



2027

Model of Care Scoring Guidelines for Contract Year (CY) 2027

FOR PLANS SUBMITTING IN MAY 2026 WITH IMPLEMENTATION ON
JANUARY 1, 2027

NCQA

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Introduction

As provided under section 1859(f)(5) and (7) of the Social Security Act (the Act), every Medicare Special Needs Plan (SNP) must have a Model of Care (MOC) recommended for approval by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework through which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

Section 1859(f)(7) of the Act also gives the Secretary the authority to establish standards for the MOC approval process. CMS established these MOC Scoring Guidelines for Medicare Special Needs Plans (scoring guidelines) as part of the SNP approval process. NCQA provides oversight and quality review of its surveyors, who conduct the reviews based upon set criteria derived from the Department of Health and Human Services' (HHS) interpretations of the regulations. During the NCQA MOC approval process, a score is assigned to each of the clinical and non-clinical elements of the MOC. SNPs are approved for one, two, or three-year periods.

Standards, Scoring, and Approval Periods

As a component of the Medicare Advantage (MA) application and renewal process, SNPs are required to submit MOCs through the Health Plan Management System (HPMS). SNPs submit their MOCs based on the MOC Matrix document, which outlines the CMS SNP MOC standards and elements that must be addressed in the MOC narrative. MOC approval is based on NCQA's evaluation, which uses scoring guidelines and criteria established by CMS for the Secretary of the Department of Health and Human Services (HHS). The MOC Matrix is organized into four standards:

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

Each MOC standard contains elements comprised of individual factors against which SNPs are assessed. In total, there are 15 elements across the four standards. MOC scoring is based on the percentage of points earned out of 60 points across the elements. For each element, SNPs earn a score of 0–4 points, depending on the number of factors met. Points earned are converted to a percentage score (e.g., 50 of 60 points = 83.33%). A SNP must meet the following two requirements to obtain approval to operate:

- Earn a score of at least 70%.
- Meet the minimum scoring threshold of at least 50% at the element level for all 15 elements.

To relieve the burden of annual reporting, CMS grants multi-year approval to Dual-Eligible SNPs (D-SNPs) and Institutional SNPs (I-SNPs) that earn higher MOC scores. The MOC approval categories are based on the following scoring tiers:

- 3-year approval: ≥85%
- 2-year approval: 75% to <85%
- 1-year approval: 70% to <75%

The Bipartisan Budget Act of 2018 (BBA 2018) requires that Chronic Condition SNPs (C-SNPs) be limited to a 1-year approval period, regardless of the final score. This change went into effect in 2019 for the CY 2020 MOC approval process.

SNPs whose MOCs either do not meet the minimum 50% scoring threshold for each element or that score <70% overall during the initial review period are considered “failing.” These SNPs have an opportunity to correct deficiencies and resubmit updated MOC narratives to meet requirements. This one-time opportunity is called the “cure.” D-SNPs and I-SNPs required to cure may only achieve a 1-year approval status, regardless of the final score following the cure review.

Key Changes for CY 2027

- Elements and factors in these CY 2027 Scoring Guidelines have been updated to align with the revisions and additions included in the most recent version of the MOC Matrix, which was released by CMS in 2026. SNPs are encouraged to review the updated MOC Matrix and these scoring guidelines in preparation for the upcoming submission.
- Substantive changes and clarifications made to these CY 2027 Scoring Guidelines are noted in the “Summary of Changes” section of each element and labeled as “**CY 2027 Update(s)**.” Changes and clarifications from CY 2025 and CY 2026 that remain relevant have been retained in the “Summary of Changes” section; however, they are not labelled with a specific year.
- Beginning with CY 2027, the number of total elements was reduced from 16 to 15. Previous *MOC Element 4D: Ongoing Performance Improvement Evaluation of the MOC* was removed because requirements for this element are captured under *MOC 4A: MOC Quality Performance Improvement Plan*. Due to this deletion, previous *MOC Element 4E: Dissemination of SNP Quality Performance Related to the MOC* is now MOC Element 4D.
- *MOC Element 1A: Description of the Overall SNP Population and Most Vulnerable Enrollees* now requires a description of both the general and most vulnerable SNP populations; previously this element focused solely on the general SNP population. This element also now requires plans to identify both the SNP type and submission type.
- *MOC Element 1B: Services for the Most Vulnerable Enrollees* now focuses on the identification of the most vulnerable enrollees, the services provided to these enrollees, and the partnerships established to support these enrollees.
- *MOC Element 4A: MOC Quality Performance Improvement Plan* now focuses specifically on the MOC quality performance improvement plan. *MOC Element 4B: Measurable Goals* must address measurable goals and enrollee health outcome goals

and requires an analysis of the goals of the previously approved MOC, a determination of whether goals were met/fulfilled, and a plan to address improvements needed when goals are not met in the expected timeframe.

Points of Emphasis for CY 2027

- Review the requirements for all elements and factors carefully and confirm that the MOC addresses all specified requirements, paying particularly close attention to the elements and factors that have changed this year.
- Please verify that the order of elements and factors in the MOC align with the order presented in these CY 2027 Scoring Guidelines.
- Be sure to provide detailed demographic information for both the general target population and the most vulnerable subpopulation in MOC Element 1A. SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data. SNPs must also describe their SNP type, setting, and/or chronic condition and differentiate the most vulnerable population from the general population.
- Keep in mind that data included for each submission must be specific to the target population (i.e., each individual H contract number). Data must also be current; using data that predates more than three years from the current submission date is not acceptable. For CY 2027, data cannot be from earlier than 2022.
- Section 1859(f)(5)(A)(ii) requires SNPs to conduct an initial assessment and an annual reassessment of each enrollee's physical, psychosocial, and functional needs; 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; and use an interdisciplinary team in the management of care. Therefore, SNPs must include completion goals for Health Risk Assessments (HRA), Individualized Care Plans (ICP), and the Interdisciplinary Care Team (ICT) set to 100% in MOC Element 4B.

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MOC 1: Description of the Overall SNP Population

Per 42 CFR § 422.101(f)(2)(i), MA organizations offering SNPs must target one of the three SNP populations defined in § 422.2. A comprehensive description of the SNP population is an integral component of the MOC and provides the foundation for care coordination, the provider network, and quality performance and improvement. The organization must provide information about its local target population in the service areas covered under the contract, and address the full continuum of care, including end-of-life needs and considerations for current and potential SNP enrollees. The SNP's population description must address the elements below.

MOC 1 Element A: Description of the Overall SNP Population and Most Vulnerable Enrollees

The plan must include a complete description of its SNP enrollees, including both the general and the most vulnerable populations. The plan must provide demographic characteristics, health status information, and a description of health disparities faced by enrollees, differentiating between the general SNP population and the most vulnerable enrollees. The plan's MOC description of its target SNP populations must address the following factors:

- 1. Identify the specific SNP type and whether the MOC submission is an initial, renewal, or off-cycle submission.**
- 2. Detail the demographic information of SNP enrollees in the general and most vulnerable populations.**
- 3. Describe the health status of the SNP enrollees in the general and most vulnerable populations.**
- 4. Describe the conditions and/or other factors impacting the health of SNP enrollees in the general and most vulnerable populations.**

Summary of Changes

- **CY 2027 Updates:**
 - Deleted prior Factor 1 (determine, track, and verify eligibility) and replaced it with new Factor 1 (identify SNP type and submission type).
 - Shifted prior Factor 3 (demographics) up to new Factor 2.
 - Separated prior Factor 2 (health status and health disparities) into new Factor 3 (health status) and new Factor 4 (health factors and disparities).
 - Expanded Factor 4 (health factors and disparities) to require that plans address factors impacting the health of SNP enrollees such as language barriers, health literacy, food insecurity, housing stability, and transportation access.
 - For new Factors 2, 3, and 4, specified that the requested information must be provided for both the general and most vulnerable populations.
- Previously clarified that SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data.
- Previously clarified that membership data provided cannot be older than three years. For CY 2027, data cannot be from earlier than 2022.

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: Identify SNP type and specify submission type*

The plan must identify the specific SNP type for which the MOC was submitted. The MOC must include the specific type of C-SNP, I-SNP, or D-SNP.

- C-SNPs: Identify the chronic condition(s) of focus.
- I-SNPs: Identify the setting(s) in which the enrollee population resides (i.e., skilled nursing facility, community, other residential or institutional settings, etc.). Specify whether the SNP is facility-based, an institutional-equivalent, or hybrid. Of note, the setting(s) in which the enrollee population resides should match the type of I-SNP (e.g., a facility-based I-SNP should exclusively enroll individuals who continuously reside for 90 days or longer in long-term care facility settings, whereas institutional-equivalent I-SNPs should not focus on populations residing in long-term care facilities and instead focus on populations living in the community that require an institutional level of care).
- D-SNPs:
 - Indicate if the D-SNP(s) are seeking to become a fully integrated dual eligible (FIDE) SNP, highly integrated dual eligible (HIDE) SNP, coordination only D-SNP, or will include multiple D-SNP subtypes. **Note:** *CMS ultimately determines the integration level of the D-SNP.*
 - Describe the eligibility categories and criteria for the D-SNP [Qualified Medicare Beneficiary (QMB Only); QMB Plus; Specified Low-Income Medicare Beneficiary (SLMB Only); SLMB Plus; Qualifying Individual (QI); Qualified Disabled and Working Individual (QDWI); Full Benefit Dual Eligible (FBDE)].

As part of the response to this factor, the plan must also specify whether the MOC is an initial, renewal, or off-cycle submission.

Factor 2: Identify demographics of general and most vulnerable populations

The MOC must identify and describe the demographic details of the general **and** the most vulnerable SNP populations. This requires the provision of population demographics, including (but not limited to) average age, sex, ethnicity, language, education level, and socioeconomic status. This

description must differentiate between the general SNP population and the most vulnerable enrollees.

SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data. Data must be current; using data that predates more than three years from the current submission date is not acceptable. For CY 2027, data cannot be from earlier than 2022. All data provided should be dated and include the data source.

Providing information about national population statistics without drawing a correlation to the SNP's target population is insufficient. If a plan is using national statistics, it cannot earn credit in the absence of identifying why the national statistics are representative of the intended target and/or most vulnerable population.

For new plans or plans without enrollees: The plan may use enrollee information from other product lines (e.g., Medicare Advantage or Medicaid plans) as an example of the intended general and most vulnerable populations. Otherwise, it must provide details compiled from the intended plan service area. In each of these scenarios, the plan must identify the rationale for using the data provided in terms of how it relates to the general and most vulnerable populations.

Factor 3: Describe health status of general and most vulnerable populations

The MOC must provide a detailed profile of the current medical/health status of its general and most vulnerable SNP populations. This description must address social, cognitive, and environmental aspects, in addition to living conditions and co-morbidities associated with the general and most vulnerable SNP populations in the plan's geographic service area. This includes a review of relevant diseases and comorbidities, such as the incidence and prevalence of major diseases and chronic conditions. Again, this description must differentiate between the general SNP population and the most vulnerable enrollees.

SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data. Data must be current; using data that predates more than three years from the current submission date is not acceptable. For CY 2027, data cannot be from earlier than 2022.

Providing information about national population statistics without drawing a correlation to the SNP's target population is insufficient. If a plan is using national statistics, it cannot earn credit in the absence of identifying why the national statistics are representative of the intended target and/or most vulnerable population.

Factor 4: Describe factors impacting the health of SNP enrollees and actions taken to address their needs

The MOC must describe conditions and/or other factors impacting SNP enrollees (e.g., how these factors impact health disparities for both the general and most vulnerable SNP populations as well as the associated challenges these characteristics pose). Examples may include language barriers, deficits in health literacy, poor socioeconomic status, housing, food, transportation insecurities, cultural beliefs/barriers, caregiver considerations, etc. The description must differentiate between these populations. The MOC must also describe how the SNP addresses enrollee needs for both the general and most vulnerable populations.

SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data. Data must be current; using data that predates more than three years from the current submission date is not acceptable. For CY 2027, data cannot be from earlier than 2022.

Providing information about national population statistics without drawing a correlation to the SNP's target population is insufficient. If a plan is using national statistics, it cannot earn credit in the absence of identifying why the national statistics are representative of the intended target and/or most vulnerable population.

MOC 1 Element B: Services for the Most Vulnerable Enrollees

Per 42 CFR § 422.101(f)(2)(iv), MA organizations offering SNPs must coordinate the delivery of specialized benefits and services that meet the needs of the most vulnerable enrollees among the three target special needs populations as defined in § 422.2, including frail/disabled beneficiaries and beneficiaries near the end of life. The plan must detail the additional benefits provided to the most vulnerable enrollees beyond those available to general SNP enrollees. The plan must include a complete description of the services tailored for enrollees considered especially vulnerable (using specific terms and details) and the establishment of community partnerships to support access to necessary resources and services for these enrollees. The plan’s MOC must address the following factors:

1. Describe the internal health plan procedures used to identify the most vulnerable enrollees within the SNP population.
2. Describe the specially tailored care management practices used for enrollees considered especially vulnerable and detail the additional benefits available to the most vulnerable enrollees beyond those available to enrollees in the general SNP population.
3. Describe the established partnerships with community organizations that provide, facilitate, or assist in identifying resources for the most vulnerable enrollees and/or their caregivers, including the process to support and/or maintain these partnerships and facilitate access to community services. This requires a list of the partnerships and available services specific to the SNP’s service area.
4. Explain the challenges associated with the establishment of community organization partnerships that impact the ability to connect enrollees to specific community services.

Summary of Changes

- **CY 2027 Updates:**
 - Revised element to focus specifically on the identification of the most vulnerable enrollees, the services provided to these enrollees, and the partnerships established to support these enrollees.
 - Added new Factor 2 (tailored care management practices and benefits for the most vulnerable enrollees).
 - Added new Factor 4 (challenges with establishing community partnerships).
- For Factor 1, previously clarified that SNPs must detail the criterion or set of criteria used to determine whether an enrollee is included in the most vulnerable population.

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 process for identifying most vulnerable enrollees***

Although the definition of “SNP enrollee” typically implies beneficiaries requiring additional care and services compared to the general Medicare population, this factor focuses on the sickest or most vulnerable SNP enrollees.

The MOC must describe the internal health plan procedures (i.e., methodology) used to identify the most vulnerable enrollees within the SNP. The MOC must also detail the specific criterion or set of criteria the plan uses to determine whether an enrollee is considered part of the most vulnerable population. Examples include but are not limited to:

- Multiple hospital admissions within a specified timeframe.
- High pharmacy utilization (count and timeframe).
- High risk and resultant costs. This should include a discussion of risk scores/categories.
- Specific diagnoses and subsequent treatment.
- Specific medical, psychosocial, cognitive, or functional challenges.

As part of this response, the MOC must detail how the plan differentiates between the most vulnerable enrollees compared to those that are less resource-intensive or have lower risk stratification scores.

Factor 2: Describe specially tailored care management practices and benefits for most vulnerable enrollees

The MOC must describe in detail the specially tailored care management practices used to support enrollees considered especially vulnerable. This description must detail the additional benefits, specially tailored services, and resources the plan anticipates offering to provide care to these most vulnerable enrollees above those available to general SNP members. As part of this response, the plan must address how the SNP will meet the needs of these vulnerable enrollees throughout the full continuum of care, including end-of-life considerations.

Factor 3: Describe established partnerships with community organizations to support most vulnerable enrollees

The MOC must describe the SNP’s established partnerships with community organizations that provide, facilitate, or assist in identifying resources for the most vulnerable enrollees and/or their caregivers, including the processes to support and/or maintain these partnerships and facilitate access to community services.

The response must include a list of the SNP’s current community partnerships specific to the SNP’s service area and the associated services they provide to the most vulnerable enrollees. The MOC must describe how the SNP collaborates with its partners to facilitate access to community services, deliver needed services, and maintain continuity of services for the most vulnerable

enrollees and/or their caregivers.

Factor 4: Explain challenges associated with establishing community partners/organizations

The MOC must explain any challenges associated with the establishment of partnerships with community organizations that impact the ability to connect enrollees to specific community services. This description should include the strategies and solutions the SNP uses to mitigate these challenges.

MOC 2: Care Coordination

Regulations at 42 CFR § 422.101(f)(2)(ii)-(v) and 42 CFR § 422.152(g)(2)(vii)-(x) require all SNPs to coordinate the delivery of care and measure the effectiveness of the MOC delivery of care coordination. Care coordination involves deliberate organization and communication of health care activities with stakeholders, including providers both inside and outside of the SNP's network, to help ensure that enrollee health care needs, preferences for services, and information sharing across health care settings are met. Effective care coordination maximizes the use of efficient, safe, high-quality patient services and ultimately leads to improved enrollee health outcomes. The MOC 2 elements presented in this section are essential components of a comprehensive care coordination program. Together, these six elements must comprehensively address the SNP's care coordination activities, processes, and overall approach. The description of the SNP's care coordination must address the elements described below.

MOC 2 Element A: SNP Staff Structure

The plan's MOC must fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of SNP enrollees. The plan's MOC must address the following factors:

- 1. Describe the roles and responsibilities of employed and contracted clinical staff across all health plan functions, including oversight functions, that directly or indirectly affect enrollee care coordination.**
- 2. Provide an organizational chart that identifies staff responsibilities and job titles directly or indirectly related to enrollee care coordination.**
- 3. Describe contingency plans and disaster/emergency preparedness plans used to ensure ongoing continuity of critical staff functions.**
- 4. Describe how the SNP conducts MOC training for its employed and contracted staff.**
- 5. Describe how the SNP documents and maintains training records as evidence that employees and contracted staff have completed MOC training.**
- 6. Explain the challenges associated with the completion of MOC training for employees and contracted staff and describe the actions taken to ensure that MOC training is completed.**

Summary of Changes

- **CY 2027 Updates:**
 - Removed prior Factor 1 (administrative staff roles and responsibilities).
 - For new Factor 3, reintroduced requirement to address disaster/emergency preparedness plans in addition to general contingency plans.
 - For new Factor 6, emphasized that the plan should detail steps taken to ensure completion of staff MOC training.
- For Factor 4, previously clarified the requirements for staff training materials included in the MOC based on whether plans are submitting an initial or a renewal MOC.

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 *Factor 1: Identify clinical staff roles and responsibilities*

The plan must identify and fully define the SNP staff roles and responsibilities for both employed and contracted clinical staff across all health plan functions that directly or indirectly affect care coordination, excluding administrative staff with responsibilities unrelated to care coordination. The MOC must include but is not limited to the identification and detailed explanation of staff that conduct the following functions:

- Direct enrollee care and education on self-management techniques.
- Care coordination.
- Pharmacy consultation.
- Behavioral health counseling.
- Clinical oversight (including quality improvement and utilization review).

The response must identify staff in clinical oversight roles and those that conduct utilization review to ensure use of appropriate clinical practice guidelines and integration of care transition protocols.

As part of this description, the plan must identify the required licensure and/or credentials necessary for the specified clinical function. **Note:** *Contracted staff does not refer to in-network providers.*

Factor 2: Provide organizational chart

The MOC must include a copy of the SNP’s organizational chart that identifies staff responsibilities and job titles that are directly or indirectly responsible for enrollee care coordination.

Factor 3: Describe contingency and disaster preparedness plans

The SNP 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 MOC must identify and describe contingency plans proposed or currently in use to ensure ongoing continuity of critical staff functions (e.g., backup of key personnel, turnover, planned and unplanned absences) and must also describe disaster preparedness and recovery plans in the event of an emergency.

Factor 4: Describe MOC staff training

Regulations at [42 § CFR 422.101\(f\)\(2\)\(ii\)](#) require SNPs to have appropriate employed, internal, or contracted staff trained on the plan’s model of care to coordinate and/or deliver all services and benefits.*

The MOC must:

- Specify that training is conducted for employed and contracted staff.*
- Describe how MOC training is conducted, including strategies and content, and provide specific documentation as follows:
 - Initial MOCs: Detailed description of training topics and/or materials, if available.
 - Renewal MOCs: Specific detailed examples of the slides or training materials used (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/videoconferencing).

Note: A general high-level overview of content is not sufficient for either initial or renewal MOCs.

*For this element, contracted staff do not include physicians or other providers (and their staff) that the plan contracts with as part of the provider network. SNPs are expected to provide a description of in-network and out-of-network provider training as part of MOC Element 3C.

Factor 5: Document and maintain training records

The plan must describe the process and reference the system it uses to document and maintain training records as evidence that employed and contracted staff have completed MOC training (e.g., dated attendee lists, web-based attendance confirmation, electronic training records). The MOC must address how the plan tracks and stores this documentation.

Factor 6: Explain challenges and ensure completion of training

The SNP must explain any challenges associated with employed and contracted staff completing MOC training (excluding contracted in-network providers). The SNP must also describe the specific actions the plan takes to ensure that MOC trainings have been completed.

MOC 2 Element B: Health Risk Assessment (HRA)

Regulations at 42 CFR § 422.101(f)(1)(i) and 42 CFR § 422.152(g)(2)(iv) require that all SNPs conduct a comprehensive Health Risk Assessment for each individual enrolled in the SNP. SNPs should carefully review these regulations in detail to ensure compliance in their MOCs. D-SNPs that are applicable integrated plans should also carefully review the requirements under 42 CFR § 422.101(f)(1)(v).

The plan’s MOC must include a clear and detailed description of the policies and procedures for completing the HRA that addresses the following factors:

1. **Detail the process the SNP uses to conduct the initial HRA and annual reassessment for each enrollee (including the responsible staff), and describe how the HRA identifies the medical, functional, cognitive, psychosocial, and mental health needs for each enrollee.**
2. **Detail the process used to review, analyze, and stratify HRA results. This includes an explanation of how the SNP uses stratified results to improve the care coordination process.**
3. **Describe how the SNP uses the HRA to develop and update the Individualized Care Plan (ICP), in a timely manner, for each enrollee and how the SNP ensures HRA results are addressed in the ICP.**
4. **Explain how the SNP disseminates the HRA information to the Interdisciplinary Care Team (ICT) and how the ICT uses this information for care management.**

Summary of Changes

- **CY 2027 Updates:**
 - For Factor 1, specified that SNPs must address how the HRA addresses the medical, functional, cognitive, psychosocial, and mental health needs for each SNP enrollee. Also clarified that SNPs must identify and describe the HRA tool used and must identify the personnel that conduct the initial HRA and annual reassessments.
 - Reorganized the order of factors to reflect the order of operations more accurately.
 - For Factor 2, specified that plans must describe each risk stratification tier.
 - For Factor 3, specified that plans must describe how they ensure HRA results are addressed in the ICP.
- For Factor 2, previously clarified that SNPs must describe the stratification process and how the use of stratified results improves the care coordination process.

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 HRA have a direct effect on the development of the ICP and ongoing coordination of ICT activities.

Factor 1: Conduct initial and annual HRA assessments

The plan must describe how the HRA is conducted and assesses the medical, functional, cognitive, psychosocial, and mental health needs for each SNP enrollee (see [42 CFR § 422.101\(f\)\(1\)](#)), including a summary of the evidence-based tools used. Of note, there are timing requirements specified in regulations, so the plan should also describe how the initial HRA is conducted in a timely manner for new enrollees (i.e., within 90 days (before or after) of the effective date of enrollment) and the reassessment is collected annually for other enrollees. The MOC must include detailed information on the methodology employed to coordinate the initial and annual HRA for each enrollee (e.g., mailed questionnaire, in-person assessment, phone interview), the data collected via the HRA, the timing of the assessments, and how the SNP ensures the HRA process complies with the timelines set out in [42 CFR § 422.101\(f\)\(1\)](#). The MOC must also identify the personnel that conduct the initial HRA and annual reassessments and specify their licensure, as applicable.

In addition, the MOC must:

- Detail the process used to reassess enrollees, if warranted by a health status change or care transition (e.g., hospitalization, change in medication, multiple falls, etc.).
- Describe the process for attempting to contact enrollees to complete the HRA, including provisions for enrollees that cannot or do not want to be contacted or complete the HRA.
- Describe how the SNP addresses challenges associated with enrollees who decline to participate in HRA completion or are unable to be reached.

Regulations at [42 CFR § 422.101\(f\)\(1\)\(iv\)](#) specify that SNPs must:

- Make at least three attempts to reach the enrollee (not including any automated phone calls) to schedule the comprehensive initial or annual HRA, unless an enrollee agrees or declines to participate in the HRA before three attempts are made. Attempts must be made on different days and at different times of day.
- Send a follow-up letter to conduct the initial or annual HRA, if the enrollee has not responded.
- Document the attempts to contact the enrollee and, if applicable, the enrollee's choice not to participate (for any enrollees who are unable to be reached or decline to participate in the HRA).

Factor 2: Explain HRA methodology and stratification

The MOC must explain the detailed process it uses to review, analyze, and stratify HRA results. The plan should describe each risk tier, providing the inclusion criteria and acuity level for each. The MOC must also describe how the SNP uses stratified results to improve the care coordination process.

Factor 3: Use HRA information to develop the ICP

Regulations at [42 CFR § 422.101\(f\)\(1\)\(vi\)](#) require that SNPs address the results of the initial HRA, annual reassessment, and subsequent updates based on changes in health status for each enrollee within the Individualized Care Plan (ICP). The SNP must include a description of the policies and procedures it uses to develop and update, in a timely manner, the ICP for each enrollee, and how it ensures that the results from the initial HRA, annual reassessment, and any subsequent updates are addressed in the ICP. As noted in [§ 422.101\(f\)\(1\)\(vii\)](#), the ICP must be person-centered and include the preferences of the enrollee.

Factor 4: Disseminate HRA information to the ICT

The plan must describe its process for disseminating all HRA information (i.e., initial, reassessment) to the ICT and detail how the ICT subsequently uses this information for care management. The MOC must detail the mechanisms (i.e., communication plan) used to ensure communication of information to the ICT, provider network, enrollees and/or their caregiver(s) or designated representative, as well as other SNP personnel involved with overseeing the enrollee's ICP.

MOC 2 Element C: Face-to-Face Encounter

Regulations at 42 CFR 422.101(f)(1)(x) require that all SNPs must provide face-to-face encounters for the delivery of health care, care management, or care coordination services. Face-to-face encounters must occur, as feasible and with the enrollee's consent, on at least an annual basis beginning within the first 12 months of enrollment. The face-to-face encounter must be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff, or contracted plan health care providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy, and the MOC must address the following factors:

1. **Describe the policies, procedures, purpose, timing, and intended outcomes of the face-to-face encounter, including the process for obtaining and verifying enrollee consent.**
2. **Identify the staff who will conduct the face-to-face encounter and describe how the encounter will be conducted.**
3. **Describe how the SNP verifies through data collection that enrollees have participated in a qualifying face-to-face encounter.**
4. **Explain the types of clinical functions, assessments, and/or services that may be provided during the face-to-face encounter.**
5. **Provide a detailed description of how health concerns and/or active or potential health issues are addressed during the face-to-face encounter. Describe how the SNP conducts care coordination activities and ensures that appropriate follow-up, referrals, and scheduling are completed after the face-to-face counter.**

Summary of Changes

- **CY 2027 Updates:**
 - For Factor 3, specified that plans must describe follow-up communications with the enrollee/caregiver during the face-to-face encounter verification process.
 - Combined prior Factor 5 (addressing health concerns) and prior Factor 6 (care coordination activities) into new Factor 5.
 - For new Factor 5, emphasized that plans must address how they ensure that appropriate follow-up activities are completed after the face-to-face encounter.
- For Factor 1, previously clarified that plans must address the consent process for in-person and virtual face-to-face encounters.
- For Factor 5, previously clarified that plans must address how the SNP determines and conducts care coordination activities when the plan reviews data associated with a face-to-face encounter between an enrollee and a provider.

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 no factors

Explanation This element describes the mandatory face-to-face encounter that serves a clinical or care coordination/care management purpose. The face-to-face encounter should pertain to the individual’s health care and is a way of ensuring that the goals of the SNP are met.

Factor 1: Detail face-to-face encounter essentials

The MOC must detail the plan’s process for conducting the face-to-face encounter, including but not limited to the following:

- Description of the policies, procedures, purpose, timing, and intended outcomes of the face-to-face encounters.
- For encounters initiated by the SNP, a description of the process used to obtain consent (in person and virtual, as applicable) from enrollees to complete a face-to-face encounter and how the SNP verifies that an enrollee has granted consent prior to the face-to-face encounter.

Note: Information exchanged between providers and the plan in the process of paying claims would provide verification that the enrollee met face-to-face with a qualified provider and consent would be inherent in the enrollee's visit to their provider.

- How the plan verifies that encounters occur within the first 12 months of enrollment and at least annually thereafter.

CMS recognizes that a SNP may not be able to comply with the rule’s mandate of an annual face-to-face encounter and intends the “as feasible” standard in the regulation to address such situations. If the enrollee refuses an annual face-to-face encounter or if the SNP was unable to reach the enrollee after a reasonable number of attempts, the plan is considered to have complied with the requirement despite the lack of a qualified encounter. However, plans should document the basis or reason that a face-to-face encounter is not feasible in order to demonstrate that, where there are no face-to-face encounters in the year, the failure is not a violation of the regulation. **Note:** Provision of reasonable accommodations by the SNP to enable the enrollee to participate in the encounter (e.g., interpreter services) is not considered a feasibility barrier.

Factor 2: Identify qualified personnel

The plan must, at a minimum, identify the qualified employed and/or contracted staff (e.g., care managers, specialists, PCPs, social workers, behavioral health workers, community health workers, etc.) that will conduct face-to-face encounters and deliver needed services to enrollees as part of the encounter.

Qualified staff include members of an enrollee's interdisciplinary care team or the plan's case management and coordination staff, or contracted plan health care providers, including: 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 Support (MLTSS) plan staff or related MLTSS health care provider, including community health workers. These providers must be: 1) a member of the enrollee's interdisciplinary team; 2) part of the plan's case management and coordination staff; or 3) contracted plan health care providers.

The plan must also specify how the face-to-face encounter will be conducted (e.g., mode):

- In-person.
- Visual, real-time, interactive telehealth encounter.

Face-to-face encounters are restricted to those that are in-person or a visual*, real-time, interactive telehealth encounter.

*SNPs conducting virtual face-to-face encounters must ensure that the platforms used meet requirements at [42 CFR § 422.118](#) and [§ 422.504](#) for the confidentiality of health information and personally identifiable information of Medicare enrollees.

Factor 3: Verify face-to-face encounters

The plan must describe how the SNP verifies that enrollees have participated in a qualifying face-to-face encounter with a member of their interdisciplinary care team, the plan's case management and coordination staff, or contracted health care providers. The plan must do the following in circumstances in which the encounter is provided by internal staff, as well as when the encounter requires external or contracted providers to render treatment or services on behalf of the SNP:

- Detail the process for reviewing enrollee claims data and how the data is used.
- Identify responsible staff.
- Describe any follow-up communications with the enrollee/caregiver, if applicable.

Factor 4: Specify clinical functions and assessments

The MOC must detail the types of clinical functions, assessments, and/or services that may be provided during face-to-face encounters. Examples of the necessary services or engagement during the required encounter include but are not limited to:

- Engaging with the enrollee to manage, treat, and oversee (or coordinate) their health care (such as furnishing preventive care included in the ICP).
- Annual wellness visits and/or physicals.

- Completion of a health risk assessment (HRA), such as the one annually required for all SNPs under the current regulation at § 422.101(f)(1).
- Care plan review or other similar care coordination activities.
- Health-related education whereby the enrollee receives information or instructions critical to the maintenance of their health or the SNP's implementation of processes for maintaining the enrollee's health, such as the administration of a medication.

Factor 5: Address health concerns/issues and describe care coordination activities

The MOC must detail the process for how health concerns and active or potential health issues identified during encounters are addressed. This includes a description of how enrollees or their caregivers are educated about potential issues that may develop.

In addition, the MOC must describe how it will conduct care coordination activities and ensure that appropriate follow-up, referrals, and scheduling for needed care or services (e.g., handling referrals, scheduling procedures or tests, etc.) are completed, as necessary. This includes how the SNP determines and conducts these care coordination activities when the plan reviews data associated with a face-to-face encounter between an enrollee and a provider.

MOC 2 Element D: Individualized Care Plan (ICP)

Regulations at 42 CFR § 422.101(f)(1)(vii), 42 CFR § 422.101(f)(1)(viii), and 42 CFR § 422.152(g)(2)(v) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP. The plan's ICP description must address the following factors:

1. Detail how the SNP will incorporate the required essential components into the ICP.
2. Describe the process used to develop the ICP, including the personnel responsible, how the enrollee and/or caregiver(s) are involved, and how often the ICP is modified as enrollee health care needs change. This requires a description of how the plan addresses challenges associated with enrollees who decline to participate in the ICP process or who are unable to be reached.

D-SNPS Only: Describe how the ICP is used to coordinate Medicare and Medicaid services and how the D-SNP or affiliated Medicaid plan provides these services, including long-term services and supports and behavioral health services.

3. Detail how the ICP is maintained (documented, reviewed, and updated) and the methods used to ensure access by appropriate stakeholders, including enrollees/caregivers.
4. Describe how updates and modifications to the ICP are communicated to the enrollee/caregivers and other appropriate stakeholders.

Summary of Changes

- ***CY 2027 Updates:***
 - Combined prior Factor 3 (personnel, caregiver involvement) with prior Factor 2.
 - For Factor 2, specified that the plan must indicate how often the ICP is modified and describe how it addresses challenges associated with enrollees who decline to participate in the ICP process or who are unable to be reached.
 - For Factor 2, specified that D-SNPs must describe the coordination of Medicare and Medicaid services.
 - For Factor 3, specified that the plan must indicate how the ICP is stored, shared with enrollees, and how the plan ensures access by enrollees and 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 ***Factor 1: Describe essential components of the ICP***

Per 42 CFR § 422.101(f)(1)(vii), SNPs must develop a comprehensive individualized plan of care that is person-centered and based on the enrollee's preferences, including for delivery of services and benefits, and the needs identified in the HRA. Given this, the MOC must describe how the SNP incorporates the following essential components into the person-centered ICP:

- The enrollee's self-management goals and objectives to meet their medical, functional, cognitive, psychosocial, and mental health needs identified in the HRA.
- The enrollee's personal health care preferences for delivery of services and benefits.
- A description of services specifically tailored to the enrollee's needs.
- The role of the enrollee's caregiver(s).
- The identification of goals as met/not met, and how often goals will be evaluated. If the enrollee's goals are not met, the MOC must describe the plan's process for reassessing the current ICP and determining the appropriate alternative actions.

Note: *The development of a person-centric ICP is not limited to those enrollees in a care management program nor to enrollees stratified as medium or high-risk.*

Factor 2: Describe the ICP development process

The ICP is an essential tool for managing care for all SNP enrollees. The MOC must describe how the SNP develops an ICP for each enrollee to deliver appropriate care. At a minimum, the SNP must describe the process used to develop the ICP and detail how the results of the initial HRA assessment and annual re-assessment are included in the ICP as required in paragraph (f)(1)(vii). Per 42 CFR § 422.101(f)(1)(vii), SNPs must develop a comprehensive individualized plan of care within 90 days of conducting a comprehensive initial HRA or 90 days after the effective date of enrollment, whichever is later.

This description must detail the personnel responsible for developing the ICP, including roles and functions, professional requirements, and credentials necessary to perform these tasks. Plans may reference MOC Element 2A to provide a full description of the roles and associated credentials.

The MOC must also include a description of the frequency at which SNP personnel review, update, and/or modify the ICP based on the evaluation of enrollee goals (as prioritized by the enrollee), changes in health care needs or status, and/or the availability of more recent HRA information. Per 42 CFR § 422.101(f)(1)(vii)(D), SNPs must update the person-centered ICP as warranted by changes in the health status or care transitions of enrollees. Additionally, per 42 CFR § 422.101(f)(1)(vii)(B), the plan must include information on how the enrollee and/or their caregiver(s)/representative(s) are involved and participate in the ICP development process.

Lastly, the plan must describe how the SNP addresses challenges associated with enrollees who decline to participate in the ICP process or who are unable to be reached. Per 42 CFR § 422.101(f)(1)(viii), the plan must specify how it documents the attempts to contact the enrollee or the enrollee's refusal to participate in the development of or updates to the comprehensive ICP. In

addition, while CMS recognizes that HRA results and enrollee/caregiver involvement is valuable in developing an ICP, SNPs are still expected to formulate an ICP in the absence of these resources, based on information gathered from other assessments, face-to-face encounters, medical records, claims data, or other available data sources.

D-SNPs Only: For D-SNPs, the MOC must describe how the ICP is used to coordinate Medicare and Medicaid services and how the D-SNP or affiliated Medicaid plan provides these services, including long-term services and supports and behavioral health services. This component of Factor 2 is specific to D-SNPs.

Factor 3: Specify process for ICP maintenance and dissemination to appropriate stakeholders

The MOC must describe how the ICP is maintained and updated based on changes in health status or care transitions. As an example, this can be from information collected from more recent HRA assessments or following hospitalizations or other care transitions. As part of this response, the SNP must address where the ICP is documented/stored.

The MOC must also detail how the plan ensures that the ICT, provider network, appropriate stakeholders, and enrollees and/or caregiver(s)* have access to the ICP. The plan must describe the delivery mechanism for providing the ICP to these stakeholders. Beyond this, the MOC must specify how the SNP provides enrollees and/or their caregivers with copies of or electronic access to their ICP.

*Since many enrollees may have a responsible person assisting with their care coordination, it is important that SNPs address the role of “caregivers” as it relates to this factor and their significance in the process.

Factor 4: Describe communication of ICP updates and modifications

The MOC must describe how the SNP communicates ICP updates and modifications to enrollees and/or their caregivers*, the ICT, applicable network providers, other SNP personnel, and stakeholders, as necessary.

*Since many enrollees may have a responsible person assisting with their care coordination, it is important that SNPs address the role of “caregivers” as it relates to this factor and their significance in the process.

MOC 2 Element E: Interdisciplinary Care Team (ICT)

Regulations at 42 CFR § 422.101(f)(1)(ix) require all SNPs to use an ICT that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the SNP’s target population. The plan’s MOC must describe the critical components of the ICT and address the following factors:

1. Provide a comprehensive description of how the SNP determines the composition of ICT membership, including the addition of team members to address the unique needs of enrollees.
2. Describe the roles and responsibilities of the ICT members (including enrollees and/or caregivers) and how each contributes to the development and implementation of an effective interdisciplinary care process.
3. Describe how SNP staff ensure that the interdisciplinary care processes are effective in meeting enrollee needs. This includes how the SNP analyzes enrollee health care needs and outcomes data to evaluate and continually manage and improve the health status of SNP enrollees, including the implementation of changes or adjustments to the ICT composition.
4. Describe how the SNP’s communication plan ensures the exchange of enrollee information occurs regularly among the ICT, including evidence of ongoing information exchange.

D-SNPS Only: Explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable.

Summary of Changes

- ***CY 2027 Updates:***
 - Revised Factor 1 to focus on the process for determining ICT membership.
 - Revised Factor 2 to focus on a description of the roles and responsibilities of the selected ICT members, including expertise and training requirements, and the facilitation of enrollee/caregiver participation in the ICT.
 - Updated Factor 3 to request information on the SNP’s use of enrollee health outcomes data to inform changes to the ICT membership.
 - For Factor 4, specified that D-SNPs must describe ICT coordination with Medicaid providers.

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: Detail determination of ICT membership*

The MOC must describe how the SNP determines the membership of the ICT and the rationale for inclusion of ICT members. It must also explain how the enrollee's HRA and ICP are used to determine the composition of the ICT, including the identification of when additional team members are needed to meet the developing needs of an enrollee.

Factor 2: Describe ICT roles and facilitation of enrollee/caregiver participation

The MOC must describe the roles and responsibilities of each member of the ICT, including how each contributes to the development and implementation of an effective interdisciplinary care process. This description must specify how the expertise, training, and capabilities of the ICT members align with the identified clinical and other needs of the SNP enrollees. The BBA 2018 provisions require, at a minimum, this description to include how the plan verifies team member training and demonstrated expertise in an applicable specialty for the targeted enrollees. Plans may reference MOC Element 2A and/or MOC Element 3A to provide a full description of these roles and associated credentials/expertise.

Enrollees and/or their caregivers play a critical role in the ICT. Given this, plans must:

- Describe how the SNP informs and invites enrollees and their caregivers to participate as active members of the ICT.
- Explain how the SNP facilitates the participation of enrollees and their caregiver(s) as members of the ICT.
- Address how enrollees and/or their caregivers are provided with needed resources and how the plan facilitates access for enrollees to ICT team members.

Factor 3: Describe use of enrollee outcomes to improve health

The MOC must describe how the SNP uses clinical managers, case managers, and other plan staff to ensure that the SNP's interdisciplinary care processes are effective in meeting enrollee needs on a continuous basis.

This description must explain how the SNP analyzes enrollee needs and outcomes data to 1) evaluate and continually manage and improve the health status of SNP enrollees, and 2) implement and manage changes and/or adjustments to the ICT composition, as needed.

Factor 4: Describe ICT communication plan for ongoing exchange of enrollee information

The MOC must provide a comprehensive description of the SNP's communication plan for promoting and ensuring that the exchange of enrollee information occurs regularly amongst the ICT. The MOC must:

- Describe how the SNP maintains effective and ongoing communication

between SNP personnel, the ICT, enrollees and/or their caregivers, community organizations, and other stakeholders.

- Explain how this established communication plan is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC.
- Detail the types of evidence used to verify that communications have taken place (e.g., ICT meeting minutes, documentation in the ICP, etc.).
- Describe how communication is conducted with enrollees who have hearing, visual, or other impairments, in addition to language barriers, cognitive deficiencies, and/or those that need information provided in alternate formats or other languages (verbal or written).

D-SNPs Only: The MOC must explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable. This component of Factor 4 is specific to D-SNPs.

MOC 2 Element F: Care Transition Protocols

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. The plan’s MOC must describe care transition protocols and address the following factors:

1. Describe how the plan uses care transition protocols to maintain continuity of care for SNP enrollees.
D-SNPS Only: Explain how the plan coordinates with providers of any Medicaid covered services during a care transition.
2. Identify and describe the personnel responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed.
3. Explain how the SNP ensures elements of the ICP and other relevant information are transferred between health care settings when an enrollee experiences a transition in care, either planned or unplanned.
4. Describe the process used to ensure that enrollees can access and adequately utilize their personal health information to share with other providers, help facilitate care, and make informed decisions.
5. Explain how enrollees and/or caregivers will be educated about the enrollee’s health status to foster appropriate self-management activities, including expectations for demonstrating understanding of appropriate self-management.
6. Detail how and when the enrollees and/or caregivers are informed about the point of contact throughout the transition process.

Summary of Changes

- **CY 2027 Updates:**
 - For Factor 1, specified that plans must explain the process used to manage both planned and unplanned transitions in care. In addition, D-SNPs must describe how the plan coordinates with providers of Medicaid covered services during a care transition.
 - Revised Factor 4 to specify that plans must describe the method for granting enrollees access to their personal health information.
- Previously emphasized that care coordination is required for all enrollees and is not limited to medium and high-risk stratified enrollees.

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

Definitions

- **Health care setting:** The setting where an enrollee receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for an enrollee's medical care. Settings include home (or place of residence), home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, and outpatient/ambulatory care/surgery centers.
- **Transition:** Movement of an enrollee from one care setting to another as the enrollee'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 an enrollee who is at risk for a care transition through completion of a transition (before, during, after). This process includes planning and preparation for transitions and the follow-up care after transitions are completed.

Explanation ***Factor 1: Describe use of care transition protocols to facilitate care continuity***

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, SNPs must work actively to coordinate transitions. The SNP must specify how care transitions are used to maintain continuity of care for enrollees, including the process for connecting all enrollees with the appropriate providers, services, and community resources, regardless of network affiliation. Care coordination is not limited to those enrollees in a care management program nor to enrollees stratified as medium or high-risk.

The MOC must explain the process for managing planned and unplanned transitions. For planned transitions in care, the MOC must describe the steps that take place before, during, and after the transition occurs. For unplanned transitions in care, the MOC must describe the steps that take place during (if known) and after the transition occurs.

D-SNPs Only: The MOC must explain how the plan coordinates with providers of any Medicaid covered services during a care transition. This component of Factor 1 is specific to D-SNPs.

Factor 2: Identify care transition personnel

The plan 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: Describe transfer of ICP elements during care transitions

The plan must describe how it ensures that elements of the enrollee's ICP and/or other relevant information are transferred between health care settings (e.g., community, hospital, or institutional settings) when the enrollee

experiences a transition in care, whether planned or unplanned. Specifically, the MOC must include:

- The process used to share the ICP and other relevant information for a transition. This description must specify the methodology (e.g., hardcopies, email, virtual meeting, etc.) used to share the ICP.
- The personnel responsible for transferring the ICP and other important health information for a transition.

Factor 4: Describe enrollee access to personal health information

Enrollees and/or their caregivers need access to the enrollee's personal health information to communicate about care with health care providers in other health care settings and/or health specialists outside of the primary care network. The plan must describe the process for ensuring that SNP enrollees and/or their caregiver(s) have access to and can adequately utilize the enrollee's personal health information to share with other providers, help facilitate care, and make informed decisions. The description must specify the method of access (e.g., hardcopy, electronic).

Factor 5: Describe approach to self-management and education activities

The MOC must describe how enrollees and/or their caregivers will be educated about their condition(s), including signs and symptoms that their condition is improving or worsening. This description must address how enrollees and/or their caregivers will be taught appropriate self-management techniques and demonstrate understanding of changes in their condition. For example, they should be educated about signs and symptoms signaling a change in their condition and how and when to respond to such changes (e.g., when to contact their providers or seek care). Self-management activities can include regular measurements and assessment of progress, goal setting, and problem-solving support to reduce crises and improve health outcomes.

Factor 6: Describe notification process for designated point of contact

The plan must describe the process for how and when enrollees and/or their caregivers are informed of the SNP personnel responsible (point of contact) for supporting them through transitions between any two care settings.

MOC 3: Provider Network

Per 42 CFR § 422.101(f)(1), MA organizations offering SNPs must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees. The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP enrollees. The SNP is responsible for maintaining a network that includes relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population. The description of the SNP provider network must address the elements described below.

MOC 3 Element A: Specialized Expertise

Regulations at 42 CFR § 422.101(f)(1)(ix) and 42 CFR § 422.152(g)(2)(vi) require SNPs to demonstrate that the provider network has specialized clinical expertise in the delivery of care to enrollees. The plan must establish a provider network with specialized expertise and describe the components of the network. The MOC must address the following factors:

- 1. Provide a complete and detailed description of the specialized expertise available to enrollees in the SNP's provider network that corresponds to the SNP target population, including providers and facilities.**
- 2. Describe how the SNP provides each enrollee with an ICT comprised of appropriate expertise and explain how the SNP oversees its provider network and ensures that providers are actively licensed and competent to provide specialized health care services to SNP enrollees.**
- 3. Describe how providers collaborate with the ICT and SNP enrollees, contribute to the ICP, and ensure the delivery of necessary specialized services. This requires a description of how providers communicate enrollee care needs to the ICT and other stakeholders, how specialized services are delivered in a timely and effective manner, and how relevant information/data is shared with the ICT and incorporated into the ICP.**
- 4. Describe how the SNP documents, updates, and maintains current information on providers, including the process and frequency used to ensure an accurate provider network directory.**

Summary of Changes

- **CY 2027 Updates:**
 - Switched the order of prior Factor 3 (maintaining accurate provider directory) and prior Factor 4 (facilitating collaboration with the ICT) to improve flow.
 - For new Factor 3, specified that the plan must also address how providers collaborate with SNP enrollees (in addition to the ICT) and contribute to the ICP.
- For Factor 4, previously clarified that SNPs must provide the process and frequency for updating provider information.

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 SNPs must have an adequate and specialized provider network that maintains appropriate licensure/competency to address the needs of the target population.

Factor 1: Describe specialized expertise in provider network

The MOC must identify and describe the provider network’s specialized expertise. This may include but is not limited to PCPs/internists, endocrinologists, cardiologists, oncologists, nephrologists, OBGYNs, mental health providers, and other specialists that address the needs of the SNP’s target population. As part of this description, the MOC must also specify and describe the facilities included in the network that provide care for enrollees.

Factor 2: Describe appropriate provider expertise in enrollee ICTs and explain oversight of provider network

The SNP must include evidence that it provides each enrollee with an ICT comprised of providers with demonstrated experience and training in the applicable specialty or area of expertise, or as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the target population.

The plan must also describe how it oversees its provider network and ensures its providers and network facilities have and maintain active licenses (e.g., verification of licensure) and are competent (e.g., confirmation of applicable board certification) to provide specialized health care services to SNP enrollees. The MOC must describe license and competency verification that relates to the specific population being served (e.g., geriatric training for I-SNP providers, special training for physicians and other clinical staff for C-SNP services for enrollees with HIV/AIDs).

Factor 3: Facilitate collaboration with the ICT

The MOC must describe how providers in the network collaborate with members of the ICT and SNP enrollees, contribute to the ICP, and ensure that specialized services are delivered to the SNP enrollee in a timely and effective way. The MOC must describe how providers communicate an enrollee’s care needs to the ICT and other stakeholders, how reports regarding services rendered are shared with the ICT, and how relevant information is incorporated into the ICP.

Factor 4: Maintain updated provider information

The MOC must describe how it documents, updates, and maintains current information on providers. This description must address both the process and frequency used to ensure an accurate provider network directory.

MOC 3 Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

Regulations at 42 CFR § 422.101(f)(2)(iii)-(v) and 42 CFR § 422.152(g)(2)(ix) require SNPs to demonstrate the use of clinical practice guidelines (CPG) and care transition protocols (CTP). The plan must oversee how network providers use evidence-based medicine, when appropriate. The MOC must address the following factors:

1. Describe the process for ensuring that network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to the SNP’s target population, including the methods used to monitor, track, and verify compliance.
2. Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified to fit the unique needs of vulnerable SNP enrollees and describe how the SNP oversees these enrollees. Provide details on how decisions to modify guidelines or protocols are made for clinically complex enrollees, incorporated into the ICP, and communicated to the ICT.
3. Describe how the SNP ensures that care transition protocols are used both internally and by contracted providers to maintain continuity of care.

Summary of Changes

- **CY 2027 Updates:**
 - For Factor 1, specified that plans must describe the methods used to monitor, track, and verify compliance with clinical practice guidelines and nationally recognized protocols.
 - Combined prior Factor 2 (challenges requiring exceptions to guidelines) and Factor 3 (decision process to modify guidelines) into new Factor 2. Given this, this element now includes three instead of four factors.
 - For new Factor 2, specified that plans must detail how they oversee vulnerable SNP enrollees for whom clinical practice guidelines have been modified.
 - For new Factor 3 (oversight of care transition protocols), specified that plans must explain how care transition protocols are used both internally and by contracted providers to maintain continuity of care.
- For Factor 2, previously clarified that SNPs must specify the person(s) or group/committee responsible for making decisions to modify guidelines.

Scoring

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

Explanation ***Factor 1: Monitor use 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 MOC must address the plan's process for ensuring that network providers utilize appropriate clinical guidelines, including the methods used to monitor, track, and verify compliance. The plan may use electronic databases, web technology, manual medical record review, or other methods to oversee use of clinical practice guidelines.

Factor 2: Specify challenges requiring exceptions to guidelines and detail decision process to modify guidelines

Certain clinical practice guidelines and protocols may not always be appropriate for some patients with complex health care needs. In these cases, the plan must include their process to identify challenges to using clinical practice guidelines and nationally recognized protocols for certain enrollees with complex health care needs. The plan must describe how the SNP oversees these vulnerable enrollees whose complex health care needs require modification of clinical practice guidelines and nationally recognized protocols to fit their unique needs.

The plan must also provide details regarding how decisions to modify guidelines (clinical practice or utilization management) for clinically complex enrollees are made, incorporated into the ICP, and communicated with the ICT. This description must specify the person(s) or group/committee responsible for making decisions to modify the guidelines.

Factor 3: Oversee care transition protocol implementation

Care transitions present challenges for plans to maintain continuity of care. The plan must explain how it ensures that care transition protocols are used both internally and by contracted providers to maintain continuity of care.

MOC 3 Element C: MOC Training for Provider Network Staff

Regulations at 42 CFR § 422.101(f)(2)(ii) require that SNPs conduct MOC training for appropriate staff (employed, contracted, or non-contracted). The plan’s MOC must describe oversight of provider network training and address the following factors:

1. Detail how the SNP conducts MOC training for network providers/staff and out-of-network providers/staff seen by enrollees on a routine basis, with detailed examples provided for renewal plans.
2. Describe how the SNP tracks, verifies, and maintains training records as evidence of MOC training completion for network providers/staff and out-of-network providers/staff.
3. Explain any challenges associated with the completion of MOC training for both in-network and out-of-network provider staff.
4. Describe the strategies the SNP will implement to facilitate compliance with the MOC training requirement.

Summary of Changes

- **CY 2027 Update:** For Factor 4, clarified that plans must address the strategies it will implement to facilitate MOC training completion.
- For Factor 1, previously clarified that provider staff may include care coordination staff, administrative staff, or other clinical or support staff.

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: Describe implementation of MOC provider training**

The MOC must describe the process for how the plan provides training for network providers/provider staff and any out-of-network providers/staff (i.e., those seen by enrollees on a routine basis due to plan directed care). Provider staff may include care coordination staff, administrative staff, or other clinical or support staff. The MOC must detail training documents and materials, including how training is conducted (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/videoconferencing, availability of instructional materials via the SNP plan’s website).

The plan must also provide examples of detailed training content beyond a table of contents or general high-level overview.

- Initial MOCs must provide a detailed description of the training topics covered (again, not a general high-level overview) and/or training materials, if available.

- Renewal MOCs must provide examples of actual training materials (e.g., slide deck, printed materials, etc.).

Plans must describe how they ensure inclusion of both in-network and out-of-network providers and provider staff in MOC provider training activities.

The MOC training for staff (MOC Element 2A) and providers (MOC Element 2C) may be similar in content; however, the provider staff training should include additional information that is clinical in nature and is directed specifically to clinicians and/or their staff.

The intent of the requirements at [42 CFR § 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 MOC training available to all appropriate in-network and out-of-network providers.

In addition, MA organizations sponsoring SNPs must have appropriate staff (employed, contracted, or non-contracted) trained on the SNP MOC to coordinate and/or deliver all services and benefits. Consistent with regulation [42 CFR § 422.101\(f\)\(2\)\(ii\)](#), 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 and 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 at least once within this 3-year approval period. This also applies to training on policy expectations of internal staff as well.

Factor 2: Describe process to document and maintain evidence of training

The plan must make training on the MOC available and offer it to all in-network providers (and/or their staff) and out-of-network providers seen by enrollees on a regular basis (and/or their staff). The MOC must describe how the plan tracks, verifies, and maintains training records as evidence of MOC training completion. Documentation may include copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, electronic training records, physician attestations, etc.).

Factor 3: Describe challenges to training completion

The MOC must explain the challenges (e.g., geographically distant network, large volume of providers, etc.) associated with completion of the MOC trainings for network providers and/or their staff and out-of-network providers (and/or their staff) used on a routine basis.

Factor 4: Provide strategies to facilitate training compliance

The MOC must also describe the strategies the SNP will implement (e.g., incentives or other best practices to encourage provider training participation and compliance) and how the SNP will work with providers to connect with the appropriate staff to facilitate compliance with the MOC training requirement. The SNP must describe the method(s) it employs to persuade providers and/or their staff to complete the required training.

MOC 4: MOC Quality Measurement and Performance Improvement

Regulations at 42 CFR § 422.152(a), 42 CFR § 422.152(f), and 42 CFR § 422.152(g) require that all SNPs conduct a quality improvement program that measures the effectiveness of the MOC.

The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver high-quality health care services and benefits to SNP enrollees in a timely manner. The SNP's leadership team and governing body must have a comprehensive quality improvement program in place to measure its current level of performance and a methodology for assessing improvement and distributing performance results.

SNPs are required to establish measurable goals related to overall MOC performance and enrollee health outcomes for the SNP population. MOC Element 4A establishes the SNP's overall quality performance improvement plan. MOC Element 4B establishes goals for achieving the overall MOC performance outcomes (e.g., improving access, affordability, care coordination, etc.), as well as goals for enrollee health outcomes (e.g., improving rates for preventive services and screenings, medication adherence, etc.).

The description of the MOC quality measurement and performance improvement plan must address the elements described below.

MOC 4 Element A: MOC Quality Performance Improvement Plan

The plan must develop an MOC quality performance improvement plan that addresses the following factors:

- 1. Describe the overall quality performance improvement plan and how it ensures delivery of appropriate services to SNP enrollees based on their unique needs.**
- 2. Describe the process by which the SNP continuously collects, analyzes, evaluates, and reports MOC quality performance, and supports ongoing improvement of the MOC.**
- 3. Describe how leadership, management groups, other SNP personnel, and stakeholders are involved with the internal quality performance process.**
- 4. Describe how the goals established for overall MOC performance and enrollee health outcomes (later outlined in MOC Element 4B) are integrated into the overall performance improvement plan and the process used by the SNP to determine if goals/outcomes are met/not met (including the use of benchmarks and timeframes for remeasurement when goals are not achieved).**
- 5. Describe the process used to systematically identify enrollees who received no covered Medicare services during a defined period of time and the action taken by the SNP to identify and connect with these enrollees.**

Summary of Changes

- **CY 2027 Update:** Added new Factor 5 (systematic identification of enrollees with no covered Medicare services and subsequent actions taken to support these enrollees).

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 no factors

Explanation *Factor 1: Detail quality improvement (QI) process*

The quality improvement process should be data-driven. Regulations at [42 CFR § 422.152\(g\)\(1\)](#) stipulate that the quality improvement program provide 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 conditions) at the plan level.

The MOC must describe the overall quality performance improvement plan and address how this plan ensures that appropriate services are delivered to SNP enrollees. The quality performance improvement plan must be designed to determine whether the overall MOC structure effectively accommodates enrollees’ unique health care needs, while delivering high quality care and services. At a minimum, the quality performance improvement plan must address the SNP’s process for improving access to and coordination of care, member and provider satisfaction, and program effectiveness.

Factor 2: Describe QI data collection process

The MOC must describe the SNP’s process for continuous collection, analysis, evaluation, and reporting of quality performance data to support ongoing improvement of the MOC. Beyond a description of these activities, the MOC must specify the frequency of these activities.

Factor 3: Describe QI staff/stakeholders and oversight

The MOC must describe how the SNP leadership team and other key SNP personnel and stakeholders participate in internal quality performance processes. The MOC should identify the personnel involved, their role in analyzing quality performance information, and the decision-making authority given to such personnel.

Factor 4: Describe integration of goals into overall improvement plan and processes used to determine whether goals met/not met

The MOC must describe how the goals established for the overall MOC performance and enrollee health outcomes (as outlined in MOC Element 4B) are integrated into the overall performance improvement plan. The MOC must also include a description of the processes used by the SNP to determine if goals

and outcomes are met/not met. This includes how benchmarks and timeframes for measurement are used, and in the event that goals are not achieved, the remeasurement process and frequency.

Factor 5: Identify enrollees with no covered Medicare services

The MOC must describe the process the SNP uses to systematically identify enrollees that have received no covered Medicare services during a defined period of time. The MOC must also indicate the actions taken by the SNP to identify and connect with these enrollees.

The purpose of this factor is for plans to identify members who have received no services so that the SNP can implement processes to encourage these members to obtain primary and preventive care services that may be warranted for their individual health status.

MOC 4 Element B: Measurable Goals

Per 42 CFR 422.101(f)(3)(ii), as part of the evaluation and approval of the SNP model of care, NCQA must evaluate whether goals were fulfilled from the previous model of care. The plan must identify and clearly define the SNP’s measurable goals related to overall MOC performance and enrollee health outcomes for the SNP population as a whole. All goals must be measurable and specific, contain relevant information, data sources(s), and frequency for measurement. The MOC must describe how these goals are communicated throughout the MOC and to stakeholders. The MOC must address the following factors:

1. **Identify and detail the specific measurable goals used to assess overall MOC performance.**
2. **Identify and detail the specific enrollee health outcome goals used to measure overall SNP population health at the plan level.**
3. **Describe how these goals are communicated throughout the SNP and to stakeholders and detail the methods used to assess and track the MOC’s impact on SNP enrollees’ health outcomes.**
4. **Indicate whether the overall MOC performance and health outcome goals of the previously approved MOC (if applicable) are met/not met and describe the steps the SNP will take if goals are not met in the expected timeframe.**

Summary of Changes

- **CY 2027 Updates:**
 - Revised Factor 1 to focus on overall MOC performance goals.
 - Revised Factor 2 to focus on enrollee health outcome goals.
 - For Factor 3, clarified that the response must address how goals are communicated throughout the SNP and to stakeholders.
 - Revised Factor 4 to specify that plans must indicate whether goals of the previously approved MOC (if applicable) were met/not met and describe action steps for goals not met.

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: Identify and detail overall MOC performance goals*

The MOC must identify and detail the specific measurable goals it will use to assess overall MOC performance. All goals must be measurable and specific. SNPs must provide relevant information on how they will achieve these goals, and include specific data sources, benchmarks, and the timeframes and frequencies used to measure, evaluate, and achieve the specified goals.

This factor requires bullet points, a table, or other means to identify overall MOC performance goals and other specific details for demonstrating MOC improvement.

Overall MOC performance goals include but are not limited to:

- Improving access and affordability of care for the SNP population.
- Improving care coordination and appropriate delivery of services through the direct alignment with HRA, ICP, and ICT.

Note: SNPs are required to include separate goals specific to HRA, ICP, and ICT completion. Each of these goals must be set to 100% (or a Medicare Stars rating of 5).

- Enhancing care transitions across all providers and health care settings.

Factor 2: Identify and detail enrollee health outcomes measure goals

The MOC must identify and detail the specific enrollee health outcomes goals it will use to assess the health of the SNP population as a whole. All goals must be measurable and specific. SNPs must provide relevant information on how they will achieve these goals, and include specific data sources, benchmarks, and the timeframes and frequencies used to measure, evaluate, and achieve the specified goals.

This factor requires bullet points, a table, or other means to identify enrollee health outcomes measure goals and other specific details for demonstrating improvement.

Examples of enrollee health outcomes goals include but are not limited to:

- Ensuring appropriate utilization of services for chronic conditions.
 - Improving hemoglobin A1c rate levels in enrollees with diabetes.
 - Improving medication adherence.
 - Lowering all cause readmissions.
- Ensuring appropriate utilization of preventive health services.
 - Improving rates of breast cancer or colorectal screenings.
 - Improving rates of depression screenings.
 - Improving influenza, pneumonia, respiratory syncytial virus (RSV), or shingles vaccination rates.

Factor 3: Describe communication of established goals and enrollee impact

The SNP must explain how overall MOC performance goals and enrollee health outcomes measure goals are communicated throughout the SNP and to stakeholders. In addition, the MOC must describe the methods used to assess and track how its overall quality program, including the goals and specific measures it uses, affect the health outcomes of its enrollees.

Factor 4: Specify whether goals met/not met and identify actions to address goals not met

Per 42 CFR 422.101(f)(3)(ii)(A), plans must provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment of the previously approved MOC's goals (if applicable).

- Renewal MOCs must provide results associated with the goals of the previously approved MOC and include a determination of whether each goal is met or not met. Goal results and other information/data should be presented at the SNP level. Renewal MOCs should also indicate in their renewal submission how the plan will achieve or modify these goals in this upcoming MOC.
- Per 42 CFR 422.101(f)(3)(ii)(B), initial MOCs need to provide relevant information pertaining to the MOC's goals for review and approval.

Note: This requirement is fulfilled under Factor 1 (overall MOC performance goals) and Factor 2 (enrollee health outcomes goals) above.

Per 42 CFR 422.101(f)(3)(ii)(C), SNPs that did not achieve the previous MOC's goals (renewal MOCs) within the expected timeframe must describe the specific actions taken (i.e., action plan) to achieve or revise goals for the plan's next MOC, including a remeasurement and analysis process.

Note: Initial MOCs must describe the general process used when the SNP determines that a goal is not met, including implementation of additional steps to achieve goals (or revise them), remeasurement, and analysis.

MOC 4 Element C: Measuring Patient Experience of Care (SNP Enrollee Satisfaction)

The plan’s MOC must describe the process for measuring SNP enrollee satisfaction by addressing the following factors:

1. Describe the specific SNP survey(s) used and the rationale for the selection of a particular survey (or surveys) to measure enrollee satisfaction.
2. Detail the methodology used to collect survey data and specify the sample size for each survey used.
3. Explain how the results of enrollee satisfaction surveys are analyzed, integrated into the overall MOC performance improvement plan, and used to implement new programs that target areas for improvement.
4. Describe the process used to address issues identified in the survey results.

Summary of Changes

- **CY 2027 Updates:**
 - Combined prior Factor 1 (survey description) and prior Factor 2 (rationale for survey selection) into new Factor 1.
 - Added new Factor 2 (methodology and sample size), which includes some explanatory language from prior Factor 3.
 - Expanded Factor 3 (analysis of enrollee feedback) to require a description of how results are used to implement new programs that target areas for improvement.
 - Factor 4 now focuses on the process the SNP uses to address identified issues.
- Previously clarified that, if more than one survey is used, then the SNP must describe each survey and the selection rationale for each survey.
- Previously emphasized that the SNP must specify the sample size used for each survey.

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: Describe survey(s) and specify selection rationale**

The MOC must describe the specific survey(s) used to assess SNP enrollee experience. If more than one survey is selected for use, a description must be included for each one.

The MOC must also include the rationale for the selection of the chosen survey (or surveys). If more than one survey is selected for use to collect information on enrollee experience, the selection rationale must be included for each survey.

Factor 2: Detail survey methodology and specify sample size

The plan must describe how it proactively solicits feedback from a broad sample of enrollees, not only those enrollees who contact the plan to share their feedback. Enrollee feedback may be obtained by conducting focus groups or by administering experience surveys to a representative sample of enrollees throughout the plan.

The plan must describe the methodology (e.g., modes, attempts, frequency) used to administer each enrollee experience survey noted under Factor 1 and must also specify the sample size used for each implemented survey tool.

- Renewal submissions must provide the actual sample size for each implemented survey described under Factor 1.
- Initial submissions must provide a sample size estimate for each survey described under Factor 1.

The SNP enrollee satisfaction survey(s) must evaluate the enrollee's experience and gather information about the overall SNP program or program staff (e.g., ICT or case managers), the usefulness of the information disseminated by the plan, and the enrollee's ability to adhere to recommendations.

Factor 3: Describe analysis of enrollee feedback and integration of survey responses into performance improvement plan

The plan must describe how it analyzes feedback collected via SNP enrollee experience surveys to identify issues and opportunities for improvement. The MOC should explain how the results of SNP enrollee satisfaction surveys are integrated into the overall MOC performance improvement plan and used to implement new programs that target areas for improvement.

Factor 4: Describe process used to address identified issues

The plan must describe the process used and specific steps taken to address issues identified in response to SNP enrollee experience survey results.

MOC 4 Element D: Dissemination of MOC Quality Performance Results

The plan must address the process for communicating quality improvement performance results and address the following factors:

1. Describe how performance results and other pertinent information will be shared routinely with stakeholders.
2. Detail the scheduled frequency and methods for communications with stakeholders.
3. Identify the individual(s) responsible for communicating performance updates/results in a timely manner.
4. Describe how performance improvement updates/results will be documented.

Summary of Changes

- **CY 2027 Updates:**
 - Removed prior Factor 3 (description of ad hoc communications).
 - Added new Factor 4 (documentation of performance improvement updates/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 **Factor 1: Describe communication of performance results**

The plan must describe how quality performance results are routinely shared with stakeholders, which include but are not limited to:

- SNP leadership teams.
- SNP board of directors.
- SNP personnel and staff.
- SNP provider networks.
- SNP enrollees and caregivers.
- General public.
- Regulatory agencies.

Factor 2: Describe frequency and methods for routine communications with stakeholders

The plan must describe the frequency of routine communications with the various stakeholders noted under Factor 1 above and specify the methods used to disseminate these communications (e.g., webpages, printed newsletters, bulletins, other forms of media).

Factor 3: Identify staff responsible for communication of performance results

The plan must identify the individual(s) responsible for communicating performance updates and results in a timely manner and the individual(s) who provide oversight for this task.

Factor 4: Describe documentation of performance results

The plan must describe how performance improvement results and updates will be documented.