DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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TO: Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States

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SUBJECT: Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013

On January 25, 2012, the Centers for Medicare and Medicaid Services (CMS) issued an initial guidance memorandum for organizations interested in offering capitated financial alignment demonstration plans in interested States[1] in contract year (CY) 2013 (refer to http://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf for more information). In that memorandum, CMS provided information about: (1) the payment principles underlying the demonstration; (2) standards in key programmatic areas; (3) State demonstration approval process key dates; (4) a number of Medicare plan selection process key dates; (5) submission of a notice of intent to apply as a demonstration plan; and (6) network adequacy determinations for Medicare-covered services.

This guidance document offers additional information for interested organizations in the following areas:

- Medicare Plan Selection Requirements. To be selected to participate in the demonstration, interested organizations must demonstrate their capacity to meet all Medicare and State-specific plan selection requirements. This section summarizes the Medicare requirements necessary for interested plans to establish qualification for participation in the demonstration. These include approval of a formulary consistent with Part D requirements; approval of a medication therapy management program (MTMP) consistent with Part D requirements; approval of an integrated plan benefit package (PBP); approval of a demonstration-specific application, including demonstration of adequate access to providers and pharmacies for Medicare drug and medical benefits; and approval of a unified model of care. Additionally, CMS and States will consider an organization's past Medicare performance, if applicable, and, accordingly, may impose conditions on a plan's demonstration participation.

- Other Demonstration Programmatic Areas. This section provides an update on the mechanism by which States and CMS will jointly review interested organizations' marketing and beneficiary

[1] We use the term "interested organizations" throughout this document to refer to health plans and other qualified entities interested in participating in this demonstration in interested States.

notification materials. We also summarize key principles underlying an oversight and monitoring framework to be used by States and CMS under the demonstration.

- Medicare Plan Finder (MPF) Data Submission Requirements. This section summarizes the purpose of the MPF tool and the drug pricing data submission requirements for interested organizations.

As detailed in section I.H. of this guidance, the Medicare-Medicaid Coordination Office (MMCO) will partner with other CMS components, as well as States interested in pursuing capitated financial alignment demonstrations, to provide an overview of this guidance, as well as topic-specific technical training, for interested organizations. In addition, questions related to demonstration timelines and requirements should be sent to MMCOcapsmodel@cms.hhs.gov.

I. Medicare Plan Selection Requirements

A. CMS/ State Joint Plan Selection Process

Demonstration plans will ultimately be selected through a CMS/State joint selection process utilizing State-based plan selection vehicles. These State-based plan selection processes are based in part on feedback received through various State stakeholder outreach processes currently underway. To be selected to participate in the demonstration, interested organizations must demonstrate their capacity to meet all Medicare and State-specific plan selection requirements. The goal of the selection process is to implement the demonstration with interested organizations that can coordinate all medical, drug, behavioral health, and long-term supports and services in a manner that creates a more seamless and person-centered experience for beneficiaries.

Therefore, the Medicare plan selection requirements described in this section are not the only selection criteria in the CMS/State joint selection process, but they are necessary for interested plans to establish readiness for participation in the demonstration. As initially communicated in our January 25, 2012 guidance and supplemented in this guidance document, interested organizations must meet the following required Medicare components:

- Approval of a unified formulary consistent with Part D and Medicaid requirements (refer to section I.B. of this document for more detail);
- Approval of a medication therapy management program (MTMP) consistent with Part D requirements (refer to section I.C. of this document for more detail);
- Approval of an integrated plan benefit package that meets the minimum requirements for Part D drugs, Medicare-covered items and services, Medicaid-covered items and services, and any required demonstration-specific items and services (refer to section I.D. of this document for more detail);
- Approval of a demonstration-specific application, including demonstration of adequate access to providers and pharmacies for Medicare drug and medical benefits (refer to section I.F. of this document for more detail); and
- Approval of a unified model of care consistent (refer to section I.G. of this document for more detail).

Additionally, CMS and the States will consider an organization's past Medicare performance, if applicable, and, accordingly, may impose conditions on a plan's demonstration participation (refer to section I.E. of this document for more detail).

This section contains additional detail about each of these requirements. A detailed calendar of key dates for interested organizations is provided in Appendix 1 of this document

Given the joint nature of the plan selection process under this demonstration, CMS will share with States information received from interested organizations via the Health Plan Management System (HPMS)[2] in support of the Medicare components of the plan selection process. In some cases – and as explained in further detail in this guidance document – this information will be reviewed jointly by States and CMS. In other cases, plan submissions will be shared with States on an informational basis, with the goal of eliminating duplication between the State and CMS components of the plan selection process. State reviewers will be provided user access to HPMS to facilitate review of information submitted in connection with the plan selection process.

B. Formulary Submissions

1. Base Formulary Submission

As stated in our January 25, 2012, guidance memorandum, interested organizations must either submit a base formulary or request a crosswalk to a previously submitted non-demonstration plan formulary. Base formulary submissions are due in HPMS on April 30, 2012, for interested organizations that are submitting a new formulary (e.g., those that have not submitted a formulary for CY 2013 for non-demonstration plans). Interested organizations that wish to use a previously submitted CY 2013 non-demonstration plan formulary for their demonstration plans must associate their demonstration contract to the appropriate formulary ID by May 14, 2012.

Organizations have the ability in HPMS to associate demonstration contracts to non-demonstration formularies from March 26, 2012 through April 16, 2012. Interested organizations that elect to associate their demonstration contract to a non-demonstration plan formulary after April 16, 2012 must request that CMS make this association on their behalf. Interested organizations must submit the following information via e-mail to CMS: 1) the demonstration contract number; 2) the CY 2013 non-demonstration plan formulary ID (for example, 13xxx) to be crosswalked; and 3) the contracts currently associated with the non-demonstration plan formulary. Demonstration plan applicants must submit the requested information to the Part D Benefits mailbox at PartDbenefits@cms.hhs.gov with "Hxxxx (contract number to be associated) contract to formulary association" in the subject line no later than May 14, 2012. CMS will validate the request and complete the formulary-to-contract association.

2. Supplemental Formulary File Submissions

In addition to submission of a base formulary, interested organizations must submit supplemental formulary files in HPMS on June 8 and 15, 2012, as appropriate, to support CMS and State review of an

[2] HPMS is a system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about provider networks, plan benefit packages, formularies, and other information via HPMS.

integrated formulary that includes drugs required under Part D, as well as by State Medicaid agencies (consistent with Medicaid requirements). Interested organizations covering any drugs in categories of Part D excluded drugs[3] in their integrated formulary must submit an Excluded Drug file to CMS by June 8, 2012.

The Part D program allows plans the option of providing over-the-counter (OTC) drugs as part of their administrative cost structure, either as (1) a part of general drug utilization management, or (2) as part of a step therapy protocol, but always at no cost to the enrollee.[4] Interested organizations may cover OTC drugs under their integrated formulary more broadly than the Part D program allows. However, interested organizations should only include on the OTC Drug file due to CMS on June 8 those OTC drugs that are being provided under the plan consistent with Part D rules – that is, either as part of a general utilization management program or as part of a step therapy protocol, and at no cost to the enrollee.

If the State requires coverage of additional drugs – whether prescription or OTC drug products that cannot be captured in the base formulary, Excluded Drug file, or OTC Drug file – or, alternatively, interested organizations wish to cover additional drugs as supplemental benefits under the demonstration, interested organizations must submit an Additional Demonstration Plan Drug file to CMS by June 15, 2012. CMS will provide interested organizations with additional instructions about the submission and content of this supplemental file later this spring.

In addition, interested organizations that offer free first fill, partial tier gap coverage, and/or bundled home infusion drug benefits must also submit supplemental files to CMS no later than June 8, 2012.

3. Review of Formulary Submissions

States will have access to information in HPMS about base formularies and supplemental files submitted by organizations interested in offering demonstration plans in their respective States. Both CMS and States will ensure that the integrated formulary submitted by each interested organization meets both entities' requirements.

4. Additional Information and Training on Formulary Submissions

Additional guidance on the CY 2013 formulary submission process for all organizations offering Part D benefits was released by CMS via an HPMS memorandum on March 9, 2012 (refer to Appendix 1 of this document for more detail on key dates). The memorandum provides information about the CY 2013 formulary training webinar, which is currently available online (see https://webinar.cms.hhs.gov/e39303730/event/event_info.html; a Part C and D User Call on April 4, 2012, dedicated to answering previously submitted questions on the formulary submission process; availability of the formulary reference file and CY 2013 formulary submission module; availability of the

[3] Refer to section 20.1 and Appendix B of Chapter 6 of the Prescription Drug Benefit Manual (https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf for more detail about excluded categories of drugs in the Part D program. Please also note that the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that barbiturates (when used for the medical indications of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines be included as Part D drugs starting in 2013.

[4] Refer to section 60.2 of Chapter 7 of the Prescription Drug Benefit Manual (https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf) for more detail about the provision of OTC drugs under Part D.

CY 2013 HPMS Formulary Submission & Reports Technical User Manual; formulary-related compliance officer training on the April 18, 2012, Part C & D User Call; and key dates associated with the formulary submission process. In addition, an HPMS memorandum released on March 7, 2012 (refer to http://www.cms.gov/PrescriptionDrugCovContra/Downloads/FormularyConsultantMemo_03072012.pdf), provides instructions for requesting formulary consultant access to HPMS.

C. Medication Therapy Management Program (MTMP) Submissions

Interested organizations must establish a medication therapy management program (MTMP) that:

- Is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries (those that have multiple chronic conditions, are taking multiple Part D drugs, and are likely to incur annual Part D drug costs above a certain threshold) are appropriately used to optimize therapeutic outcomes through improved medication use;
- Is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries;
- May be furnished by a pharmacist or other qualified provider; and
- Offers a minimum level of MTM services for each beneficiary enrolled in the MTMP that includes interventions for both beneficiaries and prescribers, an annual comprehensive medication review (CMR) with written summaries in CMS standardized format (the CMR must include an interactive person-to-person, or telehealth, consultation), and quarterly targeted medication reviews with follow-up interventions when necessary.

Additional guidance on the MTMP requirements is provided under 42 CFR §423.153(d) and in Chapter 7 of the Prescription Drug Benefit Manual (refer to http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf).

MTMP submission deadlines for CY 2013 have changed for all plans – including demonstration plan applicants – relative to the dates stated in our January 25, 2012 guidance memo. The CY 2013 MTMP module will now be released in HPMS on May 18, 2012. MTMP submissions will be due in HPMS on May 25, 2012.

The Center for Medicare expects to release guidance on the 2013 MTMP submission requirements via an HPMS memorandum in April 2012. In the meantime, interested organizations should also refer to the guidance memorandum provided to Part D sponsors regarding CY 2012 MTMP submissions (refer to http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoMTMPSubmissionCY2012_03.03.11v1.pdf).

D. Plan Benefit Package (PBP) Submissions

1. Integrated PBP Submissions

Interested organizations must submit a plan benefit package detailing the integrated benefit package (PBP) they will offer for CY 2013 – including all Medicare, Medicaid, and supplemental benefits. Interested organizations must submit their integrated PBPs to CMS by June 4, 2012, using the PBP software in HPMS. The PBP software has been modified for demonstration plans to include additional categories of Medicaid-covered services so that interested organizations can submit an integrated

benefit package. Capturing all demonstration plan benefits via the PBP software is necessary for display of integrated benefit information in the Medicare Plan Finder tool on www.medicare.gov.

Interested organizations can download the PBP software on April 6, 2012 and begin entering their benefit packages (excluding the additional categories for Medicaid-covered services). On April 20, 2012, a PBP software patch will be released for demonstration plans that will open up new PBP screens to allow data entry of additional categories of Medicaid-covered services. Data entry performed in the April 6, 2012 version of the PBP will not be affected by the installation of the April 20, 2012, PBP software patch.

2. Review of PBP Submissions

The PBP review will be conducted jointly between CMS and States. CMS and States will review PBPs to ensure the data entry is consistent with minimum coverage requirements under Medicare Parts A , B, and D and Medicaid, as well as any demonstration-specific supplemental benefits (for example, inclusion of specific new supplemental benefits not currently covered under Medicare Parts A and B, or under Medicaid).

3. Cost-Sharing for Medicare-Covered Services

Per our January 25, 2012 guidance memorandum, demonstration plans will not charge Part C or Part D premiums. In addition, as provided in this guidance document, demonstration plans must provide Medicare Parts A and B services at zero cost-sharing to plan enrollees under their integrated package of benefits.

4. Additional Information and Training on PBP Submissions

The CY 2013 PBP online training module will be released on April 6, 2012. As specified on the key dates calendar in Appendix 1 and in section I.H. of this document, CMS will provide general CY 2013 PBP training at the annual Parts C & D Spring Conference on April 11-12, 2012. In addition, demonstration-plan specific PBP training for interested organizations will be conducted via webinar on April 24, 2012. In the meantime, interested organizations should consult the CY 2012 Bid User's Manual in HPMS for more information (HPMS navigation path is:
HPMS > Plan Bids > Bid Submission > Contract Year 2012 > Documentation > Bid User's Manual).
Interested organizations may also access the training module for the 2012 PBP by creating a User ID and password at https://hpmstraining.cms.hhs.gov/pbptraining2012/event/registration.html. An email will confirm the registration and will provide a link to the training. Interested organizations may also use the following link to access the training with their user ID and password:
https://hpmstraining.cms.hhs.gov/pbptraining2012/event/login.html.

E. Past Performance

As specified in our January 25, 2012, guidance memorandum, the joint plan selection process will take into account previous performance in Medicare and Medicaid, as applicable. CMS will not consider an organization eligible to offer a demonstration plan if it is currently under a Medicare enrollment and/or marketing sanction. In addition, CMS will consider an organization's previous performance in the Medicare program, if applicable, for purposes of permitting new enrollees to be passively enrolled into an approved demonstration plan.

CMS will use two mechanisms for assessing an organization's Medicare performance: (1) the Past Performance Review methodology; and (2) the "low performing" icon. The past performance review is a tool CMS uses to evaluate the performance of all Medicare contractors and to identify organizations with performance so impaired that CMS would prohibit the organization from further expanding its Medicare operations. For more information, refer to an HPMS guidance memorandum released on December 2, 2011, that provides additional background and the methodology that is being used for this review for CY 2013 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PastPerformanceMethodologyFall2011UpdateFinal_12.01.11.pdf). Organizations with a history of poor plan ratings (also called "star ratings" or "quality ratings") for three or more consecutive years are marked with a "consistently low performing" icon on the Medicare Plan Finder (MPF) website.

An organization interested in offering demonstration plans in 2013 that is either an outlier in CMS' past performance analysis for CY 2013 and/or has a "consistently low performing" icon on the MPF website may qualify to offer a demonstration plan, provided it can meet all plan selection requirements in the CMS-State joint plan selection process; however, it will not be eligible to receive any new passive enrollments. Any such organization will only be able to accept: (1) current enrollees from a Medicare or Medicaid managed care plan the organization also sponsors; and (2) voluntary enrollments, until such time as it is no longer considered by CMS to be a past performance outlier and/or no longer has a "consistently low performing" icon on MPF. When an organization is no longer considered by CMS to be a past performance outlier and/or no longer has a "consistently low performing" icon on MPF, it may begin to receive new passive enrollments.

The past performance review for the CY 2013 Medicare and Part D application and contracting cycle will be finalized in early April. Organizations that currently contract under the MA and/or Part D programs and also intend to offer capitated financial alignment demonstration plans should be aware that CMS will share any applicable information about past performance under the Medicare program with States interested in offering demonstrations. States may consider this information, along with any applicable previous performance in the Medicaid program, in their plan selection processes.

F. Demonstration Plan Application Submission

Interested organizations will be required to submit a Capitated Financial Alignment Demonstration Application to CMS by May 24, 2012. Interested organizations will complete the application in HPMS for this submission, and may begin completing the applications in HPMS on April 12, 2012. Technical instructions for completing the application are provided in the attachment to this guidance document.

The HPMS application module has been modified for demonstration plans to focus on key Medicare criteria necessary for interested organizations to demonstrate that they satisfy CMS' requirements for participation in the demonstration, including:

- Part D requirements under 42 CFR Part 423;
- Part D and Medicare medical service network adequacy standards under 42 CFR §422.112, §422.114, and §423.120;
- A model of care for the targeted population (refer to section I.G. of this guidance for more information about these requirements) consistent with requirements under 42 CFR §422.152(g);

- Documentation to demonstrate State licensure and solvency requirement, as well as CMS standards for fiscal soundness, consistent with 42 CFR §422.2 and §422.400; and
- Administrative and management requirements consistent with 42 CFR 422 §422.503(b) and 42 CFR 423 § 423.504(b).

CMS will review the applications to ensure that Medicare requirements are met consistent with applicable requirements in 42 CFR Parts 422 and 423, as specified in the Capitated Financial Alignment Demonstration Application document. States will have access to interested organizations' application submissions in HPMS and may use any of the submitted documentation to support the State component of the joint plan selection process. States will jointly review the model of care submissions as described in more detail in section I.G. of this guidance. States will also jointly review exceptions requests submitted by interested organizations with respect to the Medicare medical service network adequacy requirements.

CMS will work with interested organizations to correct problems with their application submissions prior to July 30, 2012. As specified on the key dates calendar in Appendix 1, CMS has tentatively scheduled a training webinar on the demonstration application process for interested organizations on April 17, 2012. We emphasize that an organization that meets all the plan selection criteria outlined in this memorandum must still meet the State's specific criteria for plan selection to ultimately be selected to offer demonstration plans by our target date of July 30, 2012.

G. Model of Care (MOC) Submission

1. MOC Submissions and Review

As stated in our January 25, 2012, guidance memorandum, interested organizations must develop a model of care (MOC) for their enrollees that incorporates both CMS and State requirements. This guidance document provides additional information on the requirements for the unified MOC for demonstration plans. All interested organizations must submit a MOC specific to the demonstration's targeted population and benefits, regardless of whether the organization has an approved MOC for any non-demonstration Medicare Advantage (MA) special needs plan (SNP) it may also operate.

Interested organizations will be required to submit a MOC narrative and MOC crosswalk document (i.e., a document that provides a crosswalk to a page number in the narrative document for each element of the MOC) to CMS as part of their Capitated Financial Alignment Demonstration Application by May 24, 2012 (refer to the application's technical instructions for more detail). Our expectation is that the MOC narrative will be a unified document that accounts both for CMS' requirements and any additional requirements the State wishes to include.

As described in greater detail in section I.G.2, CMS will review and approve MOC submissions based on the same eleven elements and scoring standards CMS has established for approval of MA SNP MOCs.[5] We emphasize that CMS will score the MOCs strictly based on its current scoring criteria for the 11 required elements. However, it is our expectation that interested organizations' MOC submissions will be structured to satisfy both CMS and any additional State requirements. CMS will coordinate review of

[5] Refer to section 90 and Appendix 1 of Chapter 16b of the Medicare Managed Care Manual (http://www.cms.gov/manuals/downloads/mc86c16b.pdf) for more information about CMS' model of care requirements for SNPs.

the MOC with the State, and both the State and CMS will need to approve the MOC prior to the target date for joint plan selection (July 30, 2012).

States may wish to require interested organizations to include additional elements in their MOCs beyond the 11 elements required by CMS or to address certain topics or State-specific requirements within the 11 elements required by CMS. For example, a State may wish to require that interested organizations include in their MOC narratives a 12th element that addresses demonstration-specific issues not otherwise captured in CMS' 11 required elements. A State may also wish to require that interested organizations' descriptions within the 11 elements are consistent with State-specific standards. For example, if a State has specific requirements with respect to the health risk assessment process and tool the organization is required to describe in Element 7 of CMS' MOC standards, the organization would be expected to describe that process or tool consistent with the State's specific requirements; however, the narrative for Element 7 would still need to be written in a way that is responsive to CMS' scoring criteria for that element. Interested organizations should work with their respective States to ensure that they are aware of any State-specific requirements that must be included in their unified MOC submission prior to submission with the demonstration plan application on May 24, 2012.

We recognize that some State-specific design parameters are still being finalized and may evolve during the MOU negotiation process. Accordingly, we will work with States and demonstration plan applicants during the MOC review process to ensure that any necessary adjustments are made. However, at a minimum, interested organizations must meet the CMS requirements described in section I.G.2.

2. CMS Standards for MOC Approval

CMS' demonstration plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC (refer to Appendix 2 for more information about the scoring criteria). The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

(1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on the scoring methodology described in Appendix 2.

(2) Elements: 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 Plan-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;
- MOC 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.

(3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the demonstration plan application. The factors for each element will be scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is our intent for MOC reviews and approvals to be a multi-year process that will allow demonstration plans to be granted up to a three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher will be granted an approval of the CMS MOC requirement for three (3) years.

- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range will be granted an approval of the CMS MOC requirement for two (2) years.

- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range will be granted an approval of the CMS MOC requirement for one (1) year.

Since the approval of the MOC will be a joint process between CMS and States, we emphasize that both parties will need to agree on both the overall approval of the MOC, as well as the number of years for which the approval will be valid.

Interested organizations will be permitted to cure problems with their MOC submissions after their initial submission. All interested organizations with MOCs scoring below 85 percent will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, MOCs that do not meet both CMS' and State standards for approval will not be eligible for selection as demonstration plans.

As specified on the key dates calendar in Appendix 1, CMS has tentatively scheduled two training conference calls on the CMS-required MOC elements on April 17 and April 18, 2012, respectively. The first training call will cover MOC elements 1 through 5, and the second training call will cover MOC elements 6 through 11.

3. Publication of MOCs

CMS expects that the information contained in demonstration plan MOCs will be made public. The information will be provided in a format that is easily understandable to the public, and without compromising any proprietary data that may be contained in plans' MOCs. We expect to issue further guidance on this issue.

We clarify that it is not our expectation that the MOC will be provided individually to beneficiaries. However, individualized care plans that are developed for each enrollee consistent with an organization's MOC must be shared individually with each enrollee.

H. Training and Technical Assistance for Demonstration Plans

CMS is committed to providing training and technical assistance on Medicare requirements under the demonstration. As detailed in the key dates calendar in Appendix 1, trainings are tentatively scheduled for the application, model of care, and PBP submissions.

CMS has tentatively scheduled a call regarding the guidance in this memorandum for interested organizations on April 5, 2012. In addition, the Center for Medicare has scheduled its annual Spring Conference on April 11 and 12, 2012 in Hunt Valley, Maryland. We anticipate that demonstration plan-specific topics will be covered and encourage interested organizations to attend, either in person or via webcast. Those wishing to attend the Spring Conference are encouraged to register as soon as possible. By accessing the CMS 2012 Medicare Advantage & Prescription Drug Plan Spring Conference web page at the following link, organizations may register to attend or watch via webcast: http://CMSDrugHealthPlanEvents.org/cms/index.php/events/cms-2012-spring-conference/. After the conference, anyone may view, download, or listen to audio files, slides, and transcripts of conference presentations at www.CMSDrugHealthPlanEvents.org, where similar information from other CMS conferences is currently available.

II. Standards in Certain Key Programmatic Areas

A. Marketing Standards and Review Processes

One of the important administrative flexibilities under the demonstration will be unified marketing requirements and review processes. As described in our January 25, 2012 guidance, the pre-established parameter for marketing is that enrollee materials will be integrated to the extent possible and must be accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency. Language used in these materials must be both culturally and linguistically accessible at every level. CMS and States will prospectively review outreach and marketing materials subject to a single set of rules as negotiated in the CMS-State Memorandum of Understanding (MOU) and the three-way contracts. Part D marketing and outreach requirements will apply to interested organizations as they currently do to MA organizations and PDP sponsors.

We expect that CMS and States will negotiate a flexible approach to both minimum marketing requirements and review processes as part of the MOU negotiations. This approach will include a consistent set of required beneficiary information, and we expect that the negotiated standards will defer to whichever standard – CMS' or the State's – is most beneficiary friendly.

While these negotiations have not been finalized, CMS is implementing modifications to the HPMS Marketing Module to accommodate a joint CMS/State review of capitated financial alignment demonstration plan marketing and beneficiary notification materials – a joint review that will be conducted consistent with the standards negotiated between CMS and the State for each demonstration.

The HPMS Marketing Module is an automated tool that is used for entering, tracking, and maintaining marketing materials that plans submit to CMS for review. The new functionality in the Marketing Module will give State reviewers access to the module (for only those demonstration plans operating in the reviewer's State) and the ability to view and review submitted materials, provide comments to and request revised submissions from plans, and view workload reports (e.g., assignments of marketing materials and status of submissions) and other system reports.

The CY 2013 Marketing Module will be released in HPMS on June 6, 2012. We anticipate conducting training after its release for both State and demonstration plan users to support a joint marketing review process in each State approved to offer a capitated financial alignment demonstration.

B. Oversight Framework

Under the demonstration, there will be a CMS-State contract management team that will ensure access, quality, program integrity, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. We also articulated a preferred requirement standard for coordinated oversight, as negotiated and determined in CMS' MOU with the State or the three-way contract. In addition, all Part D requirements and many MA requirements regarding oversight, monitoring, and program integrity will be applied to demonstration plans by CMS in the same way they are currently applied for PDP sponsors and MA organizations.

Following are some high-level principles that we expect to guide negotiations and relations between CMS, States, and interested organizations:

- The State and CMS will each retain current responsibilities toward the beneficiary such that beneficiaries maintain access to their benefits across both programs.

- We will leverage existing protocols (for example, in responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve beneficiary access problems in real-time.

- Oversight will be coordinated and subject to a unified set of requirements. CMS-State contract management teams, as described above, will be established. Oversight will build on areas of expertise and capacity of individual States and CMS.

- Oversight of the three-way contractors and providers will be at least as rigorous as is currently the case under the MA, Part D, and the relevant State Medicaid managed care programs. We believe that through more efficient coordination between the various oversight entities, we can achieve better results with less duplication and confusion.

- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the States. Demonstration plans will be included in all existing MA and Part D oversight activities, including (but not limited to) data-driven monitoring, mystery shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.

- Mechanisms will be developed with the goal of performance improvement and removal of consistently poor performers from the program.

We expect to operationalize these high-level principles in State-CMS MOU negotiations.

III. Demonstration Impacts on Non-Demonstration Plans

The Center for Medicare is working to provide guidance for all current MA and PDP contractors on the potential impacts of demonstration plans in their States as part of its annual bid guidance released in early to mid-April. This guidance will include instructions on submission of CY 2013 bids by non-demonstration MA and Part D plans. We are also committed to providing the most current information we have on demonstration proposals and their respective scopes to help organizations assess the potential enrollment impacts of a demonstration in their service area.

IV. Medicare Plan Finder (MPF) Data Submission Requirements

The Medicare Plan Finder (MPF) tool on www.medicare.gov provides a pricing data display to give beneficiaries the most accurate drug cost estimates when evaluating plans to select one that best suits their needs. MPF data are refreshed on the website every other Monday.

Interested organizations will be required to submit drug pricing data to be displayed on MPF, in line with current requirements for PDPs and MA-PD plans. We expect the CY 2013 data and submission requirements to be available by the beginning of May 2012. Interested organizations may review the CY2012 Data Requirements and Submission Guidelines document, as well as the calendar, to obtain insights on current data submission expectations. These CY 2012 documents can be found at: http://www.cms.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp (refer to download entitled "2012 Pricing Data Guidelines and Calendar (V01.27.12).zip").

Interested organizations will participate in test data submissions and plan previews before the CY 2013 MPF goes live. After live data are posted on the MPF tool, organizations will be required to submit bi-weekly pricing data based on the CY 2013 pricing data guidelines and calendar. Submitted data will go through quality assurance analyses to identify outliers or potential data errors. These identified outliers will be communicated to each organization.

Appendix 1: Calendar of Key Dates for Medicare Requirements Portion of the Demonstration Plan Selection Process

Key Date	Action
Ongoing – Summer 2012	States submit demonstration proposals that are evaluated against Standards and Conditions. States and CMS negotiate MOU for proposals that meet the Standards and Conditions. The MOU will outline specific programmatic design elements, technical parameters, and approval package for necessary Medicare and Medicaid authorities and payment/financial models.
March 16, 2012	Posting of CY 2013 Part D Formulary Reference File in the Health Plan Management System (HPMS). **Applies to organizations offering demonstration and non-demonstration plans*
March 19, 2012 – ongoing	CY 2013 Formulary Training Webinar available at https://webinar.cms.hhs.gov/e39303730/event/event_info.html.* **Applies to organizations offering demonstration and non-demonstration plans*
March 19, 2012	Posting of HPMS Formulary Submission Module & Reports Technical User Manual.* **Applies to organizations offering demonstration and non-demonstration plans*
March 26, 2012	Release of HPMS Part D formulary submission module for CY 2013.* **Applies to organizations offering demonstration and non-demonstration plans*
April – July 2012	Interested organizations are selected through a CMS-State joint selection process. The CMS portions of the joint plan selection requirements will be consistent with this guidance document, as well as our January 25, 2012 guidance memorandum. CMS and States review and select participating plans.
April 2, 2012	Release of CY 2013 Parts C and D Final Call Letter.

Key Date	Action
April 2, 2012	Latest date for Interested plans to submit their Notice of Intent to Apply (NOIA) to offer demonstration plans electronically to CMS through an online Web tool at http://vovici.com/wsb.dll/s/11dc4g4ddb7.
April 4, 2012	Question and Answer Part C and D User Call on formulary training webinar. If not already registered, register at www.mscginc.com/registration. A valid CMS contract number is required.* **Applies to organizations offering demonstration and non-demonstration plans*
April 5, 2012 (tentative)	Conference call for interested organizations on guidance provided in this document.
April 6, 2012	Release of the 2013 plan creation module and Plan Benefit Package (PBP) software in HPMS. **Applies to organizations offering demonstration and non-demonstration plans*
April 6, 2012	Release of the 2013 PBP online training module. **Applies to organizations offering demonstration and non-demonstration plans*
April 9, 2012	CMS User ID connectivity form submissions must be received no later than this date to ensure user access to the HPMS for purposes of submission of formulary and plan benefit package information.
April 11-12, 2012	Medicare Advantage and Prescription Drug Plan Spring Conference.* **Applies to organizations offering demonstration and non-demonstration plans*
April 12, 2012	Capitated Financial Alignment Demonstration Application module is released in HPMS.
April 17, 2012 (tentative)	Capitated Financial Alignment Demonstration Application training webinar for interested organizations.
April 17, 2012 (tentative)	Training conference call for interested organizations on CMS model of care elements #1 – #5.

Key Date	Action
April 18, 2012	Compliance Officer training on roles and responsibilities in ensuring compliance with formulary and benefits requirements on Part C & D User Call. If not already registered, register at www.mscginc.com/registration. A valid CMS contract number is required.* **Applies to organizations offering demonstration and non-demonstration plans*
April 18, 2012 (tentative)	Training conference call for interested organizations on CMS model of care elements #6 – 11.
April 20, 2012	Release of the CY 2013 Plan Benefit Package (PBP) software patch designed for demonstration plans in HPMS.
April 24, 2012 (tentative)	Demonstration plan applicant PBP training webinar.
April 30, 2012	Part D formulary submissions due to CMS for interested organizations that are submitting a new formulary (e.g., those that have not submitted a formulary for CY 2013 for non-demonstration plans).
May 14, 2012	Part D formulary crosswalk requests due to CMS for interested organizations that have already submitted a non-demonstration plan formulary for CY 2013 and intend to utilize that previously submitted formulary for their demonstration plans.[6]
May 18, 2012	Release of the CY 2013 Medication Therapy Management Program (MTMP) submission module in HPMS.* **Applies to organizations offering demonstration and non-demonstration plans*
May 24, 2012	Deadline for interested organizations to submit a Capitated Financial Alignment Demonstration Application in HPMS.
May 25, 2012	CY 2013 MTMP submission deadline. **Applies to organizations offering demonstration and non-demonstration plans*

[6] Note that organizations offering non-demonstration plans must submit their CY 2013 formularies by April 16, 2012.

Key Date	Action
June 4, 2012	Submission deadline for interested organizations' proposed plan benefit packages (including all Medicare and Medicaid benefits for demonstration plans) in HPMS.* **Applies to organizations offering demonstration and non-demonstration plans.*
June 6, 2012	Release of the HPMS CY 2013 Marketing Module, including functionality for joint CMS-State review of demonstration plan marketing materials. **Applies to organizations offering demonstration and non-demonstration plans*
June – July 2012	CMS and States review submitted plan benefit packages.
June 8, 2012	Deadline for submitting Supplemental Formulary files, Free First Fill File, Partial Gap Coverage File, Excluded Drug File, Over-the-Counter Drug File, and Home Infusion File through HPMS. **Applies to organizations offering demonstration and non-demonstration plans*
June 15, 2012	Deadline for submitting Additional Demonstration Plan Drug supplemental formulary file to CMS.
July 2012	Submission of Medicare Plan Finder Data for test files begins. **Applies to organizations offering demonstration and non-demonstration plans*
July 30, 2012 (target date)	CMS and State portions of the demonstration joint plan selection process for CY 2013 completed.
Late July - September 2012	CMS and State conduct readiness reviews for selected plans. CMS and States make final preparations for implementation, test all operational systems, and perform reviews to assure optimal preparation and adherence to contract requirements prior to implementation. CMS and States jointly confirm readiness requirements have been met.
Early August 2012	CMS releases the 2013 Part D national average bid amount. **Applies to organizations offering demonstration and non-demonstration plans*

Key Date	Action
August 20, 2012	MTMP reviews completed. **Applies to organizations offering demonstration and non-demonstration plans*
August 23-27, 2012	First CY 2013 preview of the 2013 *Medicare & You* plan data in HPMS prior to printing of the CMS publication. **Applies to organizations offering demonstration and non-demonstration plans*
August 29-31, 2012	First CY 2013 Medicare Plan Finder (MPF) preview in HPMS. **Applies to organizations offering demonstration and non-demonstration plans*
September 2012	CMS begins accepting plan correction requests upon contract approval. **Applies to organizations offering demonstration and non-demonstration plans*
September 11-14, 2012	Second CY 2013 Medicare Plan Finder preview in HPMS. **Applies to organizations offering demonstration and non-demonstration plans*
September 16-30, 2012	CMS mails the CY 2013 *Medicare & You* handbook to Medicare beneficiaries. **Applies to organizations offering demonstration and non-demonstration plans*
September 17, 2012 (target date)	Roll-out of MA and Part D plan landscape documents, which include details (including high-level information about benefits and cost-sharing) about all available Medicare health and prescription drug plans for CY 2013.* **Applies to organizations offering demonstration and non-demonstration plans*
September 20, 2012 (target date)	Three-way contracts among selected plans, States, and CMS must be finalized and signed no later than this date.

Key Date	Action
October 1, 2012	For selected plans receiving passive enrollments of Medicare-Medicaid enrollees, notification of such enrollment and information about opt-out procedures must be sent to affected beneficiaries.
October 1, 2012	CY 2013 marketing activity begins.* **Applies to organizations offering demonstration and non-demonstration plans*
October 1, 2012	Tentative date for CY 2013 plan and drug benefit data to be displayed on Medicare Plan Finder.* **Applies to organizations offering demonstration and non-demonstration plans*
October 1, 2012	Deadline for demonstration plans to request a plan correction to the plan benefit package (PBP) via HPMS. **Applies to organizations offering demonstration and non-demonstration plans*
October 15 – December 7, 2012	MA and Part D Annual Coordinated Election Period.* **Applies to organizations offering demonstration and non-demonstration plans*
January 1, 2013	Enrollment effective date.* **Applies to organizations offering demonstration and non-demonstration plans*

Appendix 2: Model of Care Approval Criteria

Centers for Medicare & Medicaid Services

Capitated Financial Alignment Demonstration Plan Model of Care Approval

Process Scoring Criteria

for

Contract Year 2013

(March 29, 2012)

Description of the Scoring Criteria for Contract Year 2013

The Capitated Financial Alignment Demonstration plan model of care (MOC) approval process is based on scoring each of the eleven (11) clinical and non-clinical elements of the Medicare Advantage (MA) Special Needs Plan (SNP) MOC. The scoring methodology includes standards for each of the eleven (11) elements of the SNP MOC. The MOC includes the following clinical and non-clinical elements: (1) description of the target population; (2) measurable goals; (3) staff structure and care management roles; (4) interdisciplinary care team (ICT); (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 (HRA); (8) individual care plan; (9) communication network; (10) care management for the most vulnerable population; and (11) performance and health outcome measurement. MOCs should be designed using the eleven elements but also should be focused on meeting the clinical and non-clinical needs of the target population for defined by the State for the demonstration plan.

Summary of MOC Evaluation Criteria for Capitated Financial Alignment Demonstration Plan MOC 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 lacking depth.	Limited examples, less 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 plan-specific Target Population (based on target population of full duals as defined by the State)

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 both Medicare and Medicaid characteristics of the population.
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. No case study is provided as an example.
2	The response provides limited information on the description of the target population. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the target population. 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 organization 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 the organization 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 organization 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.

3b. Identify the specific employed or contracted staff to perform clinical functions (at a minimum: coordinate care management, provide clinical care, provide education)

4	The response provides a detailed and in depth description that identifies all staff performing clinical functions. The staff structure and roles includes at a minimum, specific details about personnel who coordinate care management, provide clinical care, and staff education. The personnel and the assigned role(s) are to be 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 clinical functions related to providing clinical care, coordinating care management and staff education. No case study is provided as an example.
2	The response provides limited information on the description of the staff performing clinical functions related to providing clinical care, coordinating care management and staff education. No examples are included with this description.
1	The response provides incomplete details or incorrect information on the description of the staff performing clinical functions related to providing clinical care, coordinating care management and staff education. 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.

4. Interdisciplinary Care Team (ICT)

The description must include at a minimum:

- How the organization 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 organization 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 organization 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 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 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 organization'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 organization determined that its network facilities and providers were actively licensed and competent

4	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 organization 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.
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 determining licensing and competency of the network facilities and providers. No case study is provided as an example.
2	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.
1	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.
0	No description/information provided.

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 organization 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 sent to organization's 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 organization 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 organization 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 organization 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 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 organization 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 organization 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 organization 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 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 organization 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, organization, 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, organization 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, organization and any other pertinent providers in the organization. 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, organization, 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 organization's 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 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 organization 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 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 organization 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 organization defines “vulnerable” for its enrollment 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 organization 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 organization 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 organization 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 organization 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 organization 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.