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# CMS Manual System

## Pub. 100-16 Medicare Managed Care

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Department of Health &  
Human Services (DHHS)  
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**SUBJECT: Chapter 5, Quality Improvement Program**

- I. SUMMARY OF CHANGES:** *Chapter 5 has been revised with new content and clarification of policy in the following areas: Introduction, Chronic Care Improvement (CCIP) and Quality Improvement Projects (QIP), additional QIP program requirements for Special Needs Plans, Structure & Process(S&P) Measures, MAO reporting requirements, MA deeming program, and definitions.*

**NEW/REVISED MATERIAL - EFFECTIVE DATE\*: August 8, 2014**

**IMPLEMENTATION: August 8, 2014**

*Disclaimer for manual changes only, There are no red italics indicating differences between the current version and the previous version.*

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)**

**(R = REVISED, N = NEW, D = DELETED)**

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	<i>The majority of the sections in this chapter have been revised and rearranged. Additionally there are several sections with new content.</i>

**III. FUNDING:** No additional funding is currently provided by CMS; contractor activities are to be carried out within their own FY and/or future operating budgets determined by the organizations.

**IV. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Notification</b>
	<b>One-Time Notification -Confidential</b>
	<b>Recurring Update Notification</b>

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

# Medicare Managed Care Manual

## Chapter 5 - Quality Improvement Program

(Rev.117, Issued: 08-08-14 )

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## 10 Introduction

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

In early 2010, the Centers for Medicare & Medicaid Services (CMS) developed a Quality Improvement Strategy for the Medicare Advantage (MA) and Prescription Drug Plan (PDP) Programs based on the 2001 Institute of Medicine (IOM) report. That strategy was expanded in 2011 to reflect the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care.

Based on the HHS strategy and the Affordable Care Act, HHS developed the National Quality Strategy (NQS) and the National Prevention Strategy (NPS) and CMS developed and released in June, 2012 its MA and PDP Quality Strategy, entitled "Medicare Advantage and Prescription Drug Plan Quality Strategy: A Framework for Improving Care for Beneficiaries." CMS' MA and PDP Quality Strategy was the culmination of a coordinated staff effort and leadership across CMS.

The MA and PDP Quality Strategy is expected to serve as a framework to advance CMS' continuous quality improvement efforts, establish a culture of improving quality of care and services in the MA and PDP programs and improve the quality of care for Medicare beneficiaries enrolled in those programs.

The MA and PDP Quality Strategy include a vision, mission, five core values, and six goals as outlined below. The vision is to ensure that Medicare beneficiaries enrolled in MAOs receive efficient, high quality care and services every time. The mission is to lead and develop the infrastructure, tools, and performance measures for MAOs to provide integrated coordinated care and the best services for every beneficiary across all plan types. The five core values are Robust, Consumer Friendly, Comparable, Comprehensive, and Transparent. These core values provide the necessary foundation in support of the MA and PDP Quality Strategy. Specific MA and PDP Quality Strategy goals are as follows:

1. Build Solid and Dedicated Medicare Leadership and Infrastructure;
2. Foster Communications and Partnerships Across All Levels of Government;
3. Lead the Health Care Industry in Providing Cutting Edge, Integrated Coordinated Care;
4. Monitor and Assess the Quality of Health Care Services;
5. Provide Incentives for Improving and/or Excelling on Quality Assessments; and,
6. Improve Beneficiaries' Ability to Use Quality Measures to Evaluate and Compare Health Plans and Services

The MA and PDP Quality Strategy's vision, mission, core values, and goals collectively drive the quality of healthcare and ongoing quality improvement initiatives for all plans.

All Medicare Advantage Organizations (MAOs) are required, as a condition of their contract with CMS, to develop a Quality Improvement program that is based on care coordination for enrollees. The MA and PDP Quality Strategy support that requirement by providing a framework for MAOs and PDPs as they work to improve care and patient health outcomes. The foundation of the MA and PDP Quality Strategy and the Quality Improvement program is improving care coordination and encouraging provision of health care using evidence-based clinical protocols.

The complete MA and PDP Quality Strategy report, as well as other pertinent MA quality-related documents, are available on the CMS MA Quality Web site located at: <http://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.html>. Please note that this Chapter does not address quality requirements for stand-alone PDPs. Guidance on standalone PDP quality requirements can be found in Chapter 7 of the Prescription Drug Manual at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter7.pdf>.

## **20 Medicare Quality Improvement Program**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

MAOs that offer one or more MA plans must have an ongoing Quality Improvement (QI) program for each of their plans. The purpose of a QI program is to ensure that MAOs have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the QI program are based in regulation at 42 CFR § 422.152. For each plan, an MAO must:

1. Develop and implement a chronic care improvement program (CCIP) 42 CFR §422.152(c);
2. Develop and implement a quality improvement project (QIP) 42 CFR §422.152(d);
3. Develop and maintain a health information system (42 CFR §422.152(f)(1));
4. Encourage providers to participate in CMS and HHS QI initiatives (42 CFR §422.152(a)(3));
5. Implement a program review process for formal evaluation of the impact and effectiveness of the QI Program at least annually (42 CFR §422.152(f)(2));
6. Correct all problems that come to its attention through internal surveillance, complaints or other mechanisms (42 CFR §422.152(f)(3));
7. Contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS<sup>®</sup>) vendor to conduct the Medicare CAHPS<sup>®</sup> satisfaction survey of Medicare enrollees (42 CFR §422.152(b)(5)); and,
8. Measure performance under the plan using standard measures required by CMS and report its performance to CMS (42 CFR §422.152(e)(i)).
9. Develop, compile, evaluate, and report certain measures and other information to CMS, its enrollees, and the general public. Responsible for safeguarding the confidentiality of the doctor-patient relationship and report to CMS in the manner required cost of operations, patterns of utilizations of services, and availability, accessibility, and acceptability of Medicare approved and covered services (42 CFR §422.516(a)).

All MAOs, as part of their application to offer new MA products or expand the service area of an existing product, must submit a written Quality Improvement Program Plan (QIPP). The QIPP outlines the elements of an MAO's QI Program and provides a framework for how a plan will execute each of the QI program requirements stipulated above. QIPPs are submitted to CMS as part of the contract and SNP application processes. QIPP templates are included in both the contract and SNP applications.

## **20.1 Chronic Care Improvement Program (CCIP) and Quality Improvement Projects (QIP)**

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42 CFR §422.152(c) – (d)

As required by regulation, each MAO must develop and implement a CCIP and QIP as part of its required QI Program. MAOs must conduct the same CCIP and QIP for all their non-SNP coordinated care plans offered under a specified contract, including employer group plans and Medical Savings Account plans (MSA) and Private Fee for Service (PFFS) plans that have contracted networks. MAOs must also implement a CCIP and QIP specific to each SNP plan offered, including when an MAO offers multiple SNPs of the same type under a contract. Only PFFS plans that do not have contracted networks, section 1833 and 1876 cost plans, and Program of All-Inclusive Care for the Elderly (PACE) plans are exempted from the CCIP and QIP requirements.

The quality improvement model adopted by CMS for the CCIP/QIPs is based on The Plan-Do-Study-Act (PDSA) quality improvement model. PDSA is an iterative, problem-solving model used for improving a process or carrying out change. The four steps of the PDSA cycle provide a systematic, step-by-step, ongoing approach for quality improvement initiatives. Components of the PDSA are as follows:

- Plan: Describes the processes, specifications, and output objectives used to establish the CCIP/QIP;
- Do: Describes the progress of the implementation and the data collection plan;
- Study: Describes the analysis of data to determine what impact the program has had on members.
- Act: Summarizes action plan(s) based on findings; describes, in particular, the differences between actual and anticipated results, and describes specific actions or steps taken or planned based on current results.

The MAO's first step in implementing a QIP or CCIP is submitting a complete, stand-alone "Plan" section of the PDSA model for approval by CMS. Once that Plan is approved and implemented, MAOs are required to submit Annual Updates that are comprised of the Do, Study, and Act components of the PDSA model to report on the ongoing operations of that approved Plan.

The Plans and Annual Updates for both CCIPs and QIPs are submitted to CMS through the "Quality and Performance" module of the Health Plan Management System (HPMS). CMS's

expectations regarding the information that is to be included in the Plan and Annual Update submittals are discussed in greater detail below.

MAOs have access to detailed information about the submission requirements for the CCIP and QIP Plan and Annual Updates. Detailed information can be found in the CCIP and QIP User Guides available within the HPMS Quality and Performance module.

### **20.1.1 Chronic Care Improvement Program (CCIP)**

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A CCIP is a clinically focused initiative designed to improve the health of a specific group of enrollees with chronic conditions. Beginning CY 2012, CMS required that each MA plan conduct, over a 5-year period, a CCIP focused on reducing and/or preventing cardiovascular disease.

#### **CCIP Plan Section Description**

The CCIP Plan section describes all aspects of the proposed CCIP initiative, including, but not limited to: the opportunity for improvement, target goal, what specific interventions will be introduced to achieve the identified goal, members targeted for receipt of the intervention(s), and the expected results. Please note that we expect SNPs to develop interventions that are tailored to their specific target population. While an organization may choose the same basic intervention(s) for its SNP and non-SNP plans, we expect the intervention(s) and overall approach to appropriately address the unique characteristics and needs of the targeted populations. Below is a general summary of the required components of the CCIP Plan.

- Basis for Selection - An overall description of the CCIP and rationale for selection that includes impact on the member, anticipated outcomes, and rationale for selection.
- Program Design - Outlines the process used to identify the target population, risk stratification, and enrollment method.
- Evidence-Based Medicine - Includes the clinical practice guidelines and standards of care to be employed.
- Care Coordination Approach - Describes the expected collaboration and communication among a multidisciplinary team that may include providers, MAO staff and the targeted member.
- Education - The method of education and the topics that will be addressed. Includes education directed to applicable providers and/or targeted members.
- Outcome Measures and Interventions - Setting objectives in measurable terms; identifying the appropriate data source(s) to measure; and the methodology used to analyze the data to determine whether the initiative impacted the health status of the targeted population.
- Communication Sources - Methods used to inform patients, physicians, and other providers on what is occurring in the CCIP and any changes necessary over time.

MAOs with contracts that were operational in CY 2012 were required to submit the Plan Section of the CCIP for the first time through HPMS in 2012. In subsequent years, newly operating MAO contracts and SNPs must submit the Plan section of the PDSA during the CMS-determined submission window in the fall of their first year of operation; the first Annual Update for those plans will be submitted the following year.

## CCIP Annual Update Section

The CCIP Annual Update is due during the CMS-determined submission window in the fall of the first year of implementation following approval of the CCIP Plan Section and annually thereafter, until program completion. The Annual Update should include the results or findings to date, based on the intervention(s); any barriers encountered during the update period; risk mitigation activities implemented to address barriers encountered; impact on the established goal or benchmark; and, next steps for the project. Below is a general summary of the components of the CCIP Annual Update.

- Educational components - Includes the actual method(s) of education and the topics that were covered. The education may be patient and/or provider focused.
- Intervention(s) - Specific actions/approaches implemented to achieve the stated goal.
- A description of barriers encountered, if applicable, and the specific actions taken to mitigate those barriers.
- Discussion of findings and analysis of results to date in relation to the established goal, benchmark, timeframe, total population, numerator, denominator, results and other data results. Identification of next steps based on internal evaluation and ongoing assessment of the CCIP, whether or not the goals were met, and any revisions to the intervention(s), methodology, goal, or other aspects of the initiative.
- Best Practices - Any identified approaches that are proven to be reliable and appear to contribute to the success of the CCIP.
- Lessons Learned - Description of pertinent knowledge gained through the CCIP experience.

### 20.1.2 Quality Improvement Project (QIP)

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

QIPs are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. Beginning CY 2012, each MAO is required to conduct, over a 3-year period, a QIP focused on reducing 30-day all cause hospital readmission rates.

#### QIP Plan Section Description

The QIP Plan section describes all aspects of the proposed QIP initiative, including, but not limited to: the opportunity for improvement, target goal, what specific interventions will be introduced to achieve the identified goal, members targeted for receipt of the intervention(s), and the expected results. Please note that we expect SNPs to develop interventions that are tailored to their specific target population. While an organization may choose the same basic intervention(s) for its SNP and non-SNP plans, we expect the intervention(s) and overall approach to appropriately address the unique characteristics and needs of the targeted populations. Below is a general summary of the required components of the QIP Plan.

- Basis for Selection – An overall description of the QIP and rationale for selection that includes impact on the member, anticipated outcomes, and rationale for selection. (Note: The QIP Plan Section specific to a SNP may include, if applicable, any Model of Care



elements which form the basis for the QIP, e.g., the Individualized Care Plan, the Interdisciplinary Care Team, etc.)

- Program Design – An outline of the process used to identify the target population, risk stratification, and enrollment method.
- Prior Focus – A description of any previous attempts to address the problem that the QIP will be addressing. This includes intervention-specific information about the previous attempt(s), including any outcomes achieved.
- Examination of any anticipated barriers and the potential impact on the success of the QIP.
- Outcome Measures and Interventions - Setting objectives in measurable terms; identifying the appropriate data source(s) to measure; and the methodology used to analyze the data to determine whether/how the initiative affected the health status of the targeted population.

## QIP Annual Update Section Description

The QIP Annual Update is due during the CMS-determined submission window in the fall of the first year of implementation following approval of the QIP Plan Section, and annually thereafter, until project completion. The Annual Update should include the results or findings to date, based on the intervention(s); any barriers encountered during the update period; risk mitigation activities implemented to address barriers encountered; the impact on the established goal or benchmark, and next steps for the project. Below is a general summary of the components of the QIP Annual Update.

- Intervention(s) - Specific actions/approaches implemented to achieve the stated goal.
- A description of Barriers encountered, if applicable, and the specific actions taken to mitigate those barriers.
- Discussion of findings and analysis of results to date in relation to the established goal, benchmark, timeframe, total population, numerator, denominator, results and other data results. Identification of Next Steps based on internal evaluation and ongoing assessment of the QIP, whether or not the goals were met, and any revisions to the intervention(s), methodology, goal, or other aspects of the initiative.
- Best Practices - Any identified approaches that are proven to be reliable and appear to contribute to the success of the QIP.
- Lessons Learned - Description of pertinent knowledge gained through the QIP experience.

## 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs)

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

Section 1856(f)(7) of the Patient Protection and Affordable Care Act stipulates that all MAO's offering Special Needs Plans (SNPs) must submit an evidence-based Model of Care (MOC) to CMS for NCQA evaluation and approval in accordance with CMS guidance. As provided at 42 CFR §422.101(f) and §422.152(g), SNPs must develop and implement a MOC that provides the structure for care management processes and systems that will enable the health plan to provide

coordinated care for special needs individuals. An MAO must develop separate MOCs to meet the needs of the targeted population for each SNP type it offers.

All SNPs must submit the MOC Matrix Upload Document, as well as the MOC narrative, in HPMS during the MA/SNP application timeframe. Refer to Section 40.1 and 40.2 of Chapter 16b of the Medicare Managed Care Manual titled, “Special Needs Plans” for additional information regarding the application and MOC approval requirements. The MOC was re-organized and revised to promote clarity and enhance the focus on care coordination, care transition, care needs and activities. All SNPs that must submit a MOC will be required to use the revised MOC structure for the first time as part of the CY 2015 application cycle. The MOC narrative must include the following four elements:

1. Description of the SNP Population;
2. Care Coordination;
3. SNP Provider Network; and
4. MOC Quality Measurement & Performance Improvement

Section 20.2.2 below provides a detailed description of each of these elements.

## **20.2.1 Model of Care Elements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

### **1. Description of the SNP Population:**

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. It must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations, if relevant to the target population served by the SNP. The description of the SNP population must include, but not be limited to, the following:

- Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.
- A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan’s geographic service area.
- Identification and description of the health conditions impacting SNP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).
- Define unique characteristics for the SNP population served:
  - C-SNP: What are the unique chronic care needs for beneficiaries enrolled in a C-SNP? Include limitations and barriers that pose potential challenges for these C-SNP beneficiaries.

- D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.
- I-SNP: What are the unique health needs for beneficiaries enrolled in an I-SNP? Include limitations and barriers that pose potential challenges for these I-SNP beneficiaries as well as information about the facilities and/or home and community-based services in which your beneficiaries reside.

### **A. Sub-Population: Most Vulnerable Beneficiaries**

As a SNP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, “medication spending above \$4,000”). Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

- A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.
- A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.
- The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).

### **2. Care Coordination:**

Care coordination helps ensure that SNP beneficiaries’ healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP’s provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries’ caregiver(s). The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNPs’ care coordination activities.

#### **A. SNP Staff Structure**

- Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:

- Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.
- Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.
- Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.
- Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP.
- Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions.
- Describe how the SNP conducts initial and annual MOC training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.
- Describe how the SNP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records.
- Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MOC training has not been completed or has been found to be deficient in some way.

## **B. Health Risk Assessment Tool (HRAT)**

The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MOC include the following:

- A clear and detailed description of the policies and procedures for completing the HRAT including:
  - Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MOC Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MOC Element 2D).
  - Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.
  - Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiaries and/or

their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary's plan of care. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.

### **C. Individualized Care Plan (ICP)**

- The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiaries' caregiver(s); and identification of goals met or not met.
  - When the beneficiary's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.
- Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary's ICP.
- Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).
- Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders as necessary.

### **D. Interdisciplinary Care Team (ICT)**

- Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.
  - Explain how the SNP facilitates the participation of beneficiaries and their caregivers as members of the ICT.
  - Describe how the beneficiary's HRAT (MOC Element 2B) and ICP (MOC Element 2C) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual beneficiary.
  - Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs on a continuous basis.

- Identify and explain the use of clinical managers, case managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.
- Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following:
  - Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.
  - The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.
  - How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.

## **E. Care Transitions Protocols**

- Explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).
- Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.
- Explain how the SNP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.
- Describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries' personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.
- Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.
- Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.

## **3. SNP Provider Network:**

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP beneficiaries. Each SNP is responsible for ensuring their MOC identifies, fully describes, and implements the following for its SNP Provider Network:

### **A. Specialized Expertise**

- Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MOC Element 1.

- Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.
- Describe how providers collaborate with the ICT (MOC Element 2D) and the beneficiary, contribute to the ICP (MOC Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

## **B. Use of Clinical Practice Guidelines & Care Transitions Protocols**

- Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.
- Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the ICT (MOC Element 2D) and acted upon.
- Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MOC Element 2E.

## **C. MOC Training for the Provider Network**

- Explain, in detail, how the SNP conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' Web site.
- Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MOC training.
- Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP Plan will take when the required MOC training has not been completed or is found to be deficient in some way.

## **MOC Quality Measurement & Performance Improvement:**

The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts

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

### **A. MOC Quality Performance Improvement Plan**

- Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:
  - The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MOC by using specified data sources, performance and outcome measures.
  - Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process.
  - Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B).

### **B. Measureable Goals & Health Outcomes for the MOC**

- Identify and clearly define the SNP's measureable goals and health outcomes and describe how identified measureable goals and health outcomes are communicated throughout the SNP organization. Responses should include but not be limited to, the following:
  - Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC Element 1.
  - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.
  - Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.
  - Ensuring appropriate utilization of services for preventive health and chronic conditions.
- Identify the specific beneficiary health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used.
- Describe, in detail, how the SNP establishes methods to assess and track the MOC's impact on the SNP beneficiaries' health outcomes.
- Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.
- Explain the specific steps the SNP will take if goals are not met in the expected time frame.

### **C. Measuring Patient Experience of Care (SNP Member Satisfaction)**



- Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP beneficiary satisfaction.
- Explain how the results of SNP member satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.

## **D. Ongoing Performance Improvement Evaluation of the MOC**

- Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated.
- Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process.
- Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

## **E. Dissemination of SNP Quality Performance related to the MOC**

- Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.
- This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad hoc communication with the various stakeholders, such as: a webpage for announcements; printed newsletters; bulletins; and other announcement mechanisms.

Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A.

### **20.2.2 Model of Care Scoring Criteria**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

The NCQA scoring approval process is based on scoring each of the clinical and non-clinical elements of the MOC as part of the SNP application. The scoring guidelines were revised to align with the new MOC structure to be utilized starting with the CY 2015 application cycle and are modeled after the Structure & Process Measures format. The revised scoring guidelines complement the new MOC structure and help SNPs better understand and meet the requirements of the revised MOC element structure.

### **MOC 1: Description of SNP Population (General Population)**

Identification and a comprehensive description of the SNP-specific population are integral components of the MOC. All elements in this standard depend on a complete population

description that addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations (if relevant).

SNPs must include a complete description of specially tailored services for beneficiaries considered especially vulnerable (refer to Element 1B), using specific terms and details (e.g., members with multiple hospital admissions within three months, “medication spending above \$4,000”).

**Element A: Description of Overall SNP Population**

**The organization’s MOC description of its target SNP population must:**

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

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

**Explanation    Element Target population characteristics**

The organization’s description of its target population is an integral component of the MOC narrative that provides a fundamental foundation on which the other elements build to develop a comprehensive program that fully addresses the continuum of care for its beneficiaries.

The organization’s MOC must show how it identifies its members and must describe the target population that includes specific information on the characteristics of the population it intends to serve. This information must include specific components that characterize its beneficiaries, such as average age, gender and ethnicity profiles, the incidence and prevalence of major diseases, chronic conditions and other significant barriers faced by the target population.

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

**Factor 1: Determine, verify and track eligibility**

The organization must have a process for identifying, verifying and tracking SNP beneficiaries to ensure eligibility for appropriate care coordination

services. The MOC description must include information on the relevant resources (systems or data collection methodology) used to perform these tasks.

### **Factors 2, 3: Identify health conditions**

The MOC description includes specific information on the current health status of its SNP beneficiaries and characteristics that may impact their status. Factor 2 should include descriptions of the demographic, social and environmental factors, and living conditions associated with the SNP population such as average age, gender, ethnicity and potential health disparities associated with certain groups, such as language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs or barriers that may interfere with conventional provision of health care or services, caregiver considerations or other concerns. Factor 3 should identify and describe the medical and cognitive factors, co-morbidities and other health conditions that affect SNP beneficiaries.

### **Factor 4: Define unique characteristics of the SNP population (plan type)**

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

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

## Element B: Subpopulation—Most Vulnerable Beneficiaries

The organization must have a complete description of the specially tailored services it provides to its most vulnerable members that:

1. Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries.
2. Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries.
3. Illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.
4. Identifies and describes established relationships with partners in the community to provide needed resources.

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

### Explanation **Factor 1: Define most vulnerable beneficiaries**

Although the definition of “SNP beneficiary” typically implies members requiring additional care and services, the description focuses on the sickest or most vulnerable SNP members.

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

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

### **Factors 2 & 3: Correlation between demographic characteristics and clinical requirements**

The organization's MOC definition of its most vulnerable beneficiaries must describe the demographic characteristics of this population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factors) and specify how these characteristics combine to adversely affect health status and outcomes and affect the need for unique clinical interventions.

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

### **Factor 4: Establish relationships with community partners**

The organization's MOC must describe its process for partnering with providers within the community to deliver needed services to its most vulnerable members, including the type of specialized resources and services provided and how the organization works with its partners to facilitate member or caregiver access and maintain continuity of services.

## **MOC 2: Care Coordination**

Care coordination helps ensure that SNP beneficiaries' health care needs, preferences for health services and information sharing across health care staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, high-quality patient services (including services furnished outside the SNP's provider network) that ultimately lead to improved health care outcomes.

The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. Taken together, all five sub-elements must address the SNP's care coordination activities comprehensively.

### **Element A: SNP Staff Structure**

**The organization's MOC must:**

- 1. Describe the administrative staff's roles and responsibilities, including oversight functions.**
- 2. Describe the clinical staff's roles and responsibilities, including oversight functions.**
- 3. Describe how staff responsibilities coordinate with the job title.**
- 4. Describe contingency plans used to address ongoing continuity of critical staff functions.**
- 5. Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.**

6. Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.
7. Describe actions the organization takes if staff do not complete the required MOC training.

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

**Explanation**

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

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

The organization’s MOC must identify and describe the specific employed and contracted staff responsible for performing administrative functions, including:

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

**Factor 2: Clinical staff roles and responsibilities**

The organization must identify and describe the employed and contracted staff that perform clinical functions, including:

- Direct beneficiary care and education on self-management techniques.
- Care coordination.
- Pharmacy consultation.
- Behavioral health counseling.
- Clinical oversight.

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

**Factor 3: Coordination of responsibilities and job title**

To show how staff responsibilities identified in the MOC are coordinated with job title, the organization must provide a copy of its organization chart and, if applicable, a description of instances when a change to staff title/position or

level of accountability is required to accommodate operational changes in the SNP.

**Factor 4: Contingency plan**

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

**Factors 5, 6: Initial and annual MOC training; maintaining training records**

The organization must conduct initial and annual MOC training for its employed and contracted staff. The MOC must describe the training strategies and content, as well as the methodology the organization uses to document and maintain training records as evidence that staff have completed MOC training. Contracted staff does not include physicians or other providers that the organization contracts with as part of the provider network.

The description must include types of trainings and specific examples of slides or training materials. If the training plan is not currently operational, the organization's MOC must provide a description of the plan's contents.

**Factor 7: Actions if training is not completed**

The organization's MOC must explain challenges associated with employed and contracted staff completing training and must describe actions the organization will take when the required MOC training has not been completed or has been found to be deficient.

**Element B: Health Risk Assessment Tool (HRAT)**

The organization's MOC includes a clear and detailed description of the policies and procedures for completing the HRAT that addresses:

1. How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary (Element 2C).
2. How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information (Element 2D).
3. How the organization conducts the initial HRAT and annual reassessment for each beneficiary.
4. The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

**Scoring**

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

**Explanation**

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

**Factors 1&2: Use and dissemination of HRAT information**

The organization must include a description of how the HRAT is used to develop and update, in a timely manner, the ICP for each beneficiary and how the HRAT information is disseminated to and used by the ICT.

**Factor 3: Initial HRA and annual reassessment**

The organization must complete the HRAT for each beneficiary, for initial assessment, and must complete an HRAT annually thereafter. At minimum, the organization must conduct initial assessment within 90 days of enrollment and must conduct annual reassessment within one year of the initial assessment.

The description must include the methodology used to coordinate the initial and annual HRAT for each beneficiary (e.g., mailed questionnaire, in-person assessment, phone interview) and the timing of the assessments. There must be a provision to reassess beneficiaries, if warranted by a health status change or care transition (e.g., hospitalization, change in medication, multiple falls). The organization must describe its process for attempting to contact beneficiaries and have them complete the HRAT, including provisions for beneficiaries that cannot or do not want to be contacted or complete the HRAT.

**Factor 4: Plan and rationale**

The organization's MOC must describe its plan and explain its rationale for reviewing, analyzing and stratifying HRAT results. It must include the mechanisms for communicating information to the ICT, provider network, beneficiaries and/or their caregiver(s) and other SNP personnel who may be involved with overseeing a beneficiary's plan of care. If the organization uses stratified results, the MOC must explain how the SNP uses the results to improve the care coordination process.



## Element C: Individualized Care Plan (ICP)

The description of the organization's ICP must include:

1. The essential components of the ICP.
2. The process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change.
3. The personnel responsible for development of the ICP, including how the beneficiary and/or caregiver(s) are involved.
4. How the ICP is documented, updated and where it is maintained.
5. How updates and modifications to the ICP are communicated to the beneficiary and other stakeholders.

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

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

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

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

### **Factors 2, 3: ICP development process and personnel**

The organization's MOC must describe the process for developing the ICP and must detail the personnel responsible for developing the ICP. The description of responsible staff must include roles and functions, professional requirements and credentials necessary to perform these tasks, as well as how the beneficiary or their caregiver/ representative is involved in the ICP development. The MOC must also include a description of how the organization determines how often to review and modify, as appropriate, the ICP as the beneficiary's health care needs change.

**Factor 4: ICP documentation and maintenance**

The organization’s MOC must describe how the ICP is documented and updated and where the documentation is maintained so it is accessible to the ICT, provider network and beneficiaries and/or their caregiver(s).

**Factor 5: Updates and modifications**

The organization’s MOC must describe how the organization communicates ICP updates and modifications to beneficiaries and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders, as necessary.

**Element D: Interdisciplinary Care Team (ICT)**

The organization’s MOC must describe the critical components of the ICT, including:

1. How the organization determines the composition of ICT membership.
2. How the roles and responsibilities of the ICT members (including beneficiaries and/or caregiver[s]) contribute to the development and implementation of an effective interdisciplinary care process.
3. How ICT members contribute to improving the health status of SNP beneficiaries.
4. How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.

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

**Explanation Factor 1: ICT membership**

The organization’s MOC must describe the composition of the ICT, including how the SNP determines ICT membership and the roles and responsibilities of each member. The description must specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries.

The organization must:

- Explain how the SNP facilitates the participation of beneficiaries and their caregiver(s) as members of the ICT.
- Describe how the beneficiary’s HRAT and ICP are used to determine the composition of the ICT; including where additional team members are needed to meet the unique needs of a beneficiary.

- Explain how the ICT uses health care outcomes to evaluate processes established to manage changes or adjustments to the beneficiary's health care needs on a continuous basis.

### **Factors 2 and 3: ICT member roles and responsibilities**

The organization's MOC must describe how it uses clinical managers, case managers and others who play critical roles in providing an effective interdisciplinary care process; and how beneficiaries and/or their caregiver(s) are included in the process, are provided with needed resources and how the organization facilitates access for beneficiaries to ICT team members.

### **Factor 4: Communication plan**

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

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

## **Element E: Care Transition Protocols**

The organization's MOC describes the following care transition protocols:

- 1. How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.**
- 2. The personnel responsible for coordinating the care transition process.**
- 3. How the organization transfers elements of the beneficiary's ICP between health care settings when the beneficiary experiences an applicable transition in care.**
- 4. How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.**
- 5. How beneficiary and/or caregiver(s) will be educated about the beneficiary's health status to foster appropriate self-management activities.**
- 6. How the beneficiary and/or caregiver(s) are informed about the point of contact throughout the transition process.**

## Scoring

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

## Explanation

### Definitions

- **Health care setting:** The provider from whom or setting where a member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for a member's medical care.
  - Settings include home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility and outpatient/ambulatory care/surgery centers.
- **Transition:** Movement of a member from one care setting to another as the member's health status changes.
  - For example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- **Transition process:** The period from identification of a member who is at risk for a care transition through completion of a transition.
  - This process includes planning and preparation for transitions and the follow-up care after transitions are completed.

### Factor 1: Continuity of care

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

### Factor 2: Care transition personnel

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

### Factor 3: Applicable transitions

The organization must ensure that elements of the beneficiary's ICP are transferred between health care settings when the beneficiary experiences a transition in care. The MOC must describe the steps that take place before, during and after a transition in care has occurred for this process.

#### **Factor 4: Beneficiary Personal Health Information**

Beneficiaries and/or their caregiver(s) need access to beneficiaries' personal health information in order to communicate about care with healthcare providers in other healthcare settings and/or health specialists outside their primary care network. The organization must describe the process for ensuring that SNP beneficiaries and/or their caregiver(s) have access to and can adequately use personal health information to coordinate care for the beneficiary.

#### **Factor 5: Self-management activities**

The MOC must describe how beneficiaries and/or their caregiver(s) will be educated about their condition, how they will demonstrate understanding of changes in their condition (improvement, stable or worsening), and use of appropriate self-management activities. For example, they should be educated about signs and symptoms signaling a change in their condition and how to respond to such changes. Self-management activities can include regular assessment of progress, goal setting and problem solving support to reduce crises and improve health outcomes.

#### **Factor 6: Notification of point of contact**

The organization must describe the process it uses to notify beneficiaries and/or their caregiver(s) of the personnel responsible for supporting them through transitions between any two care settings.

### **MOC 3: Provider Network**

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes and implements the following elements for their SNP provider networks.

#### **Element A: Specialized Expertise**

**The organization must establish a provider network with specialized expertise that describes the following components of the network:**

- 1. How providers with specialized expertise correspond to the target population identified in MOC 1.**
- 2. How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.**
- 3. How the SNP documents, updates and maintains accurate provider information.**
- 4. How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.**

	<b>100%</b>	<b>80%</b>	<b>50%</b>	<b>20%</b>	<b>0%</b>
<b>Scoring</b>	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

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

**Factor 1: Specialized network**

The provider network’s specialized expertise may include, but is not limited to, internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists and other specialists that address the needs of the SNP’s target population identified in MOC 1.

**Factors 2 and 3: Licensure and certification**

The organization must describe how it determines that its providers have active licenses and are competent to provide specialized health care services to SNP beneficiaries (e.g., confirmation of applicable board certification), The MOC should describe how it maintains current information on providers to maintain an accurate provider network directory.

**Factor 4: Collaboration with the ICT/ICP**

The MOC must describe how providers in the network collaborate with members of the ICT and help contribute to each beneficiary’s ICP, including how providers either deliver or coordinate care, particularly specialized services. The MOC must describe how providers communicate beneficiary care needs to the ICT and to other stakeholders or providers, how the organization shares information (e.g., as reports on services) with the ICT and how providers incorporate relevant clinical information into beneficiaries’ ICPs.

**Element B: Use of Clinical Practice Guidelines and Care Transition Protocols**

The organization must oversee how network providers use evidence-based medicine, when appropriate, by:

- 1. Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP’s target population.**
- 2. Identifying challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries.**

3. **Providing details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT.**
4. **Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.**

Scoring	<b>100%</b>	<b>80%</b>	<b>50%</b>	<b>20%</b>	<b>0%</b>
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

**Explanation**

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

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

**Factors 2 and 3: Exceptions to guidelines**

Certain clinical practice guidelines and protocols may not always be appropriate for some patients with complex health care needs. In these cases, the organization must identify challenges to using clinical practice guidelines and nationally recognized protocols for certain beneficiaries with complex healthcare needs and detail how the decision to modify or ignore such guidelines is made, incorporated into the patient’s ICP, communicated with the ICT and acted on by the patient’s ICT or by other providers.

**Factor 4: Care transition protocols**

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

## Element C: MOC Training for the Provider Network

The organization's description of oversight of provider network training on the MOC must include:

1. Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.
2. Documenting evidence that the organization makes available and offers training on the MOC to network providers.
3. Explaining challenges associated with the completion of MOC training for network providers.
4. Taking action when the required MOC training is deficient or has not been completed.

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

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

The MOC must describe how the organization provides initial and annual training for network providers and any out-of-network providers seen by beneficiaries on a routine basis; and must describe the process for annual training for current providers, including how training is conducted (e.g., in-person meetings, computer-based training), how often training occurs, training materials and examples of training content.

### **Factor 2: Evidence of training**

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

### **Factors 3 and 4: Deficient or incomplete training**

The MOC must describe specific actions taken by the organization if providers do not receive the required training and must explain challenges (e.g., geographically distant network, very large number of providers in network) associated with completion of the MOC trainings for network providers. The MOC may also describe actions the organization takes to offer incentives or



other best practices to encourage provider training participation and compliance.

## **MOC 4: MOC Quality Measurement and Performance Improvement**

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

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

### **Element A: MOC Quality Performance Improvement Plan**

The organization must develop a MOC quality performance improvement plan that:

- 1. Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.**
- 2. Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance.**
- 3. Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.**
- 4. Describes how SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B.**

**Scoring**

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

**Explanation****Definition**

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

**Factors 1–4**

The organization’s MOC must describe how the quality performance improvement plan specific to the MOC, is designed to detect whether the overall MOC structure effectively accommodates beneficiaries’ unique health care needs.

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

The MOC must provide details about how the key personnel listed in factor 3 are involved in internal quality performance processes. It should provide information about which personnel are involved, their role in analyzing quality performance information and the decision-making authority given to such personnel.

The organization must specify data used for analyses, and must identify clear measures to determine if stated goals or outcomes are achieved. Measures must have a benchmark or goal, specify time frames for achieving outcomes and state a plan for re-measurement if the goal is not achieved.

## Element B: Measureable Goals and Health Outcomes for the MOC

**The organization must identify and clearly define measureable goals and health outcomes for the MOC and:**

- 1. Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.**
- 2. Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level.**

3. Describe how the SNP establishes methods to assess and track the MOC’s impact on SNP beneficiaries’ health outcomes.
4. Describe the processes and procedures the SNP will use to determine if health outcome goals are met.
5. Describe the steps the SNP will take if goals are not met in the expected time frame.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

**Explanation**

**Factor 1**

A description of measurable goals must include benchmarks, specific time frames and how achieving goals will be determined. Responses should include, but not be limited to:

- Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC 1.
- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT.
- Enhanced care transitions across all health care settings and providers for SNP beneficiaries.
- Ensuring appropriate utilization of services for preventive health and chronic conditions.

**Factor 2**

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

**Factors 3&4**

The MOC must describe the methods the organization uses to assess and track how its overall quality program, including the goals and specific measures it uses, affect the health outcomes of its beneficiaries. This may include the data collected, how it is collected and analyzed and how often it is collected and analyzed.

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

**Factor 5**

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

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

The organization's MOC must address the process of measuring SNP member satisfaction by:

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

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

### Explanation Factors 1–4

The MOC must describe the types of surveys used to assess SNP member experience, the rationale for the use of a specific tool and how results are integrated into the overall performance improvement plan.

Member feedback can include information about the overall SNP program or program staff (e.g., ICT or case managers), the usefulness of the information disseminated by the organization and the member's ability to adhere to recommendations.

Methodology. The organization must describe how it receives feedback from a broad sample of members, not only those who contact the organization to share feedback. Member feedback may be obtained by conducting focus groups or through member experience surveys. The organization must describe how it analyzes feedback to identify and address issues. Feedback must be specific to the experience with the SNP overall programs being evaluated.

The organization must be able to describe the methodology it uses to collect patient experience surveys, including the sample size used.

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

The organization's MOC description must describe:

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

Scoring

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

### Explanation Factors 1–4

The organization must provide a written description of the ongoing performance improvement evaluation of its MOC. This process must describe how the organization will use the results to assess and evaluate its quality performance indicators on a continual basis, including how the organization improves its ongoing performance by incorporating lessons learned. Lessons learned must be documented and communicated with key stakeholders.

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

The organization must address the process for communicating its quality improvement performance by:

1. Describing how performance results and other pertinent information are shared with multiple stakeholders.
2. Stating the scheduled frequency of communications with stakeholders.
3. Describing the methods for ad hoc communication with stakeholders.
4. Identifying the individuals responsible for communicating performance updates in a timely manner.

**Scoring**

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

**Explanation Factors 1–4**

The organization describes how quality performance results are routinely shared with stakeholders, and specifies the frequency of these communications and how ad hoc and other unplanned communications are disseminated.

The organization’s plan to disseminate information must include individuals responsible for providing communication (as described in MOC 2, Element A). The MOC must describe methods for communication (regular and ad hoc) with stakeholders and time frame for communication with stakeholders, who may include, but are not limited to:

- SNP leadership.
- SNP management groups.
- SNP boards of directors.
- SNP personnel and staff.
- SNP provider networks.
- SNP beneficiaries and caregiver(s).
- The general public.
- Regulatory agencies.

**20.2.3 Special Needs Plans Health Risk Assessment Tool (HRAT)**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

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

Note that CMS requires SNPs to conduct a comprehensive HRA within 90 days of the effective date of enrollment of each beneficiary, and a re-assessment at least every 365 days in accordance with established timeframes for reporting purposes. A detailed description of the process for conducting the HRAs must be included as part of MOC Element 2 (Care Coordination) Element B (HRA Tool) in Section 20.2.1 of this chapter. This description must include when and how the initial HRA and annual reassessments

are conducted for each beneficiary, e.g., conducted by phone interview, face-to-face, or written form completed by the beneficiary and/or caregiver. Direct beneficiary and/or caregiver input is necessary and expected in order to assess the individual's perception of his/her health status and health care needs. Information obtained via the HRAT, in addition to objective assessments subsequently performed by qualified providers, contribute to the effective development and continuous update of the enrollee's individualized care plan.

Timely completion of HRAs is a Part C reporting requirement and, for the first time, in CY 2015, will be incorporated as part of the CMS Five-Star Quality rating system. Please note that only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. This means, for example, that HRAs completed only using claims and/or other administrative data, would not be acceptable. For details regarding the HRA reporting timeframes and deadlines, please see the current Medicare Part C Plan Reporting Requirements Technical Specifications document at: <http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html>.

#### **20.2.4 Structure & Process (S&P) Measures**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

In 2007, CMS contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by SNPs. That strategy resulted in development of a tool to collect information that is meant to provide CMS with a better understanding of how SNPs perform on a set of standardized national performance measures that assess internal SNP processes and operations that affect the enrolled Medicare beneficiaries' quality of care (see Section 30.1 of this chapter for information regarding SNP-specific HEDIS measures). S&P measures address the SNP structures, systems and processes in place to address quality of care in the following 6 areas:

1. Care Management;
2. Improving member satisfaction;
3. Clinical quality improvements;
4. Care transitions;
5. I-SNP relationships with facility; and
6. Coordination of Medicare and Medicaid coverage.

The S&P measures rely on a review of plan policies and procedures, data reports, prepared materials and other documentation the plans use to implement their programs, analyze internal data, document processes and convey information to members and practitioners.

NCQA collects S&P measure data from SNPs annually and provides an overview of performance results in a report submitted to CMS. For additional information regarding

S&P measures, please see the NCQA Web site at:  
<http://www.ncqa.org/Programs/OtherPrograms/SpecialNeedsPlans.aspx>.

## **30 Standard MAO Reporting Requirements for HEDIS®, HOS, and CAHPS®**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §417.106(a)(3)

42 CFR §417.418

42 CFR §422.152(b)(5)

42 CFR §422.152(e)(i)

42 CFR §422.516

### **General**

This section provides information regarding the annual Medicare HEDIS®, HOS, and CAHPS® reporting requirements. Performance measures that are derived largely from MA plan and beneficiary information form the basis of the CMS Star Ratings used to assess the quality of MA plans. Additional information regarding the Star Ratings may be found at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>. In addition, CMS makes summary, contract-level performance measures available to the public through media that are beneficiary-oriented including the Medicare Plan Finder tool at <http://www.medicare.gov>.

### **30.1 HEDIS® Reporting Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

HEDIS® is a trademark product of NCQA. All Medicare Advantage plans must submit audited summary-level HEDIS® data to NCQA, and this includes cost contracts with closed enrollment. Patient-level data must be reported to the CMS designated patient-level data contractor. Information about HEDIS® reporting requirements is posted in HPMS. During the contract year, if an HPMS contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS® data for all members of the contracts involved. If a contract status is listed as a conversion in the data year, the contract must report if the new organization type is required to report.

CMS collects audited data from all benefit packages designated as SNPs and contracts with ESRD Demonstration Plans that had 30 or more members enrolled as reported in the SNP Comprehensive Report (which can be found at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp#TopOfPage>).

The data collection methodologies for HEDIS® are either the administrative or hybrid types. The administrative method is from transactional data for the eligible populations and the hybrid method is from medical record or electronic medical record and



transactional data for the sample.

MAOs new to HEDIS® must become familiar with the requirements for data submissions to NCQA, and make the necessary arrangements as soon as possible. The organization should work with an NCQA Licensed Organization ([www.ncqa.org/audit.aspx](http://www.ncqa.org/audit.aspx)), to arrange for a HEDIS® Audit and is responsible for determining fees and entering into contracts. HEDIS® Compliance Audits result in audited rates or calculations at the measure level and indicate if the HEDIS® measures can be publicly reported. All HEDIS® measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each HEDIS® measure and survey included in the audit. For HEDIS® measures, the auditor approves the rate of report status of each measure and survey included in the audit as follows:

- A rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- Small Denominator (NA). The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
- Benefit Not Offered (NB). The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
- Not Reportable (NR). The organization calculated the measure but the rate was materially biased, or the organization chose not to report the measure or was not required to report the measure.

Following are requirements for MAOs with special circumstances:

1. MAOs with Multiple Contract Types - An MAO cannot combine small contracts of different types, e.g., risk and cost, into a larger reporting unit.
2. MAOs with contract conversions: For HEDIS® measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (within the same organization), enrollment time under the prior contract will not be counted.
3. MAOs with New Members “Aging-in” from their Commercial Product Line – These MAOs must consider “aging in” members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members who switch from an MAO’s commercial product line to the MAO’s Medicare product line are considered continuously enrolled. Please read the General Guidelines of HEDIS® Volume 2: Technical Specifications for a discussion of “age-ins” (see “Members who switch product lines”) and continuous enrollment requirements.
4. MAOs with Changes in Service Areas - MAOs that received approval for a service area expansion during the previous year and those that will be reducing

- their service area effective January 1 of the next contract and reporting year must include information regarding those beneficiaries in the expanded or reduced areas based on the continuous enrollment requirement and Utilization of the particular measure being reported.
5. HMOs with Home and Host Plans - The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with CMS. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MAO's visitor plan and the home plan are considered continuously enrolled in the plan.
  6. New Contracts - MAOs whose effective date is January 1st of the measurement year will not report HEDIS® performance measures for the corresponding reporting year.
  7. Non-renewing/Terminating MAOs - Entities that meet the HEDIS® reporting requirements but which have terminated contracts effective January 1st of the reporting year will not be required to submit a HEDIS® report or participate in the Medicare CAHPS® or Medicare HOS surveys.
  8. MAOs with Continuing Section 1876 Cost Contracts - For cost contracts, CMS has modified the list of HEDIS® measures to be reported. Cost contractors will not report the inpatient Utilization measures. The measures to be reported are listed on Exhibit I.A. CMS does not require cost contractors to report inpatient (e.g., hospitals, skilled nursing facilities (SNFs)) measures because MAOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from the MAO. Thus, CMS and the public would not know to what degree the data for these measures are complete.
  10. Section 1876 Cost Contracts: Cost contracts will provide patient-level data for all the HEDIS® Effectiveness of Care and the Utilization measures for which they submit summary level data.
  11. Mergers and Acquisitions – An entity that acquires and is novating an existing Medicare contract must file a HEDIS® report since the membership, benefits and medical delivery system are essentially unchanged. Therefore, during negotiations for the acquisition it is essential that parties agree on a method of data exchange that will permit the acquiring organization to file a HEDIS® report covering the measurement year in which the transaction occurred. If the Health Plan Management System (HPMS) contract status is listed as a consolidation, a merger, or a novation during the measurement year, the surviving contract must report HEDIS® data for all members of the contracts involved. If a contract status is listed as a conversion in the measurement year, the contract must report if

their new organization type is required to report.

CMS annually provides guidance in the month of August for the upcoming reporting year. This information is in an annually-issued HPMS memorandum from CMS, entitled “Updated Requirements for Reporting of HEDIS®, HOS, and CAHPS® Measures.” All MA contracts by their specific organization type, are listed, that are required to report HEDIS®. There is no minimum enrollment requirement for submitting MA HEDIS®. The HPMS Memorandum provides information about required HEDIS® measures for reporting, changes in the data specifications, data submission schedule and deadlines, and instructions about data submission. **All MA contracts shall use the annual guidance in the CMS HPMS Memorandum issued annually in August regarding the HEDIS® requirements for the upcoming reporting year.**

Refer to the annual HEDIS®, Volume 2: Technical Specifications for Health Plans for measure specifications and general guidelines for calculations and sampling.

Medicare Advantage contracts that are required to report HEDIS® summary-level data must also provide the patient-level data used to calculate the summary-level data for each MA contract. Submission of the patient-level HEDIS® data is not required for the SNP-specific HEDIS® measures.

#### Reporting HEDIS® for Medicare

All members covered under the contracts listed below are included in Medicare HEDIS® reporting. CMS communicates directly with all contracted organizations and benefit plans on HEDIS® reporting requirements (e.g., plan type, enrollment criteria). HEDIS® reporting is required for:

- Medicare Advantage (MA contracts);
- Section 1876 cost contracts with active enrollment;
- Medical Savings Account (MSA) contracts;
- Private Fee-for-Service (PFFS) contracts;
- Employer/Union Only Direct Contract PFFS contracts;
- Special Need Plans (SNPs) offered by MA contracts;
- Certain demonstration projects.

#### **Exclusions:**

The Medicare Hospice benefit is considered a gap in enrollment, and contracts shall exclude MA members electing the hospice benefit through Traditional Medicare or FFS Medicare, and choose to remain enrolled in the MA plan, beginning on the date when the hospice benefits begin.

CMS collects patient-level data with patient-level identifiers for the numerator and the denominator of each required HEDIS® measure because this allows CMS to match

HEDIS® data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (e.g., ethnic, racial, gender, geographic) are receiving fewer or more services than others.

CMS is committed to assuring the validity of the summary data collected before it is released to the public, and to making the data available in a timely manner for beneficiary information. MAOs and §1876 cost contracts must submit summary measures, after completing the NCQA HEDIS® Compliance Audit required by Medicare, by mid-June of each reporting year. MAOs, including PPO, PFFS, and §1876 cost contracts must submit HEDIS® patient-level data at the same time. CMS requires the submission of the following patient-level data on the same date as summary data to ensure that the patient-level data match the summary data. Auditors will review patient-level data for the numerator and denominator of audited measures when checking for algorithmic compliance during the HEDIS® audit. The summary data are sent to NCQA and the patient-level data are sent only through the designated CMS secure data submission system to the CMS contractor.

#### 1. Summary Data

- a. Required Measures - MAOs that held Medicare contracts in the measurement year and meet the criteria in the previous section of this chapter must report summary data for all required HEDIS® measures except for the HOS measures. The HEDIS® measures Flu Vaccination for Adults 65 and older, Pneumococcal Vaccination Status for Older Adults, and Medical Assistance with Smoking and Tobacco Use Cessation are collected through the CAHPS® survey instrument. MAOs must attempt to produce every Medicare required measure, and report a numerator and denominator even if the numbers are small, i.e., the denominator is less than 30.
- b. Data Submission - NCQA will annually post Health Organization Questionnaires (HOQ) on the NCQA Web site in late January. MAOs must accurately complete the HOQ in order to receive the appropriate Interactive Data Submission System (IDSS). MAOs must submit HEDIS® results for the measurement year using this web-based tool.

#### 2. Patient-Level Data - Analysis of data with patient-level identifiers for the numerator and denominator of each measure allows CMS to match HEDIS® data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (e.g., ethnic, racial, gender, geographic) are receiving fewer or more services than others.

- a. Required Measures – MAOs must provide patient-level data identifying the contribution of each beneficiary to the denominator and numerator of every required summary measure.
- b. Data Submission – Patient-level HEDIS® data are submitted via the CMS

Enterprise FTP client system that contracts use to submit other beneficiary specific information to CMS. Contracts use their existing system that connects to the designated CMS secure data transmission system to upload patient-level data files. The CMS contractor accesses the patient-level data through the same secure system to perform data validations. Contracts must retain the data used for reporting for six years. As specified in 42 CFR §422.504 and §423.505, all MA contracts are required to maintain the privacy and security of protected health information and other personally identifiable information of Medicare enrollees. There have been questions expressed about the provision of behavioral health measures in the patient-level data files. Contracts are accountable for providing patient-level data, unless prohibited by State laws. In such cases, contracts must notify CMS with appropriate documentation of the legal prohibition for consideration.

### **30.1.1 HEDIS® Compliance Audit Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

Because of the critical importance of ensuring accurate data, CMS continues to require an external audit of the HEDIS® measures before public reporting. MAOs and §1876 cost contracts are responsible for submitting audited data, according to the audit methodology outlined in Volume 5: HEDIS® Compliance Audit: Standards, Policies and Procedures.

CMS requires each MAO and §1876 cost contract to contract with an NCQA licensed organization for an NCQA HEDIS® Compliance Audit. The licensed audit firms are listed on NCQA's Web site at <http://www.ncqa.org/>. CMS requires that the licensed organizations follow the established standards, policies and procedures in NCQA's HEDIS®, Volume 5. All contracts must ensure that the site visit audit team is led by a NCQA Certified HEDIS® Compliance Auditor. In addition, the plan's chief executive officer, president, or other authorized person, such as the medical director, will be required to provide an electronic attestation to the validity of the plan-generated data in IDSS.

### **30.1.2 Final Audit Reports, Use and Release**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

Following the receipt by the MAO of the Final Audit Report from the NCQA-licensed audit firm, the MAO must make available a copy of the complete final report to the CMS ROs as needed. CMS ROs may request the report upon completion or as part of the pre-site monitoring visit package. In addition, the reports should be available for review onsite during monitoring visits. CMS will use the Final Audit Reports to support contract monitoring and quality improvement activities. CMS may use the assessment of the MAO's administrative and information systems capabilities that are contained in the audit report and may use the data to conduct post-submission validation. Final Audit Reports are subject to the Freedom of Information Act (FOIA). CMS will follow the FOIA requirements regarding any release of such report and will make a determination about the release of information in each audit report on a case-by-case basis. Information that both the MAO and CMS deem proprietary will not be released, unless

otherwise required by applicable law.

## **30.2 Medicare HOS Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

HOS reporting requirements specify that MAOs with Medicare contracts in effect on or before January 1 of the preceding year report the Baseline HOS, provided they have a minimum enrollment of 500 members as of February 1 of the current year. In addition, all continuing MAOs that participated in the Baseline survey two years prior are required to administer a Follow-Up survey regardless of whether they meet the current year's enrollment threshold.

The following organizations with plan contracts in effect on or before January 1 of the previous year are included in the HOS:

- All coordinated care contracts, including PFFS and MSA contracts;
- Section 1876 cost contracts even if they are closed for enrollment;
- Employer/union only direct PFFS contracts.

Additionally, MAOs sponsoring fully integrated dual eligible (FIDE) SNPs may elect to report HOS at the FIDE SNP level to determine eligibility for a frailty adjustment payment under the Affordable Care Act, similar to those payments provided to PACE programs. Voluntary reporting will be in addition to the standard HOS requirements for quality reporting at the contract level.

The Veterans RAND 12-Item Health Survey (VR-12), supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS® functional status measure, HOS. This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, the results are primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that MAOs are currently using for clinical quality improvement. Each year a baseline cohort will be drawn and 1,200 beneficiaries per reporting unit (i.e., contract) will be surveyed. If the contract-market has fewer than 1,200 eligible members, all will be surveyed.

Additionally, each year the cohort measured two years previously at baseline will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well-being of each respondent. Depending on the amount of expected change, the respondent's physical and mental health status will be categorized as better, the same or worse than expected over the two-year period. Members who are deceased at follow-up are included in the "worse" physical outcome category. Beneficiary level results are aggregated to derive the MAO, state, and HOS national percent better, same, and worse than expected values.

To expedite the survey process, MAOs may be asked to provide telephone numbers or

verify telephone numbers for the respondents unable to be identified using other means. MAOs, at their expense, are expected to contract with any of the NCQA certified vendors for administration of the survey to do both the new baseline cohort and the re-measurement cohort (if the MAO participated when an earlier cohort was drawn for baseline measurement). Contracts with vendors are expected to be in place by January of each reporting year to ensure survey implementation by early-April of the reporting year. Further details will be provided by NCQA regarding administration of the survey the preceding fall.

### **30.2.1 HOS-Modified**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

The HOS-Modified (HOS-M) is a shorter, modified version of the Medicare HOS and contains 6 ADL items as the core items used to calculate an annual frailty adjustment factor for PACE organizations. The survey also includes 12 physical and mental health status questions from the VR-12. The HOS-M survey is cross-sectional, measuring the physical and mental health functioning of beneficiaries at a single point in time.

HOS-M reporting requirements specify that all PACE organizations with a Medicare contract in effect on or before January 1st of the previous year and a minimum enrollment of 30 report the HOS-M for current year reporting.

Similar to the HOS, the HOS-M design is based on a randomly selected sample of 1,200 individuals from each participating PACE Organization. All eligible members are included in the sample for plans with populations of less than 1,200.

The survey protocols for the HOS and HOS-M data collection efforts are similar. The HOS and HOS-M technical specifications are updated annually by NCQA and published each February in HEDIS® Volume 6: Specifications for the Medicare Health Outcomes Survey. Additional information is available from NCQA's web site at <http://www.ncqa.org> under HEDIS® and Quality Measurement.

### **30.2.2 HOS Data Feedback**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

Individual member level data will not be provided to plans after baseline data collection. However, organizations will receive the following from CMS:

1. HOS Baseline Report - This report will be made available to all plans participating in the previous year's baseline cohort. This quality improvement tool, which presents an aggregate overview of the baseline health status of each MAO's Medicare enrollees, was developed and extensively tested to ensure that MAOs would find the data useful and actionable. Each MAO's QIO will also receive electronic copies of the baseline reports and is available to collaborate with MAOs on interpreting the data, identifying opportunities to improve care, assisting with planning effective, measurable interventions, and evaluating and monitoring the

results of your interventions. Using data from the HOS to plan and conduct a quality improvement project may fulfill one of the QI program requirements. All report distribution occurs electronically through HPMS. MAOs are also alerted of all HOS report and data availability through HPMS.

2. HOS Performance Measurement Report and Data - After the administration of each follow up cohort, a cohort specific performance measurement report is produced. Survey responses from baseline and follow up are merged to create a performance measurement data set. The HOS performance measurement results are computed using a rigorous case mix/risk adjustment model. The resulting aggregation of these scores across beneficiaries within a plan yields the HOS plan level performance measurement results. The performance measurement reports and corresponding data results are designed to support MAO quality improvement activities.
3. HOS-M Summary Reports - After each yearly administration of the Medicare HOS-M, a plan specific report is produced and is available for each organization participating in the survey. The HOS-M report focuses on PACE plans serving frail and elderly beneficiaries, and provides a summary of demographic information, physical and mental health status, and selected health status measures. The corresponding beneficiary level data for a report are also made available to participating PACE plans.

All distribution of HOS-M reports occurs electronically to participating PACE organizations through HPMS. Plans are also alerted of report and data availability through HPMS.

4. Survey Vendor Reports - The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

MAOs should not ask their survey vendor for additional analyses or member specific data. They are prohibited from providing this type of information. Requests for interpretation of the data or more detailed analyses of the data should be directed to each MAO's State QIO.

### **30.3 Medicare CAHPS® Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

The following organizations types of MAOs are included in the CAHPS® survey administration provided that they have a minimum enrollment of 600 eligible members as of July 1<sup>st</sup> of the previous year.



- All MA organizations, including all coordinated care contracts, PFFS, and MSA contracts.
- §1876 cost contracts even if they are closed for enrollment.
- Employer/union only contracts.

The Programs of All Inclusive Care for the Elderly (PACE) and HCPP 1833 cost contracts are excluded from the CAHPS® administration.

Medicare Advantage organizations and §1876 cost contracts are required to contract with an approved MA & PDP CAHPS® vendor for the survey administration. A list of approved survey vendors is available on [www.MA-PDPCAHP.org](http://www.MA-PDPCAHP.org). All approved survey vendors are trained by the CMS CAHPS® Survey Coordination team.

CMS issues HPMS memorandums about the CAHPS® survey each year.

If an approved CAHPS® vendor does not submit a contract's CAHPS® data by the data submission deadline, the contract will automatically receive a rating of one star for the required CAHPS® measures for the data that are updated on Medicare Plan Finder (in the fall) which also impacts the MA Quality Bonus Payments.

For additional information on the CAHPS® survey, please email [mp-cahps@cms.hhs.gov](mailto:mp-cahps@cms.hhs.gov).

## **40 – Medicare Advantage (MA) Deeming Program Overview**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

### **42 CFR §422.156, 422.157, 422.158**

Under section 1852(e)(4) of the Act, CMS established and oversees a program which allows private, national accrediting organizations (AOs) to deem compliance with certain Medicare requirements. The AOs may only grant deemed status for MAOs that it has fully accredited (and periodically re-accredited).

Accreditation is an evaluative process (usually involving both on and off site surveys) in which a health care organization chooses to undergo an examination of its policies, procedures and performance by an external organization (“accrediting body”). . In addition to the standard accreditation process, an MAO may pay an additional fee to have the AO conduct various reviews that allow the AO to “deem” that the MAO is compliant with certain Medicare requirements.

To deem an MAO, the AO must use standards (and the process for monitoring compliance) that CMS determines are no less stringent than the applicable Medicare requirements.

Additionally, the AO is responsible for enforcing compliance on the accredited MAO when deficiencies are found in those areas to which the deemed status applies. AOs who obtain deeming authority are responsible for ensuring that MAOs meet the deeming requirements established by CMS.

Organizations that seek the authority to deem must meet CMS's definition of a private, national AO, by demonstrating the following:

1. It is recognized as an accrediting body by the managed care industry and relevant national associations;
2. It has accredited and/or re-accredited MAOs in multiple states;
3. It contracts with or employs staff who are appropriately trained and have experience with monitoring managed care plans for compliance with the AOs specific accrediting standards; and
4. It contracts with or employs sufficient staff to provide accreditation services nationwide.

#### **40.1 - Deeming Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

**42 CFR §422.156 (a), (b), and (c); §423.165(b) (1), (2) and (3)**

As provided under section 1852(e)(4) of the Act, MAOs may seek deeming for certain Medicare requirements in the following areas:

1. Quality assessment and improvement;
2. Confidentiality and accuracy of medical or other enrollee health records;
3. Anti-discrimination;
4. Access to services;
5. Information on advance directives;
6. Provider participation rules;

Additionally, under 1860D-4(j) of the Act, Part D plan sponsors may seek deeming for certain Medicare requirements in the following areas:

7. Access to covered drugs;<sup>1</sup>

8. Drug utilization management, quality assurance measures and systems, medication therapy management, and a program to control fraud, waste and abuse;<sup>1</sup> and
9. Confidentiality and accuracy of enrollee prescription drug records.<sup>1</sup>

The MAO's deemed status is effective on the later of:

1. The date on which the AO is approved by CMS; or
2. The date the MAO is deemed by the AO.

## **40.2 - Deemed MAOs**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §422.156 (d)

MAOs that seek deemed status via accreditation by a CMS-approved AO can include the cost of accreditation as an administrative cost in the construction of its bid submission. Administrative costs that bear a significant relationship to the MA plan seeking deemed status are allowed to be included. However, the cost for the accreditation should be allocated between an MAO's Medicare and non-Medicare lines of business using an appropriate cost allocation method, consistent with the bid instructions.

1. If an MAO decides to pursue deeming, the AO conducts its review of the MAO.
  - a. If the MAO has an accreditation decision that included its Medicare line of business (or the Medicare population was part of the overall accreditation review) and the AO used the standards that it submitted in its application for MA deeming authority, an agreement that relates specifically for MAO deemed status is signed. The AO will only review the supplemental MA standards that were added to the AO's accreditation program in order for the AO to be granted MA deeming authority.
  - b. If this is a first time accreditation review or the organization is seeking reaccreditation with deemed status, an agreement is signed. The AO will review the MAO by using the AO's entire accreditation program for managed care plans (its regular accreditation program plus the MAO supplement).
2. The AO notifies CMS that the MAO has been approved for deemed status. The AO will provide the date of the deemed status accreditation, the MAO's contract number, and any additional information that CMS may require.
3. CMS enters the deemed status into HPMS.

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<sup>1</sup> Please note that items 7-9 have not yet been implemented into the deeming program.

## **40.2.1 - Deemed Status and Surveys**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

### **42 CFR §422.156(d) (1), (2)**

As noted in section 40.1 of this chapter, to be granted deemed status, an MAO must be accredited and periodically re-accredited by a CMS-approved AO. In addition, an MAO deemed to meet Medicare requirements must submit to surveys to validate its AO's accreditation process.

There are two types of validation surveys:

1. Observational (commonly referred to as concurrent); and
2. Retrospective (or look behind) surveys.

An MAO that seeks deemed status must also agree to authorize its AO to release to CMS a copy of its most current accreditation survey, as well as any survey-related information that CMS may require (including CAPs and summaries of unmet CMS requirements).

MAOs that are accredited by CMS-approved AOs are still subject to CMS surveys. As noted, an approved accrediting organization may only deem an MAO for one or more of the nine areas described in section 40.1 of this chapter. If the AO only has deeming authority in one of the nine<sup>2</sup> deemable areas, such as access to services, then CMS may conduct a survey to assess the other 8 areas, as well as non-deemable requirements such as grievances and appeals, beneficiary disclosure, marketing, enrollment, and organization determinations. CMS always retains the authority to investigate complaints about an MAO.

## **40.2.2 - Removal of an MAO's Deemed Status**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

### **42 CFR §422.156(e)**

CMS will remove part or all of an MAO's deemed status if:

1. CMS determines, based on its own evaluation, that the MAO does not meet the Medicare requirements for which deemed status was granted;
2. CMS withdraws its approval of the AO that accredited the MAO; and/or
3. The MAO fails to meet the obligations of a deemed MAO, which are

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<sup>2</sup> Please note that only 6 of the 9 deeming requirements have been implemented into the deeming program.

addressed in section 40.2.2 of this chapter.

CMS will not overrule an AO's decision without doing its own investigation. However, if CMS' evaluation reveals that a condition is not met, CMS reserves the right to remove deemed status even though the AO has not removed accreditation with respect to that condition.

Additionally, if CMS withdraws its approval of deeming authority from an AO, all MAOs with deemed status provided by that AO, will also be withdrawn. The MAO will be notified of the withdrawal of deemed status via a public notice. The AO must notify all its accredited MAOs within 10 days. Upon removal of an MAO's deemed status, CMS immediately resumes responsibility for ensuring that the organization meets Medicare program requirements.

### **40.3 - CMS's Role in Deeming**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.157(a)(d)**

CMS has many different roles in the deeming program. For example, CMS approves the applications of the organizations that are applying for the authority to deem. CMS may approve the organization for deeming authority if it demonstrates that its accreditation program is at least as stringent as CMS' and it meets the application requirements described in section 40.4.1 of this chapter. CMS must approve an AO by deeming area, rather than by individual requirement. However, an AO must have a comparable standard for every one of the MAO requirements within a deeming area.

As mentioned above, CMS conducts validation surveys and other audits to ensure compliance with Medicare program requirements. CMS also conducts monitoring of non-deemable requirements. If, during the course of monitoring for non-deemable requirements, CMS staff determines that an MAO is not in compliance with a requirement for which it has been deemed, it will notify the AO of the failure; to ensure the AO initiates a corrective action process, when and if appropriate. CMS will not issue the corrective action requirement for deficiencies found in deemed areas.

#### **40.3.1 - Oversight of AOs**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.157(d)**

After approving an AO for deeming authority, CMS provides oversight of the AOs' performance. CMS has a number of mechanisms available to fulfill its oversight responsibilities, including:

1. Conducting equivalency reviews if CMS or the AO adds or changes requirements;
2. Conducting validation surveys to examine the results of the AO's survey;

3. Conducting onsite observations of the AO's operations and offices to verify the organization's representation and assess the organization's compliance with its own policies and procedures; and
4. Investigating accredited MAOs in response to serious complaints.

If CMS staff detects a pattern of complaints in deemed areas, they contact the appropriate AO.

### **40.3.2 - Enforcement Authority**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.156(f)**

CMS retains the authority to initiate enforcement actions against any MAO that it determines, on the basis of its own evaluation, no longer meets the Medicare requirements for which deemed status was granted. Enforcement actions may include the imposition of intermediate sanctions and civil money penalties (42 CFR §422 Subpart O) or the termination or non-renewal of the MAOs contract (42 CFR §422 Subpart K).

### **40.3.3 - Withdrawal of Approval**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.157(d)(4)**

If an equivalency review, validation review, onsite observation, or CMS' daily experience with the AO suggests that the AO is not meeting the requirements specified in 42 CFR §422, Subpart D, CMS will give the AO written notice of its intent to withdraw approval.

CMS may withdraw an AO's approval for deeming authority at any time, if CMS determines that:

- Deeming based on accreditation no longer guarantees that the MAO meets the requirements, and failure to meet those requirements could jeopardize the health or safety of Medicare enrollees and constitutes a significant hazard to the public health; or
- The AO has failed to meet the obligations specified in sections 40 and 40.4 of this chapter.

### **40.4 - Obligations of AOs with Deeming Authority**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.157**

AOs must apply and enforce the standards that CMS determines, as a condition of approval, are at least as stringent as the applicable Medicare requirements. To be approved, an AO must comply with the application and reapplication procedures that are addressed in section 40.4.1 of this chapter.

To prevent conflicts of interest, AOs must ensure the following:

- When the AO deems an MAO, any individual associated with the AO who is also associated with the MAO, does not influence the deeming decision concerning that MAO;
- That the majority of the membership of the AOs governing body is not comprised of managed care organizations or their representatives;
- The AOs governing body acts without bias and has a broad and balanced representation of interests.

To avoid actual conflicts of interests (or the appearance of conflicts of interests), CMS encourages any personnel involved in a conflict to recuse themselves from the deeming process for the MAO in conflict.

Additionally, if CMS takes an adverse action based on accreditation findings, the approved AO must permit its surveyors to serve as witnesses.

#### **40.4.1 - Reporting Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §422.157(c)

When an AO is approved by CMS for deeming authority, the AO agrees to certain ongoing activities, including:

1. Providing to CMS, in written form and on a monthly basis, all of the following:
  - a. Copies of all accreditation surveys, together with any survey-related information that CMS may require (including CAPs and summaries of unmet CMS requirements);
  - b. Notice of all accreditation decisions;
  - c. Notice of all complaints related to deemed MAOs;
  - d. Information about any MAO against which the AO has taken remedial or adverse action, including revocation, withdrawal or revision of the MAO's accreditation within 30 days of taking the action; and
  - e. Notice of any proposed changes to its accreditation standards or requirements or survey process. If an AO implements any changes before or without CMS approval, CMS may withdraw its approval.

2. If an AO finds a deficiency in an MAO that poses an immediate jeopardy to the organization's enrollees or to the general public, it must give CMS written notice of the deficiency within three days of identifying the deficiency.
3. When CMS gives notice that it is withdrawing its approval for deeming authority, the AO must notify all its accredited MAOs within 10 days.
4. AOs must provide, on an annual basis, summary data to be specified by CMS that relate to the past year's accreditation activities and trends.
5. Within 30 days after CMS changes a Medicare MAO requirement, the AO must:
  - a. Send a written acknowledgement of CMS' notice of the change;
  - b. Submit a new crosswalk reflecting the new requirement; and
  - c. Send a written explanation of how it plans to alter, within a time frame that CMS will specify in the notice of change, its standards and review process to conform to CMS' new requirement.
6. AOs must have a mechanism for publicly disclosing the results of an MAO's accreditation survey.

Accreditation surveys of MAOs performed by private AOs under section 1852(e)(4) of the Act may not be released to the public by CMS, except to the extent that such surveys relate to an enforcement action taken by the Secretary. AOs must, however, have methods to disclose the accreditation status of deemed MAOs.

#### **40.4.2 - Application Requirements**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

##### **42 CFR §422.158**

A private, national AO may seek deeming authority for any or all of the 9 categories listed in section 40.1 of this chapter. For each deeming category for which the AO is applying for deeming authority, it must, demonstrate that its standards and processes meet or exceed Medicare requirements within that particular category.

A private, national AO applying for approval must furnish to CMS all of the following materials. When reapplying for approval, the organization need furnish only the particular information and materials requested by CMS.

1. The type(s) of MA coordinated care plans that they seek authority to deem;
2. A crosswalk that provides a detailed comparison of the organization's accreditation requirements and standards with the corresponding Medicare requirements;



3. A detailed description of the organization's survey process for each type of MAO it is seeking authority to deem, including:
  - a. Frequency of surveys performed, whether the surveys are announced or unannounced, and how far in advance surveys are announced;
  - b. Copies of survey forms and guidelines and instructions to surveyors;
  - c. A description of the organization's survey review and accreditation status decision making process;
  - d. The procedures used to notify accredited MAOs of deficiencies and the procedures to monitor the correction of those deficiencies; and
  - e. Procedures the organization uses to enforce compliance with their accreditation requirements;
4. Detailed information about the individuals who perform surveys for each type of MAO that the organization seeks authority to deem, including:
  - a. The size and composition of and the methods of compensation for its accreditation survey teams;
  - b. The education and experience requirements surveyors must meet to participate in its accreditation program;
  - c. The content and frequency of the in-service training provided to survey personnel;
  - d. The evaluation system used to monitor the performance of individual surveyors and survey teams; and
  - e. The policies and practices with respect to participation in surveys or in the accreditation decision process pertaining to an individual who is professionally or financially affiliated with the entity being surveyed.
5. A description of the data management and analysis system with respect to surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by the organization's data system;
6. The procedures it will use to respond to and investigate complaints or identify other problems with accredited organizations, including coordination of these activities with licensing bodies and ombudsmen programs;
7. The policies and procedures regarding withholding, denying and removal of

- accreditation for failure to meet the organization's standards and requirements, and other actions the organization will take in response to non-compliance with their standards and requirements;
8. The policies and procedures regarding how the organization deals with accreditation of organizations that are acquired by another organization, have merged with another organization, or that undergo a change of ownership or management;
  9. A description of all the types (full, partial, or denial) and categories (provisional conditional, or temporary) of accreditation offered by the organization, the duration of each category of accreditation, and a statement identifying the types and categories that would serve as a basis for accreditation if CMS grants the organization MA deeming authority;
  10. A list of all the MAOs that the organization has currently accredited, by State and type, and the category of accreditation and expiration date of accreditation held by each organization;
  11. A list of all the managed care organizations (MCOs) that the organization has surveyed in the past three years, the date each was accredited (if denied, the date it was denied), and the level (category) of accreditation it received;
  12. A list of all managed care surveys scheduled to be performed by the organization within the next 3 months indicating organization type, date, state, and whether each MCO is an MAO;
  13. The name and address of each person with an ownership or controlling interest in the AO;
  14. A written presentation that demonstrates that it will be able to furnish data electronically, in a CMS compatible format;
  15. A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities. The resource analysis should include financial statements for the past 3 years (audited if possible) and the projected number of deemed status surveys for the upcoming year; and
  16. A statement acknowledging that, as a condition of approval, the organization agrees to comply with the ongoing responsibility requirements that are addressed in section 40 of this chapter.

If CMS determines that it needs additional information for a determination to grant or deny the AO's request for approval, it will notify the AO and allow it time to provide the additional information.

As part of the application process, CMS may visit the AO's offices to verify representations made by the organization in its application, including, but not limited to, reviewing documents, auditing meetings concerning the accreditation process, evaluating survey results or the accreditation status decision-making process, and interviewing the organization's staff.

### **40.4.3 - Application Notices**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

#### **42 CFR §422.158(e)**

Each application will be reviewed for completeness. Approximately 60 days after an application has been determined to be complete, CMS will publish a proposed notice in the Federal Register. This notice will announce that CMS has received an application from the AO and is considering granting the organization's application for MAO deeming authority. The proposed notice will also describe the criteria that CMS will use in evaluating the applications. CMS will provide a 30-day period for the public to comment on the proposed notice.

After an application is determined to be complete, CMS has a 210-day period to review the application and the comments from the proposed notice. At the end of the 210 days, CMS will publish a final notice in the Federal Register indicating whether it has granted the AO's request for approval. If CMS has granted the request, the final notice will specify the effective date of the deeming authority and the term of approval for deeming authority, which may not exceed six years.

Within 210 days of receipt of its completed application, CMS must provide the AO with a formal notice that:

1. Approves or denies the request;
2. Provides a detailed rationale in the case of a denial; and
3. Describes the reconsideration and reapplication procedures.

For information regarding reconsideration of adverse determinations refer to section 40.4 of this chapter.

### **40.4.4 - Withdrawing an Application**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

An AO may withdraw its application for approval at any time before it receives the formal notice of determination specified above.

## **40.5 - Reconsideration of a Decision to Deny, Remove or Not Renew Deeming Authority**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §422.158

An AO that has received a notice of denial of its request for deeming authority (or specific deeming categories) may request reconsideration in accordance with the Subpart D of part 488. CMS will reconsider any determination to deny, remove, or not renew the approval of deeming authority to private AOs, if the AO files a written request for reconsideration. The request must be filed within 60 days of the receipt of notice of the adverse determination. The request for reconsideration must specify the findings or issues with which the AO disagrees, and the reasons for the disagreement.

In response to a request for reconsideration, CMS will provide the AO the opportunity for an informal hearing that will be conducted by a hearing officer appointed by the Administrator of CMS. The informal hearing will also provide the AO the opportunity to present in writing or in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew deeming authority.

### **40.5.1 - Informal Hearing Procedures**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §488.158(g), §§488.201-488.211

CMS will provide written notice of the time and place of the informal hearing at least 10 calendar days before the scheduled date. The hearing will be conducted in accordance with the following procedures:

1. The hearing is open to CMS and the organization requesting the re-consideration, including:
  - Authorized representatives;
  - Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and
  - Legal counsel;
2. The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action;
3. The hearing officer may accept testimony and other evidence even though it would be inadmissible under the usual rules of court procedures;
4. Either party may call witnesses from among those individuals specified in this

section.

5. The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

### **40.5.2 - Informal Hearing Findings**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

42 CFR §488.209

Within 30 days of the close of the hearing, the hearing officer will present the findings and recommendations to the AO that requested the reconsideration. The written report of the hearing officer will include separately numbered findings of fact and the legal conclusions of the hearing officer.

### **40.5.3 - Final Reconsideration Determinations**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

The hearing officer's decision is final unless the CMS Administrator, within 30 days of the hearing officer's decision, chooses to review that decision. The CMS Administrator may accept, reject, or modify the hearing officer's findings. Should the CMS Administrator choose to review the hearing officer's decision, the Administrator will issue a final reconsideration determination to the AO on the basis of the hearing officer's findings and recommendations and other relevant information. The reconsideration determination of the CMS Administrator is final. The final reconsideration determination against an AO will be published by CMS in the Federal Register.

## **50 - Definitions**

*(Rev.117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)*

Unless otherwise stated in this chapter, the following definitions apply:

### **Accreditation**

An evaluative process (usually involving both on and off site surveys) in which a health care organization chooses to undergo an examination of its policies, procedures and performance by an external organization ("accrediting body").

### **Accreditation Cycle for Medicare Advantage (MA) Deeming**

The duration of CMS's recognition of the validity of an accrediting organization's determination that a MAO is "fully accredited."

**Accrediting Organization (AO)**

A private, national accreditation organization that has been approved and authorized by CMS to deem that a MAO is in compliance with certain Medicare requirements.

**Annual Update**

The Annual Update is comprised of the information required in the components of the Do, Study, and Act sections of the Plan-Do-Study-Act quality improvement model specific to the CCIP and QIP initiatives.

**Benchmarking**

The process of measuring products, services, strategies, processes, and practices against known leaders/best-in-class companies/entities.

**Chronic Care Improvement Program (CCIP)**

An initiative with a clinical focus that includes interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions, and includes patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

**Corrective Action Plan (CAP)**

A formal process where CMS informs an MAO that it is out of compliance with one or more CMS requirements. The CAP may result from an audit or result from other ad-hoc compliance events unrelated to an audit.

**Deemed Status**

A designation granted to an MAO which concludes that the MAO has been reviewed by an AO for those standards within the categories that the AO has the authority to deem on behalf of CMS.

**Deeming Authority**

The authority granted by CMS to AOs to determine, on CMS' behalf, whether a MAO evaluated by the accrediting organization is in compliance with certain Medicare requirements.

**Equivalency Review**

The process CMS employs to compare an AO's standards, processes and enforcement

activities to the comparable CMS standards, processes and enforcement activities.

### **Fully Accredited**

Fully accredited is a designation that all the elements within the accreditation standards have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.

### **Goal**

The measurable outcome of the process under study in QIPs and CCIPs.

### **Healthcare Effectiveness Data and Information Set (HEDIS®)**

A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

### **Health Outcomes Survey (HOS)**

The first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each MAO health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

### **Health Outcomes Survey - Modified (HOS-M)**

The HOS-M is a modified version of the Medicare HOS. The HOS-M is administered to Medicare beneficiaries enrolled in Programs of All Inclusive Care for the Elderly (PACE). The instrument assesses the physical and mental health frailty level of the Program members to generate information for payment adjustment.

### **National Committee for Quality Assurance (NCQA)**

A private, 501(c)(3) not-for-profit organization that has contracted with CMS to develop a set of measures to evaluate the structure, processes, and performance of SNPs.

### **Quality**

The Institute of Medicine (IOM) defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

### **Quality Improvement Organization (QIO)**

Formerly known as Peer Review Organization, this is an entity that CMS contracts with in each state to fulfill provisions in Title XI of the Act as amended by the Peer Review Improvement Act of 1982. These provisions relate to improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting beneficiaries by addressing care related complaints and other beneficiary issues.

**Quality Improvement Project (QIP)**

An initiative that focuses on specified clinical and/or non-clinical areas.

**Sample**

A subgroup of units chosen from a diffuse and statistically representative group of units or population.

**Unit of Analysis for Deeming**

For deeming, CMS will recognize the deemed status of MAOs if they are accredited at the same jurisdictional level (whether contract, state, or multi-state) that CMS would have used it, rather than the AO, had conducted the survey.