CY 2026 SNP Model of Care Training FAQs

As of January 2025

Introduction

In collaboration with the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) held pre-recorded training sessions for health plans to review the calendar year (CY) 2026 Special Needs Plan (SNP) Model of Care (MOC) requirements. This training provided detailed information on the requirements for all MOC elements. NCQA and CMS received a variety of questions from health plans during the two pre-submission technical assistance calls, held on November 19, 2024, and the other on January 7, 2025. Given this, the SNP Project Team compiled the below frequently asked questions (FAQs) to serve as an informational resource for health plans. Following the general information section, the FAQs are organized by MOC element. In addition, a Resources section containing information on obtaining technical assistance and links to key training-related items has been included at the end of this document.

General Information

1. **Where can I find the recordings for the CY 2026 trainings?**

   The recordings for the CY 2026 trainings are available here on the NCQA SNP MOC Approval website.

2. **Where can I locate the SNP MOC Matrix?**

   The SNP MOC Matrix, along with the CY 2026 MA and Part D applications, will be available January 12, 2025, in the Health Plan Management System (HPMS) and as part of the CY 2026 Medicare Advantage (Part C) Application (for MOC renewal, see the HPMS MOC module). Additionally, the SNP MOC Matrix can be found on the SNP Approval website. You can also review the CY 2026 MOC Scoring Guidelines on this website for details related to the MOC content.

3. **If the MOC has an overall submission score of 75% or greater but does not score at least 50% on each element, will plans have the ability to resubmit the MOC so that it can be approved for multiple years?**

   No, plans must meet an overall scoring benchmark of 70% in addition to a minimum score of 50% for each element to obtain approval, regardless of the final overall score [42 CFR § 422.101(f)(3)(iii)]. Plans that do not meet this minimum threshold for each element are required to Cure, and will only receive a one-year approval, regardless of the final overall score.

4. **For a renewal MOC submission, should plans include changes over the previous MOC submission in strikethrough and/or red text?**

   No, plans submitting a renewal MOC should not include changes from the previous MOC submission in strikethrough text or red text; however, strikethrough text is required to highlight changes when submitting Cure or Off-Cycle documentation.

5. **Where should plans include additional documents (if applicable) that detail processes in the MOC?**

   Plans should not upload additional documents or attachments to the MOC. NCQA only downloads two documents from the Health Plan Management System (HPMS)—the SNP MOC Matrix and MOC narrative document. All required information must be included directly in the MOC document itself. Additional

documents, such as training slides and/or other materials, may be included as an appendix at the end of the MOC; however, ideally this information should be embedded under the appropriate factor within the MOC. SNPs should indicate at the end of a factor if NCQA should review the appendix for additional material (e.g., "see Appendix for additional information").

6. **How much detail regarding policies and procedures are SNPs expected to provide in the MOC to meet the intent of the factors? For example, do we need to include specific details or are general statements adequate?**

   To address the intent and factors of each element, plans should provide sufficient information on policies, procedures, and responsible staff. The MOC should describe a clear and holistic process that someone outside of the SNP can understand and evaluate. This can generally be accomplished by addressing the who, what, where, when, and how for that particular policy/procedure.

7. **Are there specific factors or sections that must include reference to the Bipartisan Budget Act (BBA) of 2018?**

   Plans do not need to specifically reference the regulations in the narrative; however, plans must describe in their MOC narrative the processes used to meet each of the BBA requirements, as applicable.

8. **Can factor descriptions be combined under one element or does each factor description need to be discrete?**

   Both of these approaches are acceptable. Please keep in mind that it is easier for SNP reviewers to follow the MOC narrative and to verify that all requirements have been met if the SNP includes its response under the designated factor; however, reviewers are trained to assess the entire MOC narrative to find information that may be missing from a particular factor. Typically, plans provide information factor by factor.

9. **How can we learn how the HPMS submission process works prior to the deadline?**

   Please review the HPMS Quick Reference Guide: How to Submit a Model of Care (MOC) for information on uploading MOCs in HPMS. Please note, Medicare Advantage Organizations (MAOs) should submit their initial MOCs with their initial Medicare Advantage contract application. For more information regarding MA applications, see: https://www.cms.gov/medicare/health-drug-plans/medicare-advantage-application.

10. **Is there a preferred file naming convention for MOC uploads in HPMS?**

    The preferred file naming convention is as follows: H#_Plan Name_Type (CSNP, DSNP, or ISNP) SNP Detail MOC or Matrix. For example, H1234_Smarthealth_CSNP_DM_MOC and H1234_Smarthealth_CSNP_DM_Matrix. Documents with file names that include the following symbols will not be accepted by HPMS: "<", ">", "|", ":", "*", "?", "\", "/", "#", "%", ";", "+", "&", or "- ". Please limit special characters to underscores ("_") or periods (".") . Additional details can be found in the HPMS Quick Reference Guide: How to Submit a Model of Care (MOC).

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11. Do we need to submit a SNP MOC narrative for both D-SNP and C-SNP applications? What are the requirements for the SNP MOC Matrix?

Plans must submit a separate MOC narrative for a D-SNP and a C-SNP under the same contract. Plans should not combine these submissions into one MOC narrative, even if there are similarities across the two SNPs. Plans should have been notified if they are required to renew a MOC(s) for CY 2026. Every submission must include a SNP MOC Matrix and MOC narrative. If the Matrix is not included, the requirements of the submission are not met. Please refer to the SNP MOC Matrix to review the detailed requirements for all SNPs and elements that may be specific to SNP types.

MOC 1: Description of SNP Population

12. We understand population data should be from 2021 or more recent; however, can we utilize information and/or data that are prior to 2021? (MOC 1)

No, population data prior to 2021 is not considered adequate or sufficient to determine current resource needs or to consider changes in treatment; however, the most recently published data may be used to draw a correlation to the SNP's target population. Please note that academic articles do not need to be written within the last three years; this requirement is specific to the data used to identify the target population.

13. If plans do not have member-specific data, can we use national federal (.gov) data? What if this data is from 2018? (MOC 1)

National data can serve as a starting point; however, plans should be collecting data on an annual basis. That said, the data used must be within the timeframe noted for the current year's submission requirements. In the scenario presented, the data is not within the 2021 timeframe specified.

14. If a renewal plan has low membership, can the plan use data from other plans and/or service lines to describe the target population? (MOC 1)

Yes, however, the plan must explicitly state that, since it had a limited number of members, it is using information from other service lines and will update data once the plan membership grows.

15. What is considered the minimum membership threshold for describing the target population? (MOC 1A)

Plans should be able to provide some demographic information regardless of the size of expected enrollment.

- The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient.
- The MOC must describe how the plan identifies its members and include specific information on the characteristics of the target population it intends to serve. This information must include components that characterize its enrollees (e.g., average age, gender and ethnicity profiles, incidence and prevalence of major diseases, chronic conditions, and other significant barriers faced by the target population). Information about national population statistics without drawing a correlation to the SNP's target population is insufficient.

- The organization may use enrollee information from other/similar 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.

16. Are plans required to include educational demographics for their membership? (MOC 1A)

The MOC must describe the demographic details of the target population. This requires the provision of population demographics, including but not limited to average age, gender, race and ethnicity profiles, education level, and socioeconomic status.

17. Is it required to have demographics broken down by county? (MOC 1A)

Plans use a variety of methods to display the detailed demographic information required for MOC 1A, Factor 3. The most common and generally the easiest for reviewers to follow is a table that identifies each service area and includes the demographic breakdown of age, gender, race and ethnicity, language spoken, and education level (at a minimum) across the membership within each of these areas. As a reminder, plans must provide demographic details for each service area they identify. If data for one service area is missing, the factor will be scored down. Some plans include a detailed narrative of demographic information as opposed to a table. This is also acceptable. In this case, it is still expected that the SNP provide the same level of detail.

18. Are there suggestions or guidance you can provide on how to define the most vulnerable population? (MOC 1B)

Plans must provide a description of how its most vulnerable individuals are identified and also differentiate between the general target population and its most vulnerable population. It is suggested that plans determine what makes the SNP enrollees higher risk by looking at the presence of comorbidities, service utilization, demographics, etc. As a reminder, CMS requires that MA organizations offering SNPs must coordinate the delivery of specialized benefits and services that meet the needs of the most vulnerable beneficiaries among the three target special needs populations as defined in 42 CFR § 422.2 of this part, including frail/disabled beneficiaries and beneficiaries near the end of life [42 CFR 422.101(f)(2)(iv)]. The description must include the demographic characteristics of this specific population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, and other factors). As a reminder, the data for the general target population and the most vulnerable population should not be the same as they are two distinct populations.

MOC 2: Care Coordination

19. How do you define "contracted staff"? (MOC 2A)

"Contracted staff" refers to contracted health care providers within the SNP's network; however, SNPs are also required to have all "employed" staff trained on the SNP MOC, including third party "contractors" hired to coordinate and/or deliver all services and benefits.

20. Can you provide specific timeframes for Individualized Care Plan (ICP) updates following the completion of a Health Risk Assessment (HRA)? (MOC 2B)

CMS does not currently require SNPs to follow specific timeframes for updating member ICPs. Under Title XVIII, section 1859(f)(5)(A)(ii)(II) of the Social Security Act, each SNP is required develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided. As we note in Attachment A of the MOC protocols as part of PRA package CMS-10565 (OMB 0938-1296), SNPs should 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. Any timeframe the SNP may implement should be consistent with the requirements in 1859(f)(5)(A)(ii)(II) and with the plan's approved MOC and meet the needs of their enrollees.

21. **For unable to reach members or members who refuse to complete the HRA, are we required to complete "administrative HRAs" for these members using claims or other data? (MOC 2B)**

    No, SNPs should not conduct HRAs using administrative data. MAOs offering SNPs must conduct initial and annual HRAs to assess the individuals' physical, psychosocial, and functional needs, using a comprehensive risk assessment tool that CMS may review during oversight activities [see Social Security Act, § 1859(f)(5)(A)(ii)(I) and 42 CFR § 422.101(f)(1)(i)].

    In addition, SNPs are required under 42 CFR 422.152(g)(2)(iv) to submit HRA completion data as a part of the CMS Part C Plan Reporting process. CMS provides further guidance to plans in the Part C Plan Reporting Technical Specifications found here: Part C Reporting Requirements. As noted in the Technical Specifications, 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 using only claims and/or other administrative data would not be acceptable for the purposes of meeting the Part C reporting requirements. SNPs should take this into consideration when reviewing their MOC HRA processes and incorporate appropriate enrollee refusal or "unable to reach" policies into their MOC HRA policies. Plans must provide a detailed approach for attempting to contact members, including the number of attempts, as well as assurance that efforts are documented.

22. **Are plans required to submit a copy of the HRA as part of the MOC submission? (MOC 2B)**

    Plans are not required to submit a copy of their HRA tool within their MOC submission; however, many plans choose to do so in order to showcase how the tool assesses the medical, functional, cognitive, psychosocial, and mental health needs of each SNP enrollee.

23. **Do the new Social Determinants of Health (SDOH) categories required for the health risk assessment tool (HRAT) need to be included in the MOC? (MOC 2B)**

    It is not a requirement to include the SDOH categories in the MOC; however, this may be related to other relevant processes, and we leave this to the discretion of the SNP.

24. **Does any face-to-face visit with a primary care provider (PCP) qualify towards satisfying the requirements of the Face-to-Face Encounter? (MOC 2C)**

    A qualifying face-to-face encounter can be held by a member of the enrollee's Interdisciplinary Care Team (ICT), the plan's case management and coordination staff, or contracted plan healthcare providers. This

includes: the enrollee's regular primary care physician, a specialist related to the enrollee's chronic condition, a behavioral health provider, health educator, social worker, and Managed Long-Term Services and Supports (MLTSS) plan staff or related MLTSS health care providers as long as these providers are: (i) a member of the enrollee's interdisciplinary team; (ii) part of the plan's case management and coordination staff; or (iii) contracted plan healthcare providers performing services on behalf of the plan.

25. **How is the face-to-face requirement met for a member who is in a long-term care environment, potentially with dementia, and unable to participate in their care without a representative that can be reached?**

    This requirement can be met by an encounter with the enrollee's Interdisciplinary Care Team (ICT), the plan's case management and coordination staff, or contracted plan healthcare providers (including the enrollee's PCP or a nurse practitioner).

26. **Is there a timeframe in which a face-to-face encounter must be completed? (MOC 2C)**

    The encounter must be completed at least annually, within the first 12 months of enrollment, as feasible and with the enrollee's consent.

27. **Since the ICP is supposed to be member-directed (or at least member-involved), what do we do if the member refuses to have any communication or involvement with the care coordination process? (MOC 2D)**

    CMS firmly believes that the ICP is an essential tool for managing care for all SNP beneficiaries, regardless of whether they complete an HRA. Additionally, MA regulations at 42 CFR 422.152(g)(v) require that as part of a SNPs' quality improvement program, it must implement an ICP for each beneficiary. Although we recognize that the information collected during an HRA along with involvement of the beneficiary and/or his/her caregiver/representative is valuable in developing an ICP, we expect that SNPs will formulate an ICP based on information gathered from assessments, medical records, or other available data.

28. **Are there specifics on what sources should be used to complete the ICP? (MOC 2D)**

    As required by 42 CFR 422.101(f)(1)(i), SNPs must ensure that the results from the initial assessment and annual reassessment conducted for each individual enrollee are addressed in the individual's ICP. Data sources can also include face-to-face encounters, medical records, claims data, Health Information Exchanges, and other sources, as relevant.

29. **What is the timeline requirement to complete an ICP after an HRA? (MOC 2D)**

    For the purpose of the MOC narrative, neither CMS nor NCQA is prescriptive about any timeline requirements. The expectation is that the ICP be completed in a timely manner. It is up to the organization to determine what is a reasonable timeframe; however, anything that is too lengthy or that does not meet the needs of the enrollee would not be acceptable.

30. **At a minimum, who should be included on the ICT? (MOC 2E)**

    As required by 42 CFR 422.101(f)(1)(iii), SNPs must ensure that ICT members have demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating

individuals similar to the targeted population of the plan. The development of each ICT must include a multidisciplinary approach to care coordination and must include providers and participants beyond the member and the member's primary care provider. Examples may include caregivers, specialists, social workers, pharmacists, community resources, and others as needed. The SNP must describe how it determines ICT membership and the roles and responsibilities of each member. The description in the MOC must specify how the expertise, training, and capabilities of the ICT members align with the identified clinical and social needs of the SNP member.

31. Do low risk stratified members require an ICT? (MOC 2E)

Regulations at 42 CFR § 422.101(f)(1)(iii); 42 CFR § 422.152(g)(2)(v) require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP. There are no exceptions for enrollees stratified in the low-risk group. Regarding ICT for low-risk enrollees, it was determined that these individuals may not have chronic conditions and therefore the ICT may consist of the enrollee/caregiver (if applicable) and their PCP. Additional resources must be assigned upon identification of other conditions or need for resources such as specialists or (durable medical equipment) DME suppliers.

32. Are ICT meetings/minutes required? (MOC 2E)

Plans should record meeting minutes and include this information in the ICP. NCQA is not looking for the meeting minutes specifically; however, this is part of the process that should be described in the MOC.

33. If transitions of care are provided only to those enrollees determined to be medium or high-risk members, does this meet the requirements included in MOC 2F? (MOC 2F)

No, this does not meet the intent of the element. There are no exceptions when it comes to transitions of care. Regulations at 42 CFR § 422.101(f)(2)(iii)-(v) and 42 CFR § 422.152(g)(2)(vii)-(x) require all SNPs to coordinate the delivery of care for its members. It is the SNP's responsibility to ensure that treatment protocols and needed resources related to transitions of care across health care settings and providers are delivered to all enrollees, regardless of risk stratification category.

34. Is a separate Complex Case Management Program required for SNP members even though these members are managed by a Standard Condition Case Management in the moderate and high-risk levels? (MOC 2F)

There is no specific complex care management program required. CMS and NCQA want to ensure that the federal requirement for care coordination is met.

35. What are considered transition of care episodes outside of inpatient hospitalizations? (MOC 2F)

Examples include but are not limited to the transition from home to hospital, from home to a skilled nursing facility, from a hospital to a skilled nursing facility or rehabilitation facility or transitioning back home.

36. Does a single point of contact need to be shared during each transition of care? (MOC 2F)

There should be at least one point of contact introduced to the member and/or caregiver, when possible. An exception to this rule is when an enrollee is admitted and discharged before the point of contact can be introduced.

37. Can you confirm expectations for when/how ICPs are communicated related to care transitions? (MOC 2F)

We defer to plans to define their operational procedures; however, care coordination activities should be conducted in a manner that is timely and meets the needs of the enrollees.

MOC 3: Provider Network

38. What is the difference between the ICT provider training and credentialing/verification requirements included for MOC 2E, Factor 1, versus the information requested for MOC 3A, Factor 2? (MOC 3A)

MOC 2E, Factor 1 requires a comprehensive description of how the organization determines the composition of ICT membership to address the unique needs of enrollees. We want to understand how these needs correlate with the expertise of the providers included in the ICT.

In MOC 3A, Factor 2, plans must explain how the SNP oversees its provider network and facilities and ensures that its providers are actively licensed and competent to provide these specialized healthcare services to SNP enrollees. Plans should detail how they credential, track, and monitor the providers that comprise the ICT.

The overall similarity across these two factors is that plans need to describe how they confirm that everyone on the ICT team and within the network is adequately skilled and able to accommodate the unique needs of the SNP enrollees.

39. Our MOC training is under development. If the staff training and provider training content is similar/identical, are we expected to duplicate the description under MOC 2A (staff training) for MOC 3C (provider training)? (MOC 3C)

While there will likely be similarities between the general staff MOC training and the provider MOC training, the provider training should include specific information for practitioners/clinicians.

40. Are plans required to include provider network training slides in their MOC submission? (MOC 3C)

Yes, both MOC staff training slides and provider training slides are a requirement. The two sets of slides typically have some variation. For example, the clinical slides may include details that are more pertinent to a plan's provider network. In addition, some plans use the same slides for staff training and provider training. In this case, the slides must include provider-specific details. Please note that a list of bullet points outlining a training overview or table of contents is not acceptable and will be scored down.

41. Are SNPs required to provide training annually to all network providers? (MOC 3C)

As noted during the November 2024 MOC training, CMS believes the intent of the regulation at 422.101(f)(2)(ii) is for SNPs to focus training activities on contracted and non-contracted providers who are essential to the enrollee's care coordination and management processes – including those involved in care coordination and transition tasks – rather than *all* providers who are in-network or are seen regularly by members out-of-network. In other words, SNPs should focus their training on key (i.e., appropriate) providers *and* their staff who are integral to member's care coordination and care transition. For example,

members of the enrollee's ICT are clearly critical to the SNP care coordination and care management process; therefore, they must be included in the MOC provider training.

CMS recognizes that offering training to an out-of-network provider based on a one-time encounter with a member may create an administrative burden. This means that plans can determine that some providers do not need to take the MOC training based on their roles in the provider's network or on the types of services provided. Based on this guidance, plans should determine the out-of-network providers that members see frequently, deem them "appropriate", and include them in MOC provider training.

Since the regulation stipulates that training must be offered to appropriate non-contracted providers, SNPs must describe the process for how the organization implements provider training and demonstrate or show evidence that it makes training on the MOC available to all appropriate in-network and out-of-network providers.

42. Is there a frequency at which providers (in-network and out-of-network) need to participate in MOC training? (MOC 3C)

Per 42 CFR 422.101(f)(2)(ii), MA organizations sponsoring SNPs must have appropriate staff (employed, contracted, or non-contracted) trained on the SNP plan model of care to coordinate and/or deliver all services and benefits. Consistent with this regulation, SNPs must offer MOC provider training for all appropriate in-network and out-of-network providers and staff (e.g., those with member care coordination and care management responsibilities) at least once per MOC approval period. For example, C-SNPs must train all appropriate in-network an out-of-network providers annually. D-SNPs and I-SNPs must train all appropriate in-network and out-of-network providers at least once during the MOC's period of approval. For example, if a D-SNP receives a 3-year approval period, it must train providers a least once within this 3-year approval period. That said, the submission and acceptance of off-cycle revisions begins a new period of approval and warrants additional MOC training for all appropriate in-network and out-of-network providers.

43. Tracking provider compliance for MOC provider training is extremely difficult, can NCQA provide suggestions on how provider training should be monitored? (MOC 3C)

We are not prescriptive in how SNPs should track provider compliance related to MOC training completion. CMS believes that plans are in the best position to determine how to track compliance.

44. Are provider MOC Training Attestations required for out-of-network staff even though they are not contracted? (MOC 3C)

Under 42 CFR 422.101(f)(2)(ii), MA organizations offering SNPs must have appropriate staff (employed, contracted, or non-contracted) trained on the SNP plan model of care to coordinate and/or deliver all services and benefits. This regulation does not establish the requirement that SNPs collect provider attestations. That said, SNPs should note the use of attestations (if used) as part of their training process.

MOC 4: MOC Quality Measurement and Performance Improvement

45. Given that our plan has an effective start date of January 1, 2025, we will not have sufficient data to report outcome measures related to the achievement of goals for the CY 2026 MOC submission. Is it

acceptable to note in the MOC that we have insufficient data available to measure goal achievement? (MOC 4A, 4B)

If you are a new plan with an effective start date of January 1, 2025, NCQA and CMS do not expect that you will necessarily be able to provide data in support of the goals included in MOC 4A and MOC 4B; however, please indicate within the MOC narrative that the effective start date is January 1, 2025, and that this is the reason that no data is provided. In this instance, NCQA and CMS still expect you to detail specific information about SNP goals in MOC 4A and MOC 4B.

As required under 42 CFR 422.101(f)(3)(ii)(B), plans submitting a renewal MOC must provide relevant information pertaining to the MOC's goals for review and approval. If you are a returning plan and you only have a subset of the previous year's data (e.g., three-quarters of the year), NCQA and CMS expect that you include these data to provide evidence of the level of fulfillment of the previous MOC's goals. NCQA and CMS also expect that you indicate and provide information on whether you met each goal and, if not, how the SNP plans to meet the objective in the future.

46. Are plans required to include HRAT, ICP, and ICT goals in MOC 4B? (MOC 4B)

Yes, the goal must be set at 100% because these activities are a regulatory requirement. Per the CY 2026 MOC Scoring Guidelines, the MOC must detail goals for the HRA, ICP, and ICT. The expectation is that all plans aim for 100% completion for the HRAT, ICP, and ICT goals; however, CMS understands that plans may not necessarily achieve these goals, as there are challenges that may impact the desired outcome (e.g., unable to be reach enrollees).

47. Where can I find the templates shown in the training slides? (MOC 4A, MOC 4B)

The templates shared in the training slides are only shown as an example. Plans can display their information in a similar format; however, please ensure that all the necessary components are included when developing your own table. We do have a disclaimer stating a table format is preferable; however, plans are welcome to use any format as long as all required information is included.

48. For MOC 4A and MOC 4B, are plans only required to indicate whether goals are "met" or "not met" rather than provide the actual quantified results? (MOC 4A, MOC 4B)

Plans should include benchmarks, goals, timeframes, and data sources related to their goals. In addition, plans should provide a synopsis of whether goals were met or unmet as well as any action plans for improvement (if goals were not met) along with the rationale for these improvements. NCQA reviewers are looking for a brief overview of whether goals are met/unmet. This information can be provided in the table depicting your goals or in a standalone statement. While we cannot be certain as to the significance of this information as reviewed by CMS auditors, NCQA will not validate the data specifically as we do not have actual evidence to compare against. We will instead evaluate the summary of results.

49. Do plans use the same measurable goals for MOC 4A and MOC 4B? Are the measurable goals related to the SNP population, or are they more granular (i.e., goals of the ICP)? (MOC 4A, MOC 4B)

MOC 4A goals focus on the improvement of overall plan operations (e.g., access to care, coordination of care, member/provider satisfaction and program effectiveness). MOC 4B objectives focus on health-related

improvements for the overall SNP population (not for individual member health) such as HRA completion, ICP planning, ICT formation, A1c levels, and immunizations.

50. How do plans handle measures that were in the previous MOC, but will no longer be included in the renewal this year? (MOC 4A, MOC 4B)

We understand that your goals and objectives may change and evolve over time. Please indicate that the goal has been successfully completed or revised and what you are implementing in its place.

51. The MOC 4A training slides indicate that the quality work plan includes but is not limited to access to care, coordination of care, program effectiveness, and member and provider satisfaction. Are plans required to include a metric specifically for each of these items or is the plan allowed to choose their own goals for overall plan improvement? (MOC 4A)

The plan is permitted to select its own goals for overall plan improvement. The list serves as an example of categories that meet the requirements.

52. In MOC 4C, Factor 3, are plans required to report the actual number of members sampled versus the logic used to determine the sample size? (MOC 4C)

Plans are required to provide the sample size for each listed survey tool, as well as the methodology used to collect enrollee experience surveys (e.g., modes, attempts).

Resources

Technical Assistance Resources

- For technical inquiries related to the MOC program plan requirements or regulation questions, please contact the CMS Division of Policy, Analysis, and Planning (DPAP) mailbox.

  CMS DPAP Mailbox
  https://dpap.lmi.org
  Subject: SNP MOC Inquiry

- For SNP application inquiries, please submit questions via the SNP mailbox on the Division of Medicare Advantage Operations (DMAO) website.

  CMS SNP Mailbox
  https://dmao.lmi.org
  Subject: SNP Application Inquiry

Additional Resources

- NCQA SNP Approval Website
- CY 2026 MOC Scoring Guidelines
- CY 2026 Training Slides and Recordings