Simplifying Healthcare Administration

MODEL OF CARE PROVIDER TRAINING

General MOC Training For
GBMC HealthCare Providers

Training Objectives

Define the Model of Care (MOC) and explain its relevance in the context of healthcare delivery for special needs populations.

Understand the core components of MOC required by CMS.

Complete the training acknowledgement.

What is the purpose of MOC?

- To effectively identify and address the unique needs of each member, the Model of Care (MOC) serves as the foundation for the Special Needs Plan's (SNP) care management approach, supporting quality improvement, service access, care coordination, and overall care management processes.
- The MOC must comply with all CMS requirements.
- Annual MOC training is required by CMS for all relevant staff.

References: Medicare Managed Care Manual, Chapter 5- Quality Assessment 20.2.1 - Model of Care Elements
National Committee for Quality Assurance. (2024, October). Model of Care Scoring Guidelines for Contract Year 2026.

Purpose of MOC Training

Centers for Medicare & Medicaid Services (CMS) Requirement

- All Medicare Advantage Special Needs Plans (SNPs) must have a Model of Care (MOC) that describes the care and services to be provided to SNP members
- The MOC is a detailed document that provides the framework for how SNPs identify and address the unique needs of its SNP populations
- CMS carefully reviews the MOC during an audit to make sure we are implementing all processes as described, including MOC training

References: Medicare Managed Care Manual, Chapter 5- Quality Assessment 20.2.1 - Model of Care Elements
National Committee for Quality Assurance. (2024, October). Model of Care Scoring Guidelines for Contract Year 2026.

Purpose of MOC Training (cont'd)

The Centers for Medicare and Medicaid Services (CMS) requires providers who serve Medicare Advantage SNP members to complete annual training on the SNP MOC.

MOC training helps you:

- Understand the unique characteristics and needs of SNP members
- Understand the importance of your role as a member of the Interdisciplinary Care Team (ICT)
- Learn more about the role of the Care Coordinator (CC), including how you may interface with them and how they can help with the management of your SNP patients

References: Medicare Managed Care Manual, Chapter 5- Quality Assessment 20.2.1 - Model of Care Elements
National Committee for Quality Assurance. (2024, October). Model of Care Scoring Guidelines for Contract Year 2026.

CMS Required MOC Elements

The MOC is a key quality improvement tool used by SNPs to identify and address each enrollee's unique needs through care management. It focuses on four core elements.

Element 1	Element 2	Element 3	Element 4
Description of SNP Population ▪ Determining eligibility ▪ Defines our most vulnerable members ▪ Identifies relationships with community partners	**Care Coordination** ▪ Staff structure & oversight process ▪ HRA process ▪ Annual face-to-face visit ▪ Individualized care plan ▪ Interdisciplinary care team ▪ Transition of care management ▪ Annual associate MOC training	**Provider Network** ▪ Adequate provider network with expertise to care for the SNP population ▪ Practice guidelines and care transition protocols ▪ Annual provider training	**Quality Measurement & Performance Improvement** ▪ Defines the quality improvement plan ▪ Includes how to identify, define and measure goals and health outcomes

References: Medicare Managed Care Manual, Chapter 5- Quality Assessment 20.2.1 - Model of Care Elements
National Committee for Quality Assurance. (2024, October). Model of Care Scoring Guidelines for Contract Year 2026.

MOC 1: Description of SNP Population

What is a Special Needs Plan?

Medicare Advantage (MA) Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:

- **Chronic Condition SNP (C-SNP)** - Beneficiaries with certain chronic and disabling conditions
- **Dual Eligible SNP (D-SNP)** - Beneficiaries who are eligible for both Medicare and Medicaid
- **Institutional SNP (I-SNP)** - Beneficiaries who are institutionalized or require an institutional level of care (LOC)

Reference: Centers for Medicare & Medicaid Services; https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans

MOC 2: Care Coordination Staff Structure (Intro)

Fully define SNP staff roles and responsibilities for each care coordination function including:

- Specific employed and/or contracted staff responsible for performing
  - administrative functions
  - clinical functions
  - administrative and clinical oversight functions
- Provide a copy of the SNP's organizational chart showing how staff responsibilities are identified and coordinated with the job titles in the MOC
- Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions

Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

MOC 2: Care Coordination Staff Structure (cont'd)

The Care Coordination description must include:

- How the SNP conducts initial and annual MOC training
- How the SNP documents and maintain training records and evidence of MOC training
- Challenges associated with completion of the MOC training
- 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.

Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

MOC 2: Care Coordination Health Risk Assessment Tool

- Quality and content of the **Health Risk Assessment Tool (HRAT)** identifies medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary
- Content of, and methods used to conduct the Health Risk Assessment (HRA) have direct effect on the development of the Individualized Care Plan (ICP) and ongoing coordination of Interdisciplinary Care Team (ICT) activities
- Completed by Care Management staff with member
- Completed initially within 90 days of enrollment
- Repeated annually and after a significant status change
- Identifies areas of unmet needs to address in the Individualized Care Plan
- Complete a single HRA for DSNP / Medi-Medi under Care Coordination

Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

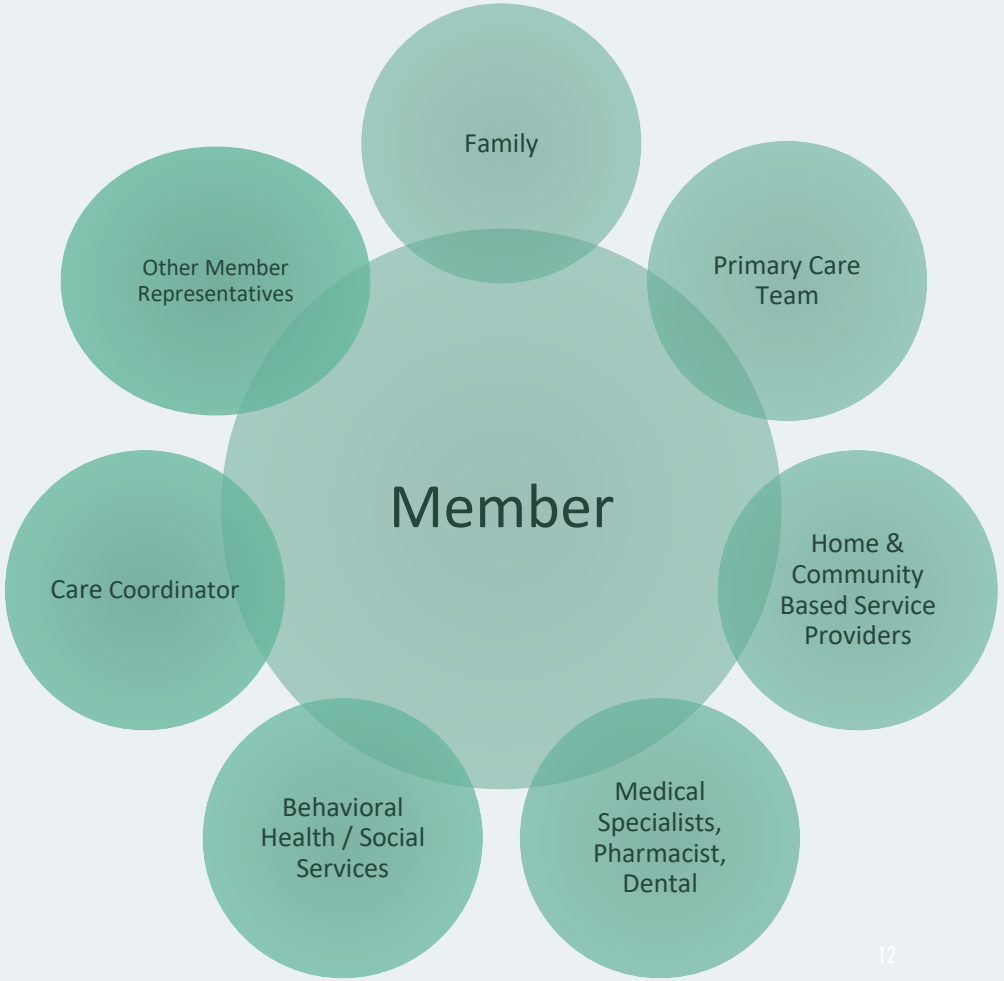
MOC 2: Care Coordination Individualized Care Plan (ICP)

- Each SNP member will have an **Individual Care Plan (ICP)** that includes:
  - Self-management goals and health objectives,
  - Interventions to meet goals and address barriers, and
  - Services tailored to the member's needs.
- ICP is updated annually or if a significant change in status occurs. The ICP is made available for the Interdisciplinary Care Team (ICT) and addresses coordination of the members care needs across specialties.
- Members with Dementia have a Dementia Care Specialist included as part of their ICT and Enhanced Care Management (ECM) Coordination of Care (COC) for D-SNP members already enrolled in ECM vs CICM under Cal AIM.
- Palliative care and Long Term Services Support (LTSS) should be included as part of the ICT under Cal AIM.

Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

MOC 2: Care Coordination Interdisclipinary Care Team (ICT)

- Collaborative communication between the Care Team members and the Medical Care Coordinator is essential to best serving the member and their needs
- Primary Care Providers (PCPs) are integral members of **the Interdisciplinary Care Team (ICT)** who can provide valuable input on the member's care plan
- Care Coordinators (CC) communicate with the PCP at least annually with information about the member's care plan and CC contact information
- Each member of the ICT has a role in providing the most effective and efficient care for the member



Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

MOC 2: Care Coordination Care Transition Protocols

- The movement of a patient from one setting of care to another (e.g., hospital to home or nursing facility) and are at risk of adverse outcomes due to fragmented care.

- Care Management team follows up with the member throughout the transition:
  - Discuss their health status changes and discharge instructions
  - Ensure that follow up appointments have been scheduled
  - Ensure member understands any changes in their medication regimen
  - Address social determinants of health issues the member may be facing
  - Determine if member needs any new services or supports upon discharge
  - Updates the member's care plan specific changes in care needs and health status

Sharing ICP updates and ensuring communication between the Interdisciplinary Care Team members and member/member representative is key to effective transition from one care setting to another or back to home.

Reference: 42 CFR § 422.101(f)(2)(ii)-(v); 42 CFR § 422.152(g)(2)(vii)-(x)

MOC 3: Provider Network

The SNP provider network is made up of healthcare providers with specialized expertise to meet the needs of the SNP population. Collaboration of the ICT is primarily facilitated through communication of the ICP.

Provider Network Elements:

- Element A - Specialized Expertise
- Element B - Clinical Practice Guidelines (CPG) & Care Transition Protocols (CTP)
- Element C - MOC Training for the Provider Network

Reference: 42 CFR § 422.101(f)(1)(iii)

MOC 3, Element A: Specialized Expertise

Regulations require SNPs, in the management of care, to use an integrated team that includes a team of providers with proven expertise and specialty training in treating targeted population of the SNP.

- Align provider network to SNP population
- Facilities (hospital, SNF, etc.)
- Communication between ICT and others

Reference: 42 CFR 422.101(F)(1)(III) AND 42 CFR § 422.152(G)(2)(VI)

MOC 3, Element B: Clinical Practice Guidelines (CPG) & Care Transition Protocols (CTP)

Regulations require SNPs to develop and implement the following MOC components to assure effective care management structure:

- Streamline care delivery across health care settings, providers, and services to achieve continuity.
- Coordinate the delivery of specialized benefits and services for the most vulnerable within the three target special needs populations, including frail/disabled and end-of-life beneficiaries.
- Coordinate communication among the SNP, providers, and beneficiaries.

Reference: 42 CFR § 422.101(F)(2)(III)-(V); 42 CFR § 422.152(G)(2)(IX)

MOC 3, Element B: Clinical Practice Guidelines (CPG) & Care Transition Protocols (CTP) (cont'd)

HICE
health industry collaboration effort

SNPs must adhere to evidence-based practices and nationally recognized clinical protocols.

- SNPs must deliver evidence-based care to its enrollees
  - Integrating evidence and clinical guidelines into member care is vital for quality and metrics like HEDIS. This supports recommended screenings (diabetics), integrated care (behavioral health), and fall risk assessments (seniors). Integrated Care Teams must use evidence to guide members to services, improving outcomes, reducing complications, and enhancing quality of life.
- SNPs must regularly review and modify CPGs & CTPs and communicate to Provider Network
  - Continuous, optimal care requires regular review and updates of CPGs and CTPs, led by clinical leadership and quality committees. This formal, evidence-based process ensures the MOC reflects current medical science, informs and educates providers, and guarantees enrollees receive the most effective care.

Reference: 42 CFR § 422.101(F)(2)(III)-(V); 42 CFR § 422.152(G)(2)(IX)

MOC 3, Element C: Training for the Provider Network

SNPs are required to have appropriate staff (employed, contracted, or non-contracted) and provider network trained in their MOC to coordinate and deliver all services and benefits.

SNPs must outline the approach to delivering MOC training to their entire provider network, including active out-of-network providers who regularly see enrollees:

- How MOC training is delivered to both in-network and out-of-network providers.
- System for tracking and documenting training, and who oversees its completion.
- What steps are taken when a provider doesn't complete the required training.

Reference: 42 CFR § 422.101(f)(2)(ii)

MOC 4: Quality Measurement & Performance Improvement

The MOC requires implementation of a **Quality Improvement Program** to monitor and evaluate its MOC performance.

- Goal is to improve the SNP's ability to deliver health care services and benefits to its SNP enrollees in a high-quality manner
- Establishes tailored measures and health objectives tied to coordination of care, appropriate delivery of services, affordability and member satisfaction.
- Establishes process and outcome measures tied to MOC goals.

References: 42 CFR § 422.152

Member satisfaction	Health Risk Assessment Timeliness
Implementation of the Individualized Care Plan	Improving access and affordability
Ensuring coordination of care across the care continuum	Appropriate utilization of services for preventive health and chronic conditions

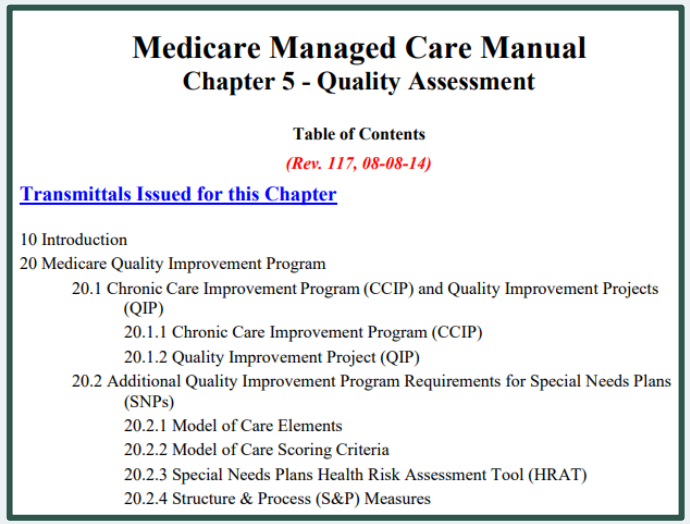
MOC Training Acknowledgement

- To document completion of this training, complete the acknowledgement following this course.
- Although most plans ask for a representative of the organization to complete one attestation on behalf of their provider organization, **all organizations must maintain evidence of each individual provider's completion of initial and annual MOC training** and provide such evidence upon request.

Reference: 42 CFR § 422.101(f)(2)(ii)

Training Resources

1. Medicare Managed Care Manual, Chapter 5- Quality Assessment 20.2.1 - Model of Care Elements
2. Model of Care Scoring Guidelines for Contract Year (CY) 2026
3. Special Needs Plans | CMS



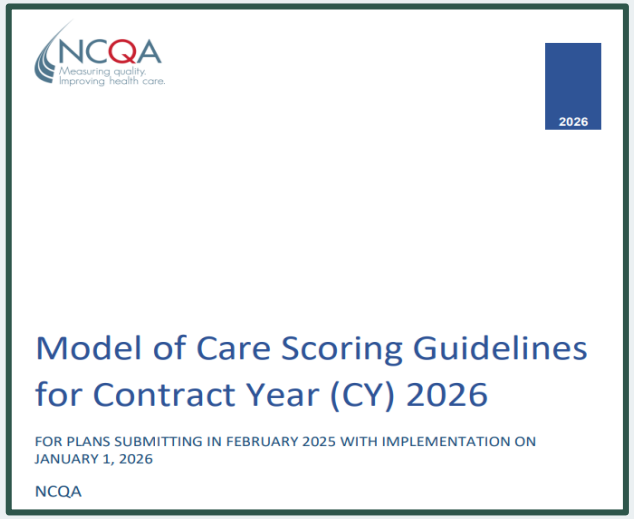
Medicare Managed Care Manual
Chapter 5 - Quality Assessment

Table of Contents

(Rev. 117, 08-08-14)

Transmittals Issued for this Chapter

10 Introduction
20 Medicare Quality Improvement Program
- 20.1 Chronic Care Improvement Program (CCIP) and Quality Improvement Projects (QIP)
  - 20.1.1 Chronic Care Improvement Program (CCIP)
  - 20.1.2 Quality Improvement Project (QIP)
- 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs)
  - 20.2.1 Model of Care Elements
  - 20.2.2 Model of Care Scoring Criteria
  - 20.2.3 Special Needs Plans Health Risk Assessment Tool (HRAT)
  - 20.2.4 Structure & Process (S&P) Measures



NCQA
Measuring quality. Improving health care.

2026

Model of Care Scoring Guidelines for Contract Year (CY) 2026

FOR PLANS SUBMITTING IN FEBRUARY 2025 WITH IMPLEMENTATION ON JANUARY 1, 2026

NCQA

CMS.gov Centers for Medicare & Medicaid Services

Medicare | Medicaid/CHIP | Marketplace & Private Insurance

Medicare › Health & drug plans › Special needs plans

Special needs plans

Model of Care (MOC)

Special Needs Plans

What is a Special Needs Plan?

Abbreviations

CC	Care Coordinator
CMS	Centers for Medicare & Medicaid Services
CPG	Clinical Practice Guidelines
C-SNP	Chronic Condition SNP
CTP	Care Transition Protocols
D-SNP	Dual Eligible SNP
ECM	Enhanced Care Management
HRAT	Health Risk Assessment Tool
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
I-SNP	Institutional SNP
MOC	Model of Care
SNP	Special Needs Plan