and reporting and evaluation of the MOC. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

11c. Describe how the MAO will use the analyzed results of the performance measures to improve the MOC (at a minimum includes: internal committee, other structured mechanism)

4	The response provides a detailed and in depth description of how the results of the performance measures will be used to improve any identified deficiencies in the MOC, the methodology used to analyze these results, a description of the corrective actions to be taken and the established timeframe in which to improve the MOC. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the how the results of the performance measures will be used to improve the MOC. No case study is provided as an example.
2	The response provides limited information on the description of the how the results of the performance measures will be used to improve the MOC. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the how the results of the performance measures will be used to improve the MOC. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

11d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the MOC (at a minimum includes: electronic or print copies of its evaluation process)

4	The response provides a detailed and in depth description, including specific examples, of the mechanism(s) used to document the effectiveness the MOC. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the mechanism(s) used to

	document the effectiveness the MOC. No case study is provided as an example.
2	The response provides limited information on the description of the mechanism(s) used to document the effectiveness the MOC. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the mechanism(s) used to document the effectiveness the MOC. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

11e. Describe the personnel having oversight responsibility for monitoring and evaluating the MOC effectiveness (at a minimum includes: quality assurance specialists, consultants with quality experience)

4	The response provides a detailed and in depth description of the personnel having responsibility for monitoring and evaluating the effectiveness of the MOC. The description includes specific personnel information including job title, years of experience, licensing and/or certification. The description also provides information about the process used to evaluate the effectiveness of the MOC and provide specific examples. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the personnel having responsibility for monitoring and evaluating the effectiveness of the MOC. No case study is provided as an example.
2	The response provides limited information on the description of the personnel having responsibility for monitoring and evaluating the effectiveness of the MOC. No examples are included with this description.

1	The response provides incomplete details or incorrect information on the description of the personnel having responsibility for monitoring and evaluating the effectiveness of the MOC. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.

11f. Describe how the MAO will communicate improvements in the MOC to stakeholders (at a minimum includes: webpage for announcements, printed newsletters, bulletins, announcements)

4	The response provides a detailed and in depth description on the process and the mechanism used to communicate improvements in the MOC to stakeholders. The description includes a timeframe for dissemination of the information and specific examples. The description includes multiple specific examples and/or a case study type of example specific to this factor.
3	The response provides a detailed description but is lacking depth. Limited examples are provided with less specificity on the description of the mechanism used to communicate improvements in the MOC to stakeholders. No case study is provided as an example.
2	The response provides limited information on the description of the mechanism used to communicate improvements in the MOC to stakeholders. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the mechanism used to communicate improvements in the MOC to stakeholders. The description may contain material that is inappropriate or irrelevant for this factor.
0	No description/information provided.