SNPs must submit their model of care (MOC) to CMS for NCQA evaluation and approval, in accordance with CMS guidance. A SNP must conduct a quality improvement program that—

(1) Provides for the collection, analysis, and reporting of data that measures health outcomes and indices of quality pertaining to its targeted special needs population (that is, dual-eligible, institutionalized, or chronic condition) at the plan level.

(2) Measures the effectiveness of its model of care through the collection, aggregation, analysis, and reporting of data that demonstrate the following:
   (i) Access to care as evidenced by measures from the care coordination domain (for example, service and benefit utilization rates, or timeliness of referrals or treatment).
   (ii) Improvement in beneficiary health status as evidenced by measures from functional, psychosocial, or clinical domains (for example, quality of life indicators, depression scales, or chronic disease outcomes).
   (iii) Staff implementation of the SNP model of care as evidenced by measures of care structure and process from the continuity of care domain (for example, National Committee for Quality Assurance accreditation measures or medication reconciliation associated with care setting transitions indicators).
   (iv) Comprehensive health risk assessment as evidenced by measures from the care coordination domain (for example, accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments).
   (v) Implementation of an individualized plan of care as evidenced by measures from functional, psychosocial, or clinical domains (for example, rate of participation by IDT members and beneficiaries in care planning).
   (vi) A provider network having targeted clinical expertise as evidenced by measures from medication management, disease management, or behavioral health domains.
   (vii) Delivery of services across the continuum of care.
   (viii) Delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries as evidenced by measures from the psychosocial, functional, and end-of-life domains.

(ix) Use of evidence-based practices and nationally recognized clinical protocols.

(x) Use of integrated systems of communication as evidenced by measures from the care coordination domain (for example, call center utilization rates, rates of beneficiary involvement in care plan development, etc.).

(3) Makes available to CMS information on quality and outcomes measures that will—
   (i) Enable beneficiaries to compare health coverage options; and
   (ii) Enable CMS to monitor the plan’s model of care performance.

(h) Requirements for MA private-fee-for-service plans and Medicare medical savings account plans. (1) Subject to paragraph (h)(2) of this section, MA PFFS and MSA plans are subject to requirements that may not exceed the requirements specified in §422.152(e).

(2) For plan year 2010, MA PFFS and MSA plans are not subject to the limitations under §422.152(e)(1)(i) and must meet the requirements using administrative claims data only.

§ 422.153 Use of quality improvement organization review information.

CMS will acquire from quality improvement organizations (QIOs) as defined in part 475 of this chapter data collected under section 1886(b)(3)(B)(viii) of the Act and subject to the requirements in §480.140(g). CMS will acquire this information, as needed, and may use it for the following functions:

(a) Enable beneficiaries to compare health coverage options and select among them.

(b) Evaluate plan performance.

(c) Ensure compliance with plan requirements under this part.

(d) Develop payment models.

(e) Other purposes related to MA plans as specified by CMS.

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