Model of Care (MOC)

Provider Training 2026

CMS Requirement

- The Centers for Medicare & Medicaid Services (CMS) requires all employees, providers, and delegated entities to complete Model of Care (MOC) training upon hire and annually thereafter.

By the end of this lesson, you will be able to:

- Describe Special Needs Plans (SNPs), including C-SNPs and D-SNPs, and the population served by the MOC.
- Define and recognize the four elements of the MOC.
- Recognize essential components in MOC care coordination.

Definitions

CAHPS: (Consumer Assessment of Health Providers and Systems): Survey that measures members' experience with health services.

CM (Care Management): Program that coordinates the member's care according to their needs.

HEDIS (Healthcare Effectiveness Data and Information Set): A set of metrics that evaluate the quality and effectiveness of medical care

HOS (Health Outcomes Survey): Survey that measures the physical and mental health status of members.

Definitions

HRA (Health Risk Assessment): Assessment that identifies risks and needs of the members.

ICT (Interdisciplinary Care Team): Interdisciplinary team that coordinates and executes the plan of care.

ICP (Individual Care Plan): Individualized care plan based on the member's needs.

PCP (Primary Care Physician): Primary physician responsible for the member's care.

Special Needs Plan (SNP)

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Background

- The SNPs were created as part of the Medicare Modernization Act in 2003.
- In 2010, the Patient Protection and Affordable Care Act, (ACA) reinforced the importance of the MOC as a fundamental component for SNPs. The ACA requires the National Committee for Quality Assurance (NCQA) to execute the review and approval of the MOC based on standards and scoring criteria established by CMS.
- Medicare Advantage plans must design special benefit packages for groups with different health care needs. These packages, through improvements in service coordination, provide additional benefits, improvements in care, and decreased cost of services for the most vulnerable.

CMS Regulation 42 CFR 42.101(f) requires that all MA organizations must implement a Model of Care for their members with Special Needs to meet their health needs and improve their quality of life.

Special Needs Populations (SNP)

D-SNP Population

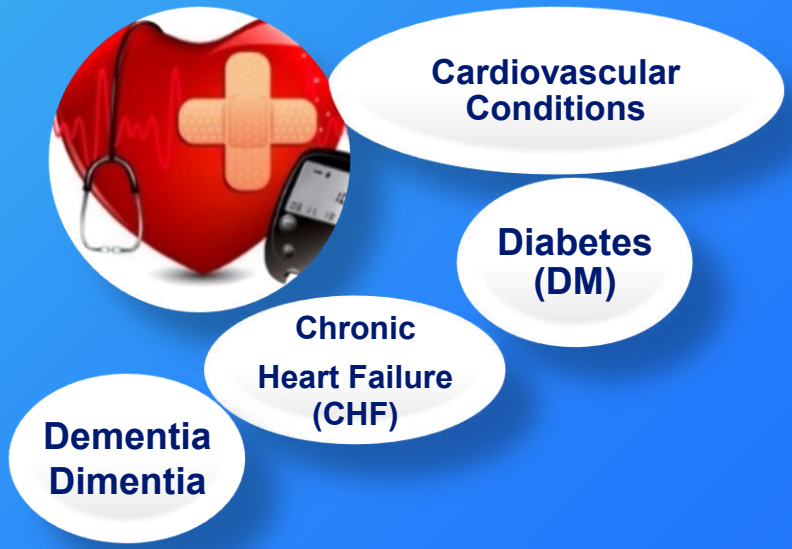
- ✓ Dual Eligible Members (Medicare + Medicaid)
- ✓ Access to Triple-S Advantage Platino products.

I-SNP: Institutional, this Special Needs plan **DOES NOT** APPLY in Triple S.

C-SNP Population

- ✓ Members with certified chronic conditions.

C-SNP



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Special Needs Populations at Triple-S Advantage

Active population in D-SNP*

Products	Members
Platino Blindao (028)	666
Platino Enlace (035)	1,068
Platino Advance (041)	1,973
Platino Plus (043)	37,519
Total	**41,226**

Active population in C-SNP*

Products	Members
Contigo Plus (022)	4,176
Contigo En Mente (046)	1,064
Total	**5,240**

* SNP active memberships (January 2026)

Model of Care

MOC

Model of Care (MOC)

Under section 1859(f)(7) of the Social Security Act, each SNP must have MOC approved by the NCQA (*NCQA-National Committee for Quality Assurance*).

It provides the basic structure under which the SNP must meet the needs of each of its members through care coordination process.

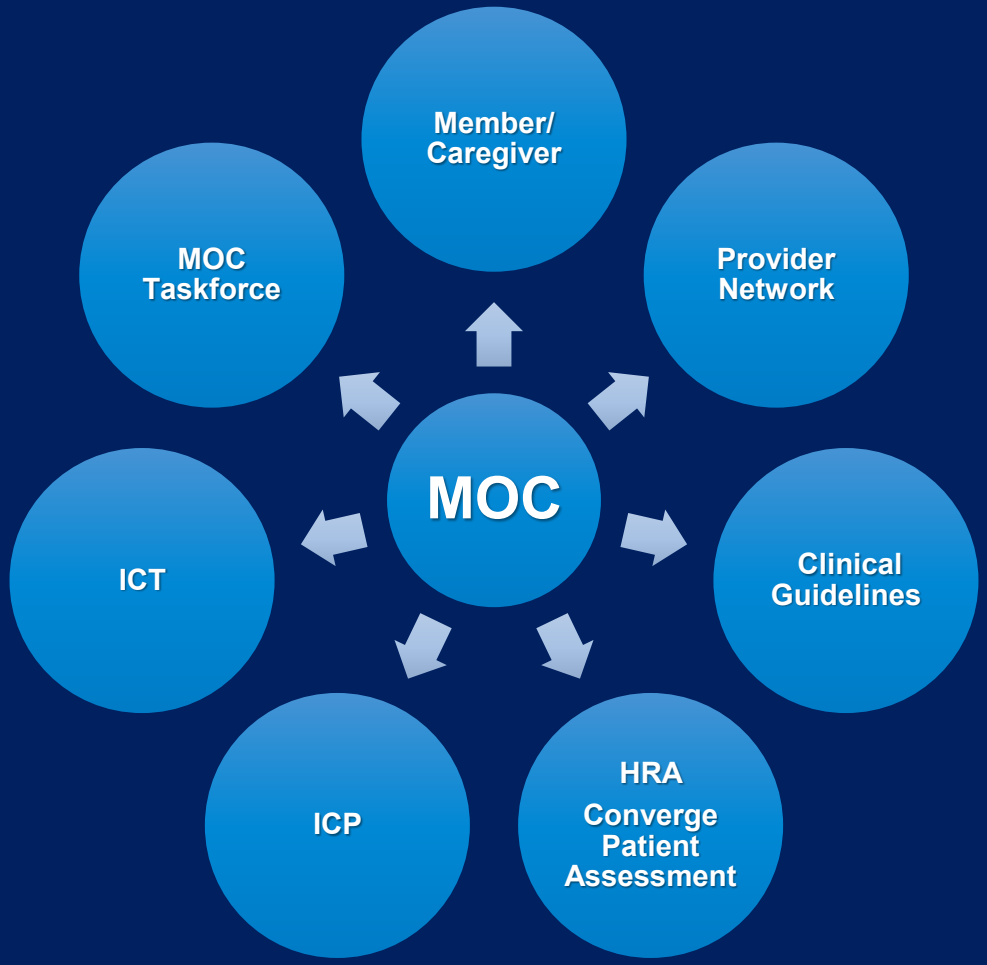
The Model of Care (MOC) is a vital quality improvement tool and a comprehensive component to identify and address the unique needs of each special needs member through care management practices, member interventions, and the development of plan strategies.

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

Components that support the MOC

At Triple-S Advantage, the MOC has the structure to communicate and effectively serve the needs of our SNP members.

- Coordination between member, PCP, and specialists
- Interdisciplinary Team Intervention (ICT)
- Continuous monitoring and compliance with CMS



Elements of the MOC

Consists of four main elements:

1:
Description of the SNP Population

2:
Care Coordination

3:
Provider Network

4:
Measurement and Performance Improvement

MOC Element 1: Description of SNP Population

Identify and describe the specific populations served by Special Needs Plans (SNPs), which are integral components of the MOC. At Triple S Advantage, the most vulnerable populations include: members over 85 years of age, those with multiple hospital admissions, polypharmacy use, and other risk factors.

Member or legal guardian

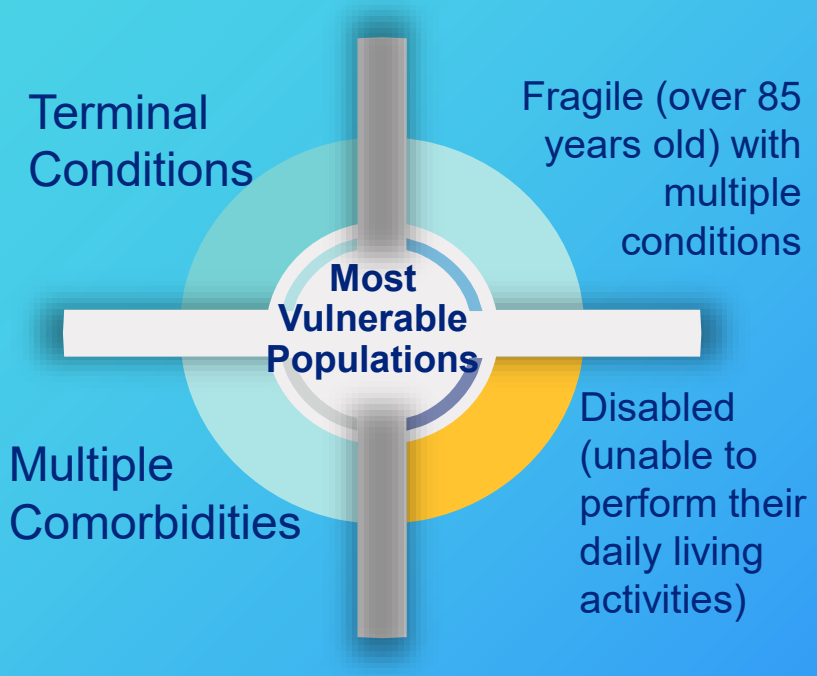
- Completes the membership form.
- Sends the form.

Enrollment Department

- Receives and verifies the form.
- Verifies and tracks eligibility.
  - ✓ Monitors that the member has not been out of the service area for more than six months.
- Sends the form to CMS within seven days.
- Receives a response from CMS.
- Sends the member a CMS welcome letter or rejection letter.

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

Higher-risk or more vulnerable populations are identified to direct resources toward members most in need of services, such as care management.



- ✓Extreme aging - population over 85 years.
- ✓ER utilization of six visits in a quarter.
- ✓Hospital admissions > than 3 in one quarter.
- ✓Polypharmacy of 8+
- ✓Multiple comorbidities (5+)
- ✓Poor socio-economic situation.
- ✓End-stage renal disease (ESRD)

MOC Element 2: Care Coordination

- Regulations 42 CFR§422.101(f)(ii)-(v) and 42 CFR§422.152(g)(2)(vii)-(x) require all SNPs to coordinate and evaluate the effectiveness of services provided as required by the MOC.
- Care coordination ensures that all health needs and service preferences of SNP members are covered.
- Ensures that medical information among healthcare professionals is shared by maximizing effectiveness, efficiency, high quality of services and improving members' health outcomes.
- Describes the roles, responsibilities, and oversight of clinical and non-clinical staff.
- Establishes a contingency plan that ensures the continuity of the critical functions of Triple-S Advantage's operation during an emergency.
- Requires that all staff must receive MOC training at the time of hire and annually.

MOC Element 2: Care Coordination – Cont.

- All individuals enrolled in an SNP are eligible for the Case Management Program.
- Affiliate are notified by letter or phone call and contacted by telephone to complete the Health Risk Assessment (HRA).
- Cases are classified according to HRA results and stratification based on claims data for each member.
- Members are informed about their participation in the Case Management Program, in which they collaborate with an interdisciplinary team to develop an individualized care plan and establish achievable goals.

MOC Element 2: Care Coordination
Health Risk Assessment (HRA)

- The HRA is conducted to identify the health risks and medical, psychosocial, cognitive, functional, and mental needs of each member.
- The initial HRA must be completed within **90 days** of enrollment. A re-evaluation should then be performed within **365 days**.
- The results of the HRA are shared with the member/caregiver and the primary care physician/specialist. These results are used to develop the individualized care plan.
- If a change in health status occurs, a re-evaluation is performed and the individualized care plan is updated. For example, after hospitalization, the member should be re-evaluated to identify new needs.

MOC Element 2: Care Coordination – Face-to-Face Encounters

- The rules of 42 CFR § 422.101(f)(1)(iv) require all SNPs to offer face-to-face meetings for the provision, coordination, or management of health care.
- Face-to-face meetings, including face-to-face or video call (where there is eye contact, and it is in real time and interactive). The video call must be made with the consent of the member or legal guardian, and this consent must be documented in the evaluation note.
- Face-to-face meetings must be held at least once a year from the first 12 months of enrollment.
- The face-to-face meeting must be between each member and a member of the ICT, or a plan provider.

MOC Element 2: Care Coordination Individual Care Plan (ICP)

Individualized care plans are developed by an interdisciplinary care team that includes:

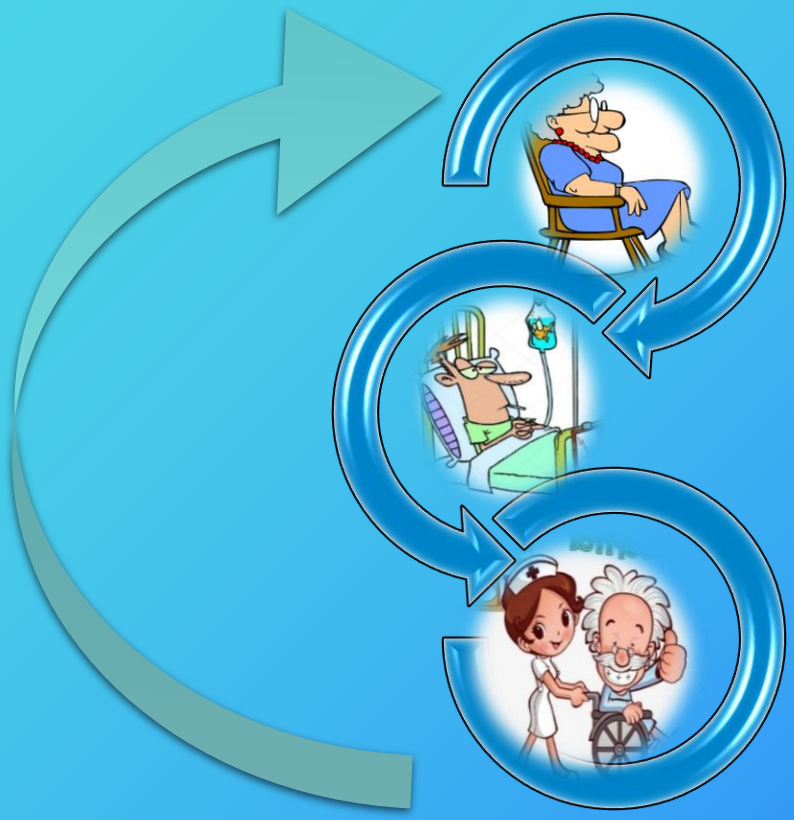
The ICP must include:

- ✓ **Objectives based on the identified needs and preferences of the member.**
- ✓ **Interventions of the interdisciplinary care team.**
- ✓ **Self-care plans and goals tailored to the needs of the member.**
- ✓ **Barriers and progress toward goals.**

MOC Element 2: Care Coordination Interdisciplinary Care Team (ICT)

- The interdisciplinary care team plays a fundamental role in the prevention of complications in the health status of our members, since it provides support in the processes and provides the necessary structure to offer and coordinate the services required for the comprehensive health care of patients.

MOC Element 2: Care Coordination Protocols for Transition of Care (TOC)



- Transition of care occurs when a member is transferred from one level of care to another.
- The most common example is hospital discharge to home.
- In the MOC, SNP members who experience a transition of care receive service coordination and pre-authorizations.

MOC Element 3: Provider Network

Under this element, a description of the provider network is documented, which includes the facilities and professionals necessary to address the unique and specialized health care needs of the SNP population. The Preventive and Health Education unit is responsible for providing educational activities to providers and Medical Groups related to the MOC. The Clinical Quality unit of the Quality Improvement Department conducts an annual review of clinical practice guidelines and MOC training materials, which are shared with all providers and clinical staff, thereby fulfilling a requirement of this element. The Regulatory Quality unit of the Quality Improvement Department conducts an annual review of the MOC course for Triple S providers and staff.

Providers

- Primary Care Physician (PCP)
- Specialists (Endocrinologists, Cardiologists, among others)
- Mental Health Service Providers

Trainings

- Compliance with MOC training for suppliers and delegated entities is evaluated.

Clinical Guidelines

- Diabetes
- Asma/COPD
- Cancer
- Alzheimer
- Heart Disease
- Among other, they are reviewed annually.

MOC Element 3: Provider Network: Role of Primary Care Physician (PCP)

- Perform the HRA complying with the established period.
- Provide access to and integrate other providers into patient care management, if necessary.
- Provide the necessary medical care.
- Use the Clinical Guidelines adopted by TSA.
- Notify the health plan of any barriers that affect access to services or the Transition of Care process.
- Encourage patient participation in Triple-S clinical programs.
- Ensure continuity of care or services.
- Review and update the Plan of Care and address members' concerns or preferences.
- Participate in Interdisciplinary Team meetings and maintain communication with the Care Manager, ICT or caregiver, and collaborate on the Plan of Care.
- Offer preventive care and guide members to maintain a healthy lifestyle and comply with quality measures (HEDIS).

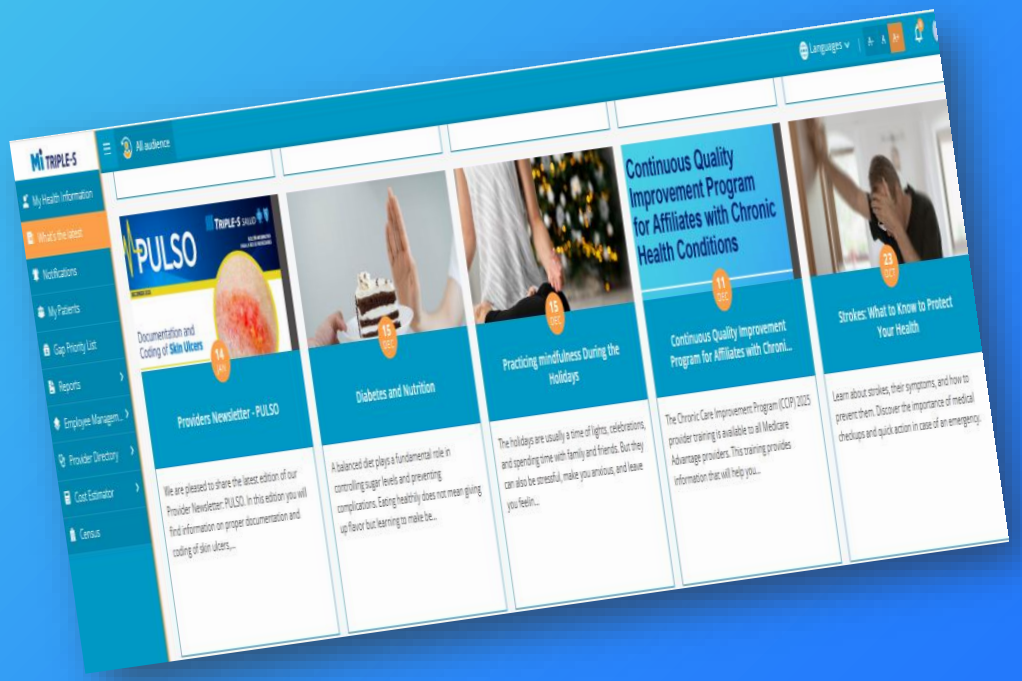
MOC Element 3: Provider Network: Role of the Specialist Physician

- Perform the HRA complying with the established period.
- Incorporate the Primary Care Physician (PCP) into the member's care.
- Provide services on time, effectively and ensure quality.
- Participate in patient care planning and be part of the Interdisciplinary Team.
- Notify the health plan of any barriers that affect access to services or the Transition of Care process.
- Encourage patient participation in Triple S clinical programs.
- Ensure continuity of care or services.
- Provide the necessary medical care.
- Use the Clinical Guidelines adopted by TSA.
- Offer preventive care and guide members to maintain a lifestyle.

MOC Element 3: Provider Network

- Triple-S Advantage provides Model of Care training to its providers and Medical Groups through:

  - ✓ Continuing Medical Education
  - ✓ Pulso Magazine
  - ✓ Regular Mail
  - ✓ Mi Triple-S Portal: mitriples.com
  - ✓ Email
  - ✓ Initial Orientation of new Provider



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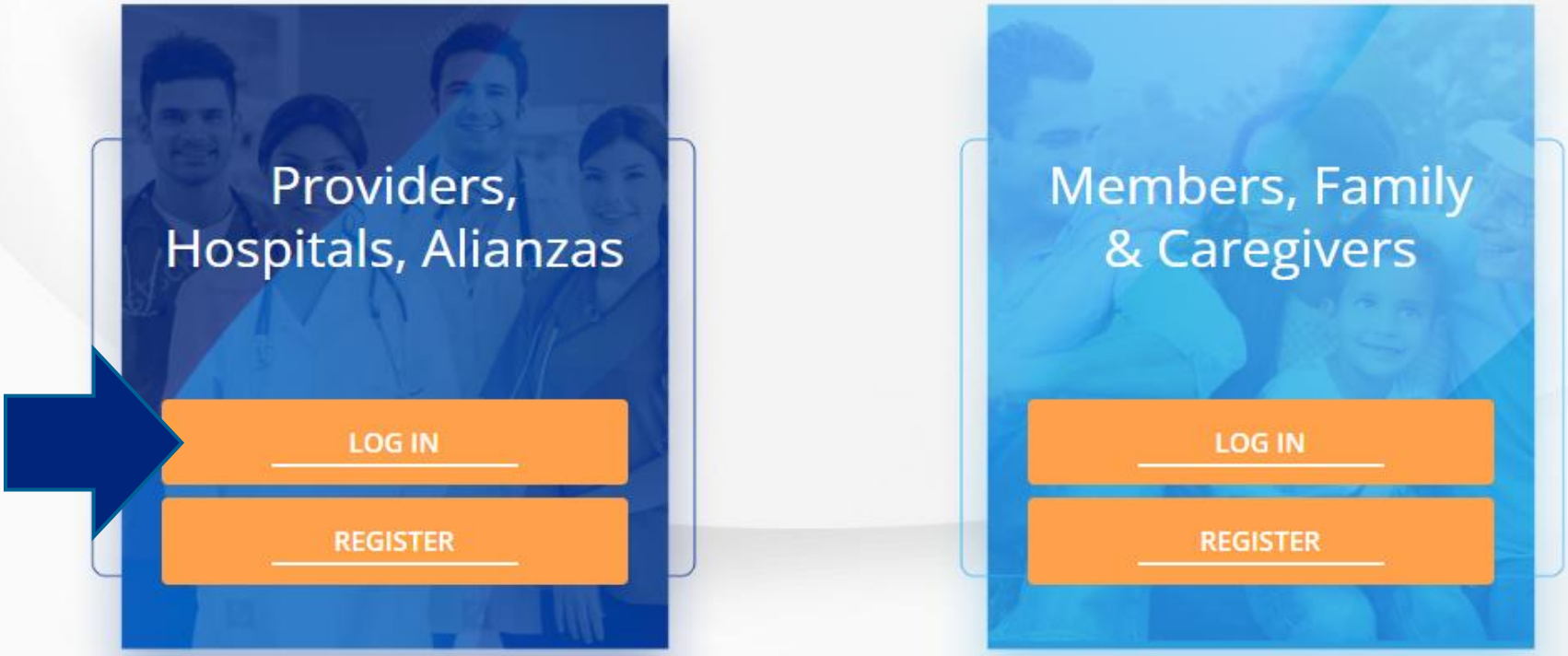
Access through the Provider Portal in Mi Triple-S



www.mitriples.com

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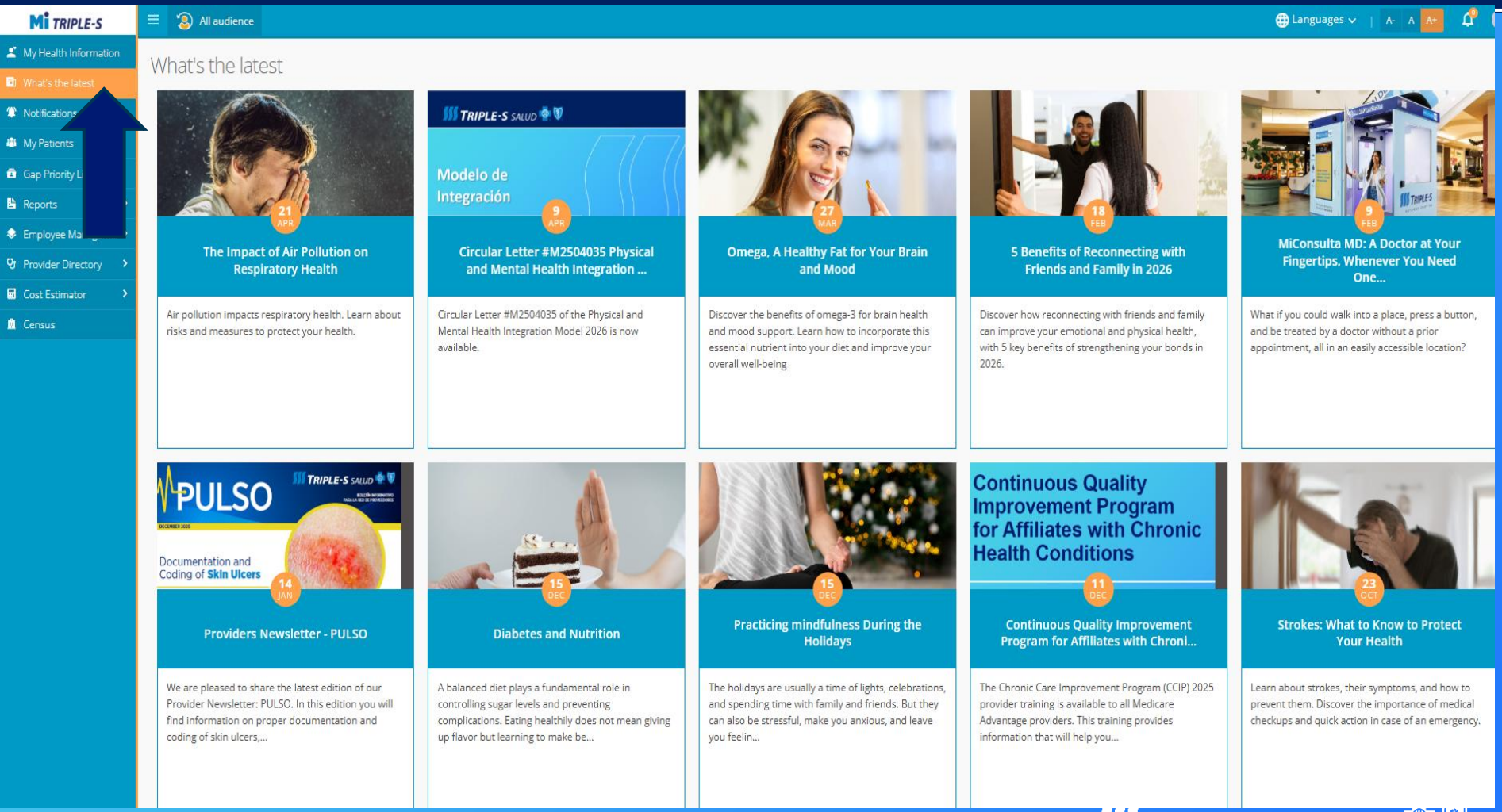
Where to find: What's the latest



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MOC Element 4: Quality Measurement and Performance Improvement

Element A: MOC Quality Performance Improvement Plan

Element B: Measurable Goals

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

Element D: Dissemination of MOC Performance Results

MOC Element 4: Quality Measurement and Performance Improvement

This element monitors the performance, results, and indicators that impact the population SNP. The objective is to improve the quality of services and organizational efficiency through continuous measurement and data-based decision-making.

At Triple-S Advantage, we have a comprehensive quality improvement program that evaluates and adjusts processes based on the results obtained.

We evaluate:

- ✓ Star Program Measures
- ✓ Quality Indicators of Members Interventions
- ✓ Member Satisfaction CAHPS & HOS
- ✓ Appeals and Grievances - submitted directly to the plan or through Medicare

MOC Element 4: Quality Measurement and Performance Improvement
Star Program HEDIS Measures

Measures	
Breast Cancer Screening	Diabetes Care – Blood Sugar Controlled
Colorectal Cancer Screening	Medication Reconciliation Post-Discharge
Care for Older Adults – Medication Review	Transitions of Care
Controlling High Blood Pressure	Statin Therapy for Patients with Cardiovascular Disease
Osteoporosis Management in Women who had a Fracture	Plan All-Cause Readmissions
Diabetes Care – Eye Exam	Follow-up after Emergency Department Visit for High-Risk Chronic Conditions patients

How do the elements of the Model of Care work with each other?

The Triple-S Advantage Model of Care integrates need identification, service coordination and provider networking to deliver high-quality care to populations with special needs.
Our focus is to continuously monitor members' health to improve their quality of life.

MOC 4
Quality Measurement and Performance Improvement

As a Triple-S Provider, you are an essential part of the Care Model to achieve integrated and holistic management of our members.

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Quality Improvement Department

If you have any questions, please write to us at:

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