Abilis Health Plan

Model of Care Annual Training

2026

Abilis Health Community Plan

OVERVIEW

welcome

- **Abilis Health (AH) is more than a Medicare Advantage (MA) health plan**. We are a comprehensive special needs plan (SNP) with a model of care delivery system created and delivered through a unique partnership between long term care providers and care management experts.
- Our model of care focuses on placing caregiving and care decision making in the hands of those who know our members best – YOU (our care team).
- All Facility-based Institutional Special Needs Plans (FI-SNPs) and Institutional Equivalent special needs plans (IE-SNP) like AH must have a Model of Care (MOC) approved by the National Committee for Quality Assurance.
- CMS requires MOC training that reviews the major elements of the MOC for new employees, providers, contractors, then annually thereafter.
- Purpose of this training is to comply with the CMS requirement that all SNPs provide a general understanding of the requirements of the MOC while building a strong integrated partnership.

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Training Objective

After the MOC training, participants will be able to:

- ✓ Understand FI-SNP and IE-SNP enrollment requirements.
- ✓ Outline the basic elements of the MOC.
- ✓ Describe the unique characteristics of Plans' population.
- ✓ Explain how care management staff coordinates care for special needs members.
- ✓ Explain the critical role of the practitioner(s) as part of the MOC required Interdisciplinary Care Team (ICT).

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What is required in order to join an FI-SNP/IE-SNP?

- ✓ Enrolled in Medicare Part A (Hospital Insurance).
- ✓ Enrolled in Medicare Part B (Medical Insurance).
- ✓ Live in Plan's service area.
- ✓ **Must reside or be expected to reside in a participating FI-SNP nursing or assisted-living facility for greater than 90 days at the time of enrollment.**

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Abilis Health Special Needs Plans

For AH PY 2026 – Two (2) SNP Types

- ✓ Abilis Health Plan (FI-SNP)
  - ✓ An FI-SNP is a type of MA plan. FI-SNPs can help meet the medical needs of people living in a long-term care setting. For instance, a skilled nursing facility.
- ✓ Abilis Health Community (IE-SNP)
  - ✓ Members who require a level of care typically found in a long-term care facility but choose to live in community-based settings like assisted living or memory care facilities. IE-SNPs are an extension of FI-SNPs and provide coordinated care to those with complex health needs outside of traditional institutional settings.

- ❖ Enrollment is limited to MA eligible individuals **needing or are expected to need, for 90 days or longer,** the level of services provided in a/an:
  - ✓ Skilled nursing facility (SNF)
  - ✓ Long-term care (LTC) nursing facility (NF)
  - ✓ Intermediate care facility (ICF)
  - ✓ Inpatient psychiatric facility (IPF)
  - ✓ Assisted living facility (ALF)
- ❖ Enrollment is accepted in one of two scenarios:
  - ✓ Institutionalized and capable of consenting for themselves; or
  - ✓ Authorized/Legal representative to act upon a resident's behalf

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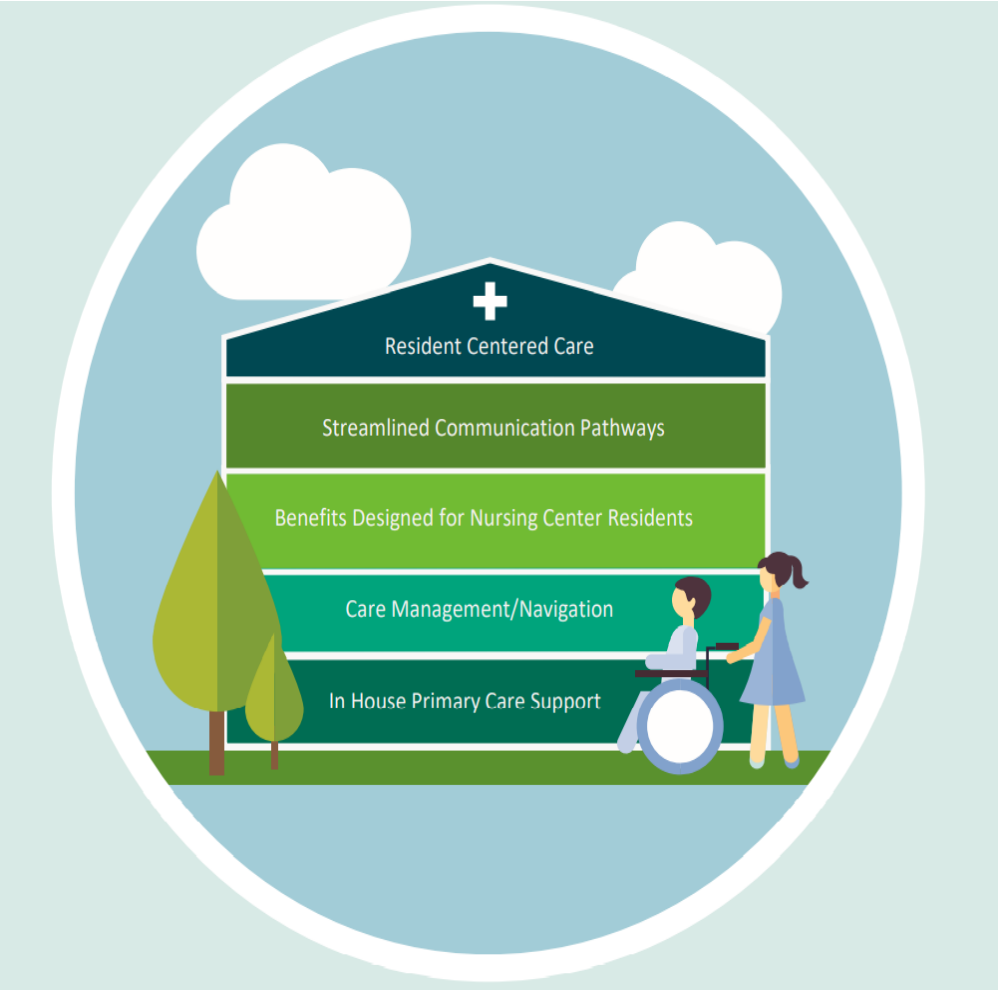
What is a Model of Care?

AH's detailed, written commitment to CMS on how the Plan will provide care to enrolled members:

The MOC is designed to:

- ✓ Reduce non-essential hospital admissions when care can safely and effectively be provided in the member's current setting.
- ✓ Improved health outcomes through high quality care and reduced gaps in care.
- ✓ Maintain the residents at an optimal level of function.
- ✓ Reduce avoidable re-admissions and improved access to preventative health services.
- ✓ Increase adherence with clinical practice guidelines.
- ✓ Enhance identification and address problems earlier to optimize member function.
- ✓ Improved care coordination and communication across all care settings.



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What are the elements of the Model of Care?

MOC 1 | MOC 2 | MOC 3 | MOC 4

Target Population

Care Coordination

Provider Network

Quality Measurement

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MOC 1: The Plan's Target Population

The characteristics of the member population that AH and its providers serve include social factors, cognitive factors, environmental factors, living conditions, and co-morbidities.
AH members reside within long term care facilities generally with the following characteristics or conditions:

- Frail/vulnerable
- More likely to be a female
- Average age is 75 and over
- Typically, widowed or single
- Primarily Caucasian
- English speaking
- Unable to make care decisions or participate in their own care
- Likely reporting daily pain
- May be confined to bed or wheelchair
- Multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)
- Likely prescribed one or more high-risk medications per month
- Needs help with activities of daily living including bed, mobility, dressing, eating, and toileting
- Moderate to severe cognitive impairment
- Overall low health literacy
- Has socioeconomic issues creating barriers to care
- May lack consistent, engaged caregiver/family support

*IE-SNP enrollees, may be more mobile and more likely to make care decisions**

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MOC 2: Care Coordination Member Rights

The Plan understands and assists Members in exercising their rights to be fully:

- Informed of his/her total health status, including but not limited to medical status
- Informed of the right to choose his/her own physician
- Informed in advance of any changes in care or treatment

- For additional Member Resource: Member Resource Information

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MOC 2: Care Coordination – Staffing Model

❖Care Coordination is how AH coordinates the health care needs and preferences of the resident.

❖ Both plan types enrollees are required to choose a primary care physician (PCP).

- PCP driven care model (onsite for the FI-SNP members/IE-SNP members onsite or preferred provider).
- Dedicated medical specialty providers supporting PCP.

❖ Dedicated Advanced Practice Clinician (APC)

- Part of care team with PCP.
- On-site primary care support.
- Direct access to member's facility record.
- Access to member Minimum Data Set (MDS) (for FI-SNP) or state Level of Care Assessment Tool (LCAT) (for IE-SNP) information.
- Serves as a key point of contact for comprehensive assessments, individualized care plans (ICP), ICT, Health risk assessment tool (HRAT), and all member care transitions.
- Centralized point of contact for members and families/caregivers.

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MOC 2: Care Coordination – Staffing Model

Clinician's role:

- Face-to-face primary care support
- Assessment, care planning (including Advanced Care Planning), and communication
- Medication review and monitoring
- Early identification and treatment of symptoms
- Upon return to the facility from a Transition of Care Event, the APC sees the Member within 2 business days; and a comprehensive assessment and an updated ICP is completed

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MOC 2: Care Coordination - Health Risk Assessment Tool (HRAT)

- **All FI-SNP and IE-SNP members are required** to receive an HRA, comprehensive history and physical exam and subsequent care plan **within 90 days** of enrollment (before or after); then annually thereafter within 365 days of the last HRA.
- APC utilizes a **HRAT** that scores and rates each member's medical condition.
- The HRA was created internally and incorporates multiple, nationally validated assessment tools and studies, including:
  - Patient Health Questionnaire 2 (PHQ-2)
  - Braden Scale for Predicting Pressure Sore Risk
  - Fall Risk Assessment Tool (FRAT)
  - General Practitioner Assessment of Cognition (GPCOG) Score and Brief Interview for Mental Status (BIMS)
  - CAGE Questionnaire
  - Mini Nutritional Assessment (MNA)
  - Activities of Daily Living Scale Assessment

Risk History							
Hospital admission (put date) within 6 months			2 points				
Takes 9 or more regularly scheduled meds			2 points				
No DNR			1 point				
PHQ-2 Score 3 or higher			1 point				
No or limited social support			1 point				
Specialized Risk Scores	Score: **0** pts for each Low Risk		**1** pt for each Moderate Risk			**2** pts for each High Risk	
Fall Risk	Low	Moderate/Med	High				
Skin Risk	Low	Moderate/Med	High				
Nutritional Risk	Low	Moderate/Med	High				
Activities of Daily Living	Low	Moderate/Med	High				
Cognitive Risk	Low	Moderate/Med	High				
			Total Score				
Resident:		**Room #:**		**Low Risk** 0-6 **Mod/Med Risk** 7-13 **High Risk** 14 or higher			

Example of HRA

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MOC 2: Care Coordination - Health Risk Assessment Tool (HRAT)

- An evidence-based algorithm is applied utilizing the HRAT scores, data resources such as MDS or LCAT, and claims to stratify into the member's health risk levels.
- Comprehensive ICP is developed, and APC coordinates plan of care with facility and member.
- Visit frequency is tailored to each member's condition and risk level to reduce complications and prevent hospitalizations and re-hospitalizations.
- Process for **member refusals** or are unable to reach:
  - After 3 failed contact attempts or member refusals (indicating low risk), the Plan representative will document the attempts in the medical record tool.
  - The Plan will continue outreach to assess the member's needs and health status.

When to Complete HRA and Care Plans…

Triggering Events:

- Enrollment to the SA Plan
- Transitions of Care:
  - Acute hospitalization (all-cause, any length of stay)
  - An ER visit
  - SNF admission
  - Change in health status

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MOC 2: Care Coordination - Health Risk Assessment Tool (HRAT)

- **All FI-SNP (Facility) members are required to receive a comprehensive history and physical exam and subsequent care plan within 90 days of enrollment (before or after); then annually thereafter within 365 days of the last HRA.**
- APC utilize a **HRAT** that scores and rates each member's medical condition.
- The plan applies an evidence-based algorithm that utilizes the HRAT scores, along with other data resources such as MDS or LCAT, and claims data (i.e., medical & pharmacy). These total scores are then stratified into health risk levels.
- Comprehensive ICP is developed and the APC coordinates plan of care with facility and member.
- The frequency of visits is unique to each enrolled Member's condition with the goal to reduce complications and prevent re-hospitalizations.

FI-SNP (Facility)		
Risk Level	Nurse Practitioner Face-to-face Visits with Members	Nurse Practitioner "Rounds" with LTC Facility Nurses
Low	1x/month	1x/month
Moderate	2x/month	1x/week
High	1x/week (or more frequently as needed)	1x/week

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MOC 2: Care Coordination - Health Risk Assessment Tool (HRAT)

- **All IE-SNP (Community) members are required to receive a comprehensive history and physical exam and subsequent care plan within 90 days of enrollment (before or after); then annually thereafter within 365 days of the last HRA.**
- APC utilize a **HRAT** that scores and rates each member's medical condition.
- The plan applies an evidence-based algorithm that utilizes the HRAT scores, along with other data resources such as MDS or LCAT, and claims data (i.e., medical and pharmacy). These total scores are then stratified into health risk levels.
- Comprehensive ICP is developed and the APC coordinates plan of care with facility and member.
- The frequency of visits is unique to each enrolled Member's condition with the goal to reduce complications and prevent re-hospitalizations.

IE-SNP (Community)		
Risk Level	Advanced Practice Clinician Face-to-face Visits with Members	Advanced Practice Clinician "Rounds" with LTC Facility Nurses
Low	1x/quarterly	1x/quarterly
Moderate	1x/bi-monthly	1x/bi-monthly
High	1x/month (or as frequently as needed)	1x/month

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MOC 2: Care Coordination - Medication Therapy Management

MTM: A CMS-required service to optimize drug therapy and improve outcomes for patients with multiple chronic conditions.

Core Components of MTM:

- **Quarterly Targeted Medication Reviews (TMRs)**
  - Quarterly, our MTM Pharmacy team reviews the member's medications for safety, missed opportunities, or issues. Any recommendations are sent to the prescriber, who will decide whether to make changes. Prescription medications will only change if the member and provider agree.
- **Annual Comprehensive Medication Review (CMR)**
  - One-on-one discussion with your APC and our MTM Pharmacy team to review all medications, including prescriptions, OTC drugs, herbal therapies, and supplements. Afterward, the member receives a Personal Medication List and, if needed, a Medication Action Plan within 14 days.
- **Follow-up interventions as needed**

CMS Requirements:

- Eligible beneficiaries must be offered a CMR annually.
- CMR completion rates are reported in Medicare Part D Star Ratings.
- Target population: ≥3 chronic diseases, ≥8 Part D drugs, annual drug costs likely > threshold
- Or if the member is identified as at-risk.

Benefits:

- Improved patient safety
- Reduced adverse drug events
- Better health outcomes
- Enhanced patient engagement

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MOC 2: Care Coordination – Medication Therapy Management

Providers collaborate with Pharmacy Consultants to:

- Review and update medications with the member, caregiver, or pharmacist
- Improve quality performance metrics
- Manage antipsychotic use in dementia patients
- Monitor high-risk medications in the population
- Detect duplicate therapies
- Optimize dosing and therapy duration (e.g., proton pump inhibitors, benzodiazepines, antidepressants)
- Promote generic use over brand when appropriate
- Ensure appropriate medication use
- Reduce drug-induced adverse events (e.g., medication-induced delirium, excessive bleeding, constipation)

MOC 2: Care Coordination - Individualized Care Plan

- ✓ Completed and monitored by the clinicians
- ✓ **Member-centric** and includes **goals** and **intervention** measures
- ✓ Drives **ICT** reviews inclusive of PCP/APC
- ✓ Member **engagement** (including condition-specific education)
- ✓ **Maintained** electronically by each facility (when available) or by APC EMR
- ✓ Evaluated and updated on a **quarterly** basis, **or when a significant change** in condition or status is identified

- ✓ If the Member chooses **not to participate** in the completion of the HRA, the APC and PCP, in conjunction with the ICT, utilizes administrative and clinical data sources, including but not limited to hospitalization history, diagnosis, medications, and previous care coordination activities, to develop and maintain an ICP.

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MOC 2: Care Coordination - Individualized Care Plan

Upon completion of the initial HRA assessment process by the clinician, the following processes occur:

- **Risk level and initial ICP generated by the Community APC and within the LTC facility**
  - Goals and interventions follow nationally recognized standards of care and evidence-based guidelines.
  - HRA and ICP are accessible in the EHR/medical record tool.

- **ICT reviews and collaborates on the ICP**
  - ICP is shared with the Member's ICT (member, caregiver, or representative) for review/input via EHR, fax, secure email, or in person.
  - Revisions are based on ICT feedback, and the final ICP is communicated to ICT through the same channels.

- **APC meet face-to-face with member, caregiver, and or representative to review and discuss ICP**
  - PCP and APC, supported by the ICT, actively monitor the Member's condition.
  - PCPs and APC frequently communicate with the staff, review medical record documentation and evaluate the Member to assure that all orders are well understood and executed timely.

- **Material changes in the Member's condition are communicated to the PCP immediately (in person or telephonically)**
  - PCP and APC collaborate to reassess risk level and update the ICP based on current needs.
  - Ad hoc meetings are scheduled as needed to address urgent issues.

- **Elements of the ICP may include:**
  - Member-driven goals with follow-up and self-management plans.
  - System for tracking and evaluating progress.

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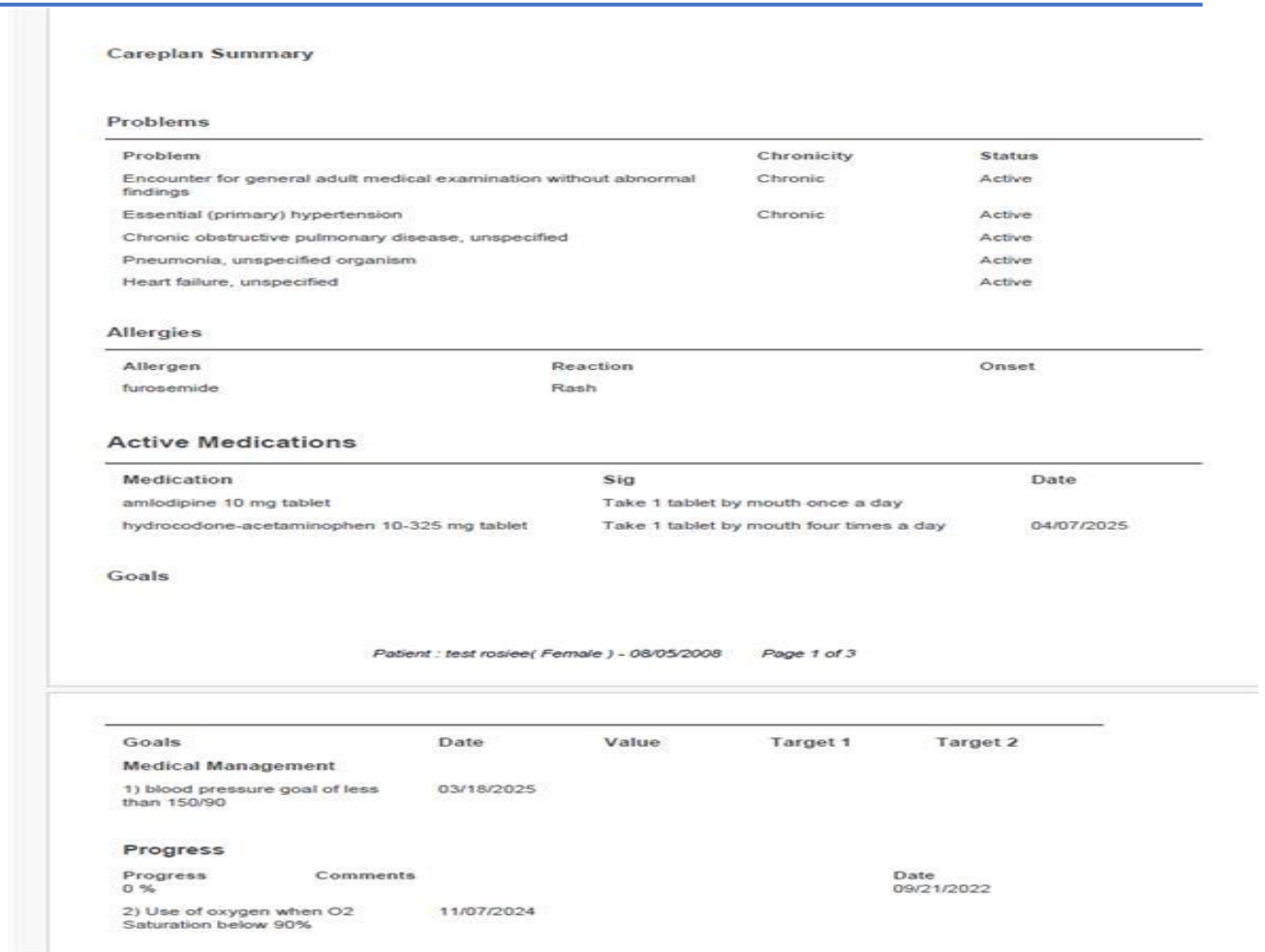
MOC 2: Care Coordination - Individualized Care Plan

Elements of the ICP may include:

- Long- term and short- term goals that take into account the Member's preferences.
- Develop a schedule for follow-up & communication.
- Development and communication of the Member's self-management plan and associated goals.
- A process to assess and track the Member's progress.

Examples of individualized heart failure goals include:

- Appropriate dietary changes.
- Monitor weight as an early indicator of worsening condition.
- Adherence to medications.
- Cholesterol management and LDL-C screening.
- Reduce preventable hospital admissions.



Careplan Summary

Problems

Problem	Chronicity	Status
Encounter for general adult medical examination without abnormal findings	Chronic	Active
Essential (primary) hypertension	Chronic	Active
Chronic obstructive pulmonary disease, unspecified		Active
Pneumonia, unspecified organism		Active
Heart failure, unspecified		Active

Allergies

Allergen	Reaction	Onset
furosemide	Rash	

Active Medications

Medication	Sig	Date
amlodipine 10 mg tablet	Take 1 tablet by mouth once a day	
hydrocodone-acetaminophen 10-325 mg tablet	Take 1 tablet by mouth four times a day	04/07/2025

Goals

Patient : test rosiee(Female) - 08/05/2008 *Page 1 of 3*

Goals	Date	Value	Target 1	Target 2
Medical Management				
1) blood pressure goal of less than 150/90	03/18/2025			

Progress

Progress	Comments	Date
0 %		09/21/2022
2) Use of oxygen when O2 Saturation below 90%	11/07/2024	

Ethizo Care Plan Example

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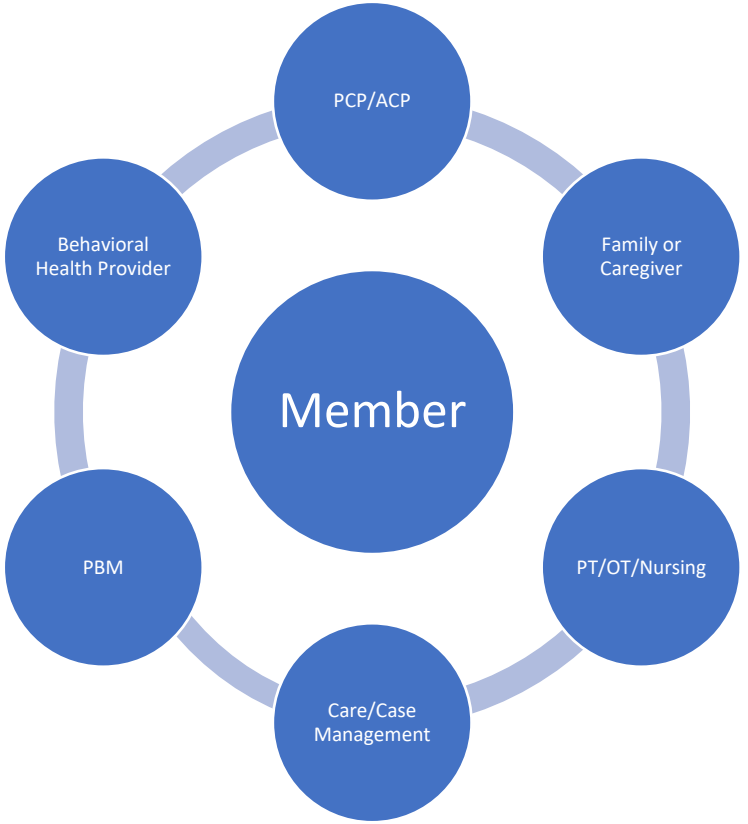
MOC 2: Care Coordination - Interdisciplinary Care Team (ICT)

The ICT carries out, at a minimum, the following duties:

- Collaborating with ICT members, including the Member/caregiver, to develop and implement the ICP, as well as communicating condition changes for review and follow-up.
    - Coordinating care for anticipatory care transitions.
    - Collaborating with Members, caregivers, discharge planners, medical staff, and the healthcare team to coordinate a comprehensive discharge plan.

- Initiating timely clinical interventions and referrals in the most appropriate care setting along the Member's health spectrum.
    - Educating the Member and caregiver to identify early changes in medical or behavioral conditions and develop contingency plans.
    - Assisting the Member/caregiver with coordinating benefits.

- Assisting with improving overall Member goals and outcomes through identification of over/underutilization of services & ongoing monitoring of quality measures.



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MOC 2: Care Coordination - Transitions Process

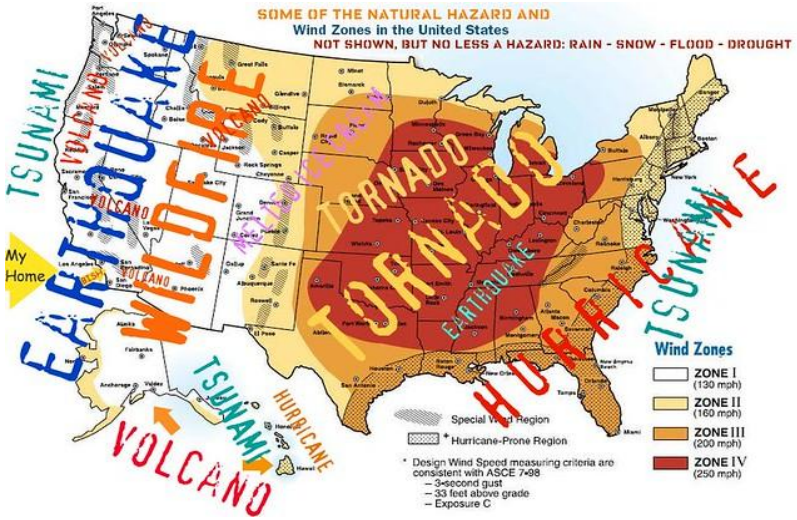
- APC and member's family/caregiver are notified of acute care transitions by facility staff.
- Prior to member's transition, facility should but is not limited to:
  - ✓ Member's face sheet (demographics, insurance, responsible party)
  - ✓ Medication list
  - ✓ Current orders
  - ✓ Advance directives

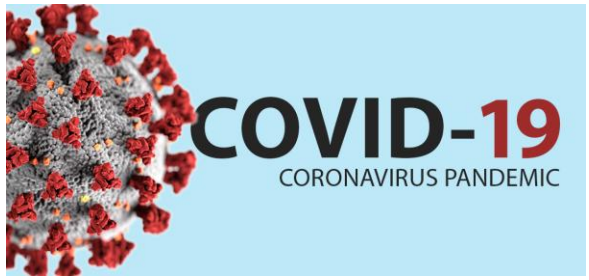
- **APC is responsible for assisting with coordinating the care transition process and is a key POC for communication with the member, their family/caregiver, the doctors, and nursing staff**
  - ✓ APC sees the member within 48 hours of return to conduct comprehensive assessment and a transition/triggering event HRA.
  - ✓ APC reviews discharge summary as well as medication reconciliation and updates care as needed.
  - ✓ APC timely (generally within 24 hours) updates the ICT on the member's status and transition plan to ensure continuity of care.

MOC 2: Care Coordination – Contingency Plans

- Natural disasters or public health emergencies can occur at any time. CMS requires SNPs and its healthcare partners to have a contingency plan to avoid disruption in care and services for members.

- Disruption can be avoided when:
  - ✓ Administrative and Clinical employees are cross-trained to ensure continuity and can work remotely using web-based program on a secure network.
  - ✓ Calls are diverted to back-up offices within the SA network during an emergency.





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MOC 3: Provider Network

- AH provides a network of primary care providers, specialists, and facilities with specialized expertise pertinent to the care and treatment of its members to:
  - ✓ Collaborate with the ICT and contribute to a Member's ICP
  - ✓ Provide clinical consultation
  - ✓ Assist with developing and updating care plans
  - ✓ Provide pharmacotherapy consultation

- AH continuously evaluates provider adequacy to ensure members have access to health care professionals with expertise in treating the chronic conditions of the SNP population.

- The Plan credential/recredentials all participating providers at least once every three years.

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MOC 3: Provider Network - Clinical Practice Guidelines & Care Transition Protocols

- **Our Utilization Management Committee** evaluates and adopts clinical practice guidelines applicable to the needs of AH's membership.
- AH will **annually review** adherence of selected clinical practice guidelines (2025-Provider-Manual.pdf) through data analysis.
- When guidelines are **not** satisfactorily adhered to by individual network providers, AH will facilitate education with the provider.
- When a systemic problem **is identified**, AH will undertake broader educational efforts with the network and then evaluate through additional data study.
- APCs receive monthly reports that identify gaps or opportunities for evaluation and intervention.

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MOC 3: Provider Network - Pharmacy Benefit Management

- Pharmacy and Therapeutics Committee provides guidance on formulary development and maintenance.
- Utilize tools/techniques to evaluate use of evidence based clinical practice guidelines.
- Pharmacy data to identify potential care gaps or potential adverse events and compliance issues.
- Identify actual and potential gaps in medication adherence and generates notice to physician and member along with quarterly reports to the Plan for review.

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MOC 3: Provider Network - Training

AH provides FI-SNP/IE-SNP Program and Model of Care training for its provider network:

- ✓ **Initially and annually thereafter**
- ✓ Training must be documented and tracked
- ✓ Training is posted to website MOC Provider Training

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MOC 4: Quality Improvement Plan

- Focus on continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services.
- Annual Quality Improvement Work Plan using standard reporting and data analysis.
- Board of Directors review and approval.
- Plan performance shared across the Plan and with Providers.
- High-volume provider's reports on individual performance against expectations and benchmarks.
- Goals also include alignment with Medicare's performance measurement systems:
  - Star Ratings Program
  - Healthcare Effectiveness Data and Information Set (HEDIS)

MOC 4: Quality Measures-HEDIS/Star

Stars

The STARS program-is a quality rating system developed by CMS to evaluate Medicare Advantage and Part D plans.

Plans are rated from 1 to 5 stars, with 5 being excellent. Ratings are based on:

- Clinical quality measures (e.g., preventive screenings, chronic condition management)
- Member experience- Customer service
- Drug safety and adherence

These ratings impact plan reimbursement, bonus payments, and consumer choice.

HEDIS

HEDIS is a set of standardized performance measures developed by NCQA (National Committee for Quality Assurance).

It's used by health plans to measure: Quality of care, Access to care, Utilization, and Health outcomes

HEDIS includes over 90 measures across six domains, such as:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

Exclusion Criteria for HEDIS Measures

Most HEDIS measures have exclusion criteria—circumstances that allow certain members to be excluded from the denominator (i.e., not counted against performance). However, most members under age 66 do not qualify for exclusions. This is because:

- Many exclusions are based on frailty, advanced illness, or long-term institutionalization, which are more common in older populations.
- Younger members typically do not meet criteria for exclusions, so they remain in the denominator, impacting performance scores.

MOC 4: Quality Measures-HEDIS/Star (Examples)

HEDIS/Stars Provider Grid for MY 2026

Measure	Description	Eligible Population	Top Codes to Close Measure	Exclusions Examples
Breast Cancer Screening (BCS-E)	Percentage of persons 40-74 of age who were recommendedfor routine breast cancer screening and had mammogram	Women aged 40-74	Mammogram CPT: 77061-77063, 77065-77067	Hospice or hospice services, receiving palliative care, bilateral mastectomy
Colorectal Cancer Screening (COL-E)	Measures the percentage of adults aged 50-75 who had appropriate screening for colorectal cancer.	Adults aged 50-75	45388-45393, 45398 Cologuard 81528 FOBT CPT: 82270, 82274 CT 74261-74263 Flex Sig: 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350	Colon cancer diagnosis, total colectomy, Hospice
Controlling High Blood Pressure (CBP)	Percentage of adults aged 18-85 with hypertension whose blood pressure was adequately controlled (<140/90).	Adults aged 18-85 with hypertensio	Systolic less than 140 CPT II: 3074F, 3075F; diastolic less than 90 CPT II: 3078F, 3079F	Hospice, palliative, ESRD, pregnancy,
Glycemic Status Assessment (GSD)	Percentage of members aged 18-75 with diabetes (type 1 or type 2) who had an HbA1c test in the measurement year.	Adults aged 18-75 with diabetes (Type 1 or Type 2)	HbA1C lab test CPT: 83036, 83037	Hospice/palliative, fraility and advanced illness
Glycemic Status- HbA1c Control (<8%, >9%) (GSD)	Percentage of members aged 18-75 with diabetes (type 1 or type 2) who's most recent HbA1c was at <8.0%/ 9.0%	Adults aged 18-75 with diabetes	CPT II 3044F (less than 7), 3051F (greater than or equal to 7, less than 8), 3052F (greater than 8 but less than/equal to 9)	Hospice/palliatve
Eye Exam for Diabetics (EED)	Percentage of adults aged 18-75 with diabetes (type 1 and type 2) who had retinal eye exam	Adults aged 18-75 with diabetes	99242-99245 CPT II with retinopathy: 2022F, 2024F, 2026F CPT II without retinopathy: 2023F, 2025F	Hospice/palliative
Care of Older Adults (COA-MDR): Medication Review	Percentage of members 66 and older whose doctor or pharmacist reviewed all medications, including prescriptions, OTC medications, etc.	Adults aged 66 and older	CPT: 90863, 99483, 99605, 99606 CPT II: 1160F	Hospice/palliative
Care of Older Adults (COA-FSA): Functional Status Assessment	Percentage of members 66 years of age and older who had documentation of at least one completed functional status assessment in measurement year	Adults aged 66 and older	CPT: 99483 CPT II: 1170F	Hospice/palliative
Follow-up after ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Members 18 and older with multiple high-risk chronic conditions with ED visit and received follow-up within 7 days	Adults aged 18 and older	99202-99205, 99211-99215, 99242-99245, 99341-99345, 99391-99397, 99401-99404, 99411-99412	Hospice

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MOC 4: Quality Measures-HEDIS/Star (Examples)

HEDIS/Stars Provider Grid for MY 2026				
Measure	**Description**	**Eligible Population**	**Top Codes to Close Measure**	**Exclusions Examples**
Statin Use in Persons with Diabetes (SUPD) - Stars	Members 40-75 with diabetes who were dispensed at least 2 diabetic prescription fills on uniques dates and statin medication during measurement year	Adults aged 40-75 with diabetes		Hospice, ESRD/HD, rhabdomyolysis/myopathy, cirrhosis, prediabetes, PCOS
Medication Adherence for Diabetes Medications- Stars	Percentage of plan members with a prescription of diabetes medication who fill their prescription often enough to cover 80% or more of the time	Adults aged 18 and older		Hospice, ESRD/HD, one or more prescriptions for insulin in treatment period
Medication Adherence for Hypertension (RAS antagonists)- Stars	Percentage of plan members with a prescription for a BP medication who fill their prescription often enough to cover 80% or more of the time	Adults aged 18 and older		Hospice, ESRD/HD, one or more prescription of sacubitril/valsartan during treatment period
Medication Adherence for Cholesterol (Statins) - Stars	Percentage of plan members with a prescription for a statin who fill their prescription often enough to cover 80% or more of the time	Adults aged 18 and older		Hospice, ESRD/HD
MTM Program Completion Rate for CMR - Stars	Percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period.	All members		
Osteoporosis Management in Women who had fracture (OMW)	The percentage of woman MA enrollees 67-85 who suffered a fracture and who had either a bone density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	Women 67-85 who suffered a fractu	CPT (bone mineral density test: 76977, 77080, 77081, 77085, 77086	Hospice/palliative
Plan All-Cause Readmissions (PCR)	Percentage of members 18 years and older discharged from IP stay who readmitted to a hospital within 30 days for any reason	18 years and older		Hospice
Statin Therapy for Members with Cardiovascular Disease (SPC)	Percentage of members 21-75 during the measurement year who were identified as having atherosclerotic cardiovascular disease and met the following criteria: received statin therapy and statin adherence at least 80% of the time.	Adults aged 21-75		Hospice/palliative, myalgia, myositis, rhabdomyolysis during measurement year, ESRD, cirrhosis
Transitions of Care (TRC)	Percentage of members 18 years of age and older who had each of the following: notification of IP admission, receipt of discharge information, patient engagement after DC, medication reconciliation post DC.	18 years and older	CPT 99495, 99496	Hospice
Medication Reconcillation Post-Discharge (TRC-MRP)	Percentage of members 18 years and older whose medications were reconcilled within 30 days after discharge froms observations or acute inpatient setting	18 years and older	CPT: 99483, 99495, 99496, 99605, 99606; CPT II 1111F	Hospice

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MOC 4: Quality Improvement Plan - Advance Care Plan/Member Survey

Advance Care Planning

Category	Details
Measure Name	Advance Care Planning (ACP)
Measure ID	CMS349 / PQRS 047
Measure Type	Process
Measure Domain	Communication and Care Coordination
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Description	% of patients ≥65 with: • ACP or surrogate decision maker documented • OR documentation that ACP was discussed and declined
Denominator (Eligible Population)	Patients ≥65 with at least one eligible encounter during the measurement period
Denominator Exclusions	None
Numerator (Performance Criteria)	Documentation of: • Advance care plan • Surrogate decision-maker • OR patient declined after discussion
Measurement Period	Calendar year (Jan 1 – Dec 31)
CPT Codes	99497 – First 30 min face-to-face ACP 99498 – Each additional 30 min
Modifiers	33 (Preventive Service), 25 (E/M with separate ACP discussion)
ICD-10 Codes	Not required specifically for ACP billing
Documentation Requirements	• Discussion of goals, preferences, and treatments • ACP or surrogate listed • Patient declined if applicable

Member Survey: Please share with Members:

Member Survey

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MOC 4: Goals

The MOC facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs, and the coordination of care to improve members overall health. AH's Special Needs Plans' MOC have the following Goals:

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Who is responsible for Compliance with the MOC?

Everyone!

Compliance with CMS requirements and the ethical administration of the AH FI-SNP/IE-SNP MOC is an enterprise-wide, shared responsibility and requires all of us to work together to benefit our members/patients.

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Click HERE to access the online attestation. (Attestation is required)

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