2018 Medicare Advantage Stars Primary Care Incentive Program:

Clinical Quality Measures

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2018 Medicare Advantage Stars Primary Care Incentive Program: Clinical Quality Measures

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Profiled/Informational

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***Not a CMS measure. Not included in aggregate Stars score calculation.**

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C01: Breast Cancer Screening

Source: HEDIS® 2018 (BCS)

Percentage of female members 50–74 years of age who had a mammogram to screen for breast cancer.

Measure weight : 1 5 Star: 85%

Numerator	Denominator	Exclusions
One or more mammograms during the measurement year or the 15 months prior to the measurement year (OCT 1, 2016 – DEC 31, 2018)	Female members 52–74 years of age as of the last date of the measurement year (female members who were 50 years of age or older as of OCT 2016)	Those who had a bilateral mastectomy any time during the member's history through the last day of the measurement year MA Members age 65 and older as of JAN 1 of the measurement year: Enrolled in an Institutional Special Needs Plan any time during the measurement year OR Living long-term in an institution any time during the measurement year **(as reported by CMS).**

Note: 2018 Breast Cancer Screening measure specifications added digital breast tomosyntheis as a method for meeting numerator criteria. Exclusions to the Medicare product line have been added for members 65 years of age and older living long-term in institutional settings. *CMS Medicare Part C monthly membership file is the determinate of LTI setting.*

C01: Breast Cancer Screening

Source: HEDIS® 2018 (BCS)

Percentage of female members 50–74 years of age who had a mammogram to screen for breast cancer.

Supplemental Data Submission

Clinical Quality Feedback (CQF) function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

Best Practice

- Cover personal review of member preventive screening needs through the Annual Wellness Visit/Initial Preventive Physical Exam. Make most of this opportunity to communicate preventive care.
- Arm your patient with a prescriptive order to enable flexibility in scheduling through walk in centers and breast cancer screening events.

Note: If screening events are free, claim may not be submitted through your patients' insurance. Make clear where you want the test result to be sent to allow submission through the CQF.

Medicare Advantage Member Benefits

Medicare Advantage denotes screening mammography as a **covered in full** benefit.

Limits: One screening every 12 months.

Please distinguish between screening and diagnostic testing.

C02: Colorectal Cancer Screening

Source: HEDIS® 2018 (COL)

Percentage of members 50–75 years of age who had appropriate screening for colorectal cancer

Measure weight: 1 5 Star: 86%

Numerator	Denominator	Exclusions
One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the three criteria below: • FOBT – **During the Measurement Year.** Regardless of FOBT type, guaiac (gFOBT) or immunochemical (FIT), assume that the required number of samples were returned. • Flexible Sigmoidoscopy – During the Measurement Year **or the four years prior** to the measurement year. • Colonoscopy – During the Measurement Year **or the nine years prior** to the measurement year. • CT colonography during the measurement year or the four years prior to the measurement year. • FIT-DNA during the measurement year or the two years prior to the measurement year.	Percentage of members 51–75 years of age who had appropriate screening for colorectal cancer	• Those with a diagnosis of colorectal cancer • Those with evidence of a total colectomy MA Members age 65 and older as of JAN 1 of the measurement year: Enrolled in an Institutional Special Needs Plan any time during the measurement year OR Living long-term in an institution any time during the measurement year (as reported by CMS).

Note: 2018 Colorectal Cancer Screening measure specifications added exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings. *CMS Medicare Part C monthly membership file is the determinate of LTI setting.*

C02: Colorectal Cancer Screening

Source: HEDIS® 2018 (COL)

Percentage of members 50–75 years of age who had appropriate screening for colorectal cancer

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

Best Practice

- The use of Fecal Occult Blood detection testing is accepted as a HEDIS numerator compliant form of non-invasive colorectal screening. This testing is required to be completed annually. Many practices have distributed home testing kits to gain compliance. Information on how a practice can work with a supplier to purchase and distribute FOBT kits can be found on the Provider Resource Center under Practice Tools for Colorectal Cancer.

- If your practice does not distribute kits, encourage patients to complete FOB tests distributed by Highmark Health Plan and its partners.

Medicare Advantage Member Benefits

Medicare Advantage denotes screening colonoscopy, sigmoidoscopy and fecal occult blood detection testing as a **covered in full** benefit. Screening benefit schedule limits:

- FOBT Limit 1 per calendar year.
- FIT-DNA (Cologuard) Limit 1 every 3 calendar years
- Colonoscopy once every 10 years, or 48 months after a previous flexible sigmoidoscopy. Sigmoidoscopy: Every 48 months.

Please distinguish between screening and diagnostic testing.

C07: Adult BMI Assessment

Source: HEDIS® 2018 (ABA) **Measure weight: 1** **5 Star: 98%**

Percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Numerator	Denominator	Exclusions
Those members who had an outpatient visit and whose body mass index was documented during the measurement year or **the year prior to the measurement year.** Height and weight alone are not numerator compliant values. Compliance requires that a BMI is calculated and documented within the medical record and submitted as a diagnosis code on a claim. For members younger than 20 years of age on the date of service, BMI must be reported with appropriate *percentile* ICD 10 code.	Attributed members 18–74 years of age as of the last date of the measurement year who had an outpatient visit	Pregnancy during the measurement year or the year prior to the measurement year

Note: Adult BMI Assessment measure specifications have not changed from 2017 specifications.

C07: Adult BMI Assessment

Source: HEDIS® 2018 (ABA)

Percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

Best Practice

- Advise billing/coding partners of need to capture ICD 10 codes reflective of calculated BMI value during claims submission.
- Program EMR to calculate BMI: Height and weight alone are not numerator compliant data. The measure requires the calculation of the BMI.
- Capture as an ICD10 diagnosis code and submit on a claim as this is a “one and done”.
- Coding to the highest level of specificity is required. Please reference Program resource document “Clinical Measures Applicable CPTII codes, BMI Diagnosis Codes and AWV G Codes”
- For those uncommon occurrences where a member cannot be weighed, an estimation of BMI can be submitted. There must be documentation within the medical record as to why an estimation was required.

C12: Osteoporosis Management in Women who had a Fracture

Source: HEDIS® 2018 (OMW) **Measure weight: 1** **5 Star: 78%**

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Numerator	Denominator	Exclusions
Those female members age 67-85 who had suffered a fracture and who had either a BMD test or filled a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. The drug classifications of Estrogen and Sex Hormone combinations are not included in numerator compliance. HEDIS provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are only provided in NOV of the year prior and may not be reflected at the start of reporting; additionally any updates received in NOV 2018 will be applied to resulting upon programming updates.	Female members, 67–85 yrs. of age by the end of the measurement year who suffered a fracture. Fractures of finger, toe, face and skull are not included in this measure Intake period is defined as a 12-month window that begins 6 months prior to the measurement year and ends after 6 months into the measurement year. The intake period is used to capture the first fracture. Intake Period: JULY 1, 2017 – JUNE 30, 2018	• Those who had a BMD test 24 months prior to the earliest date of service during the index period with diagnosis of fracture (index episode start date). • Those who received an osteoporosis therapy during the 365 days prior to the earliest date of service during the index period with diagnosis of fracture. • Those who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the index episode start date. • **Those without pharmacy benefits through Highmark.**

Note: Osteoporosis measure specifications have not changed from 2017 specifications.

C12: Osteoporosis Management in Women who had a Fracture Source: HEDIS® 2018 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Ad Hoc Osteoporosis Management Report Available

This measure has a short remediation period. Highmark Advanced Analytics has created a flash report, updated monthly which represents claims received on our members attributed to your practice for whom we have received fracture claims indication criteria that meets the denominator. This report is released as part of the monthly MA Stars report package on a separate tab. This report does NOT take into account continuous enrollment factors.

Ad Hoc Suspicious Diagnosis Reports Available

In the months APR, JULY and OCT suspicious diagnosis reports will be released via the Provider Portal. These reports show practice's members whom have had claims submitted to Highmark indicating acute fractures without x-ray claims and/or without claims indicating expected FU care. The report also reflects multiple acute fractures that may indicate carryover of original diagnosis. Please review this report for those members that may require claims correction.

Note: All claims with indicating acute fracture must be corrected in order for the member to not appear in the denominator.

C12: Osteoporosis Management in Women who had a Fracture Source: HEDIS® 2018 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Best Practice

Proper coding is essential in correctly identifying patients who have recently suffered a fracture. Recent or new fractures are fractures that are not yet healed and should be coded as such. However, if a fracture is healed, coding should indicate that the patient has a history of fracture. In this case, providers are encouraged to use the appropriate z-code from the list below* when coding for "History of Fracture".

Example ICD 10 Codes:

- Z87.311 Personal history of (healed) other pathological fracture
- Z87.312 Personal history of (healed) stress fracture
- Z87.81 Personal history of (healed) traumatic fracture
- Z42, Z49 and Z51 categories reflect after care codes
- Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

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* List is not comprehensive and is intended to provide educational support only. Providers must follow CMS coding regulations and guidelines.

C12: Osteoporosis Management in Women who had a Fracture Source: HEDIS® 2018 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Best Practice

Fracture Prevention/Assess Contributing Factors:

- Screen patients at risk for osteoporosis (bone mineral density test)
- Assess Risk of Falls
- Screen for Urinary Incontinence
- Review and evaluate Use of High Risk Medications

Osteoporosis Medications: Bisphosphonates are a class of drugs that prevent the loss of bone density, used to treat osteoporosis and similar diseases. Bisphosphonates and other agents included as compliant as a drug to treat osteoporosis for HEDIS OMW: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid, calcitonin, denosumab, raloxifene, and teriparatide.

Note: Treatment with Vitamin D **does not** meet compliance for this measure.

C12: Osteoporosis Management in Women who had a Fracture Source: HEDIS® 2018 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Best Practice

- Utilize Highmark vendor Med XM for Highmark patients requiring or requesting the convenience of in-home testing.
- Med XM will schedule and perform in-home heel scans to meet OMW compliance. There is no cost to Highmark Medicare Advantage members for this service.
- Completed services will be reflected in your monthly Stars reports.
- Reference Med XM Provider Related FAQs located under Highmark In-Home Programs on the Provider Resource Center:

  Provider-Resource-Center/Value-Based-Reimbursement-Programs/Medicare-Advantage-Member-and-Provider-Programs/Member-Programs-&-Materials/Highmark In-Home Programs

C12: Osteoporosis Management in Women who had a Fracture Source: HEDIS® 2018 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Supplemental Data Submission
CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance and exclusionary data for Highmark members who had services prior to being a Highmark carrier. Please maintain documentation within the member's medical record for future submission.
Medicare Advantage Member Benefits
Covered in full. Office visit or site of service co-pay may apply. Medicare Advantage preventive schedule limit: One BMD test every 24 months

C13: Comprehensive Diabetes Care – Eye Exam (retinal)

Source: HEDIS® 2018 (portion of CDC) **Measure weight: 1** **5 Star: 87%**

Identifies adult diabetic members who received an eye screening for diabetic retinal disease.

Numerator	Denominator	Exclusions
Diabetics who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, OR a *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. Diabetics are defined by: 1) **Pharmacy data:** members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or the year prior on an ambulatory basis. OR 2) **Claim/encounter data** members who had: a) Two face-to-face encounters in an outpatient setting observation visits, ED visits or non-acute inpatient setting on different dates of service with a dx of diabetes b) One face-to-face encounter in an acute inpatient setting, with a diagnosis of diabetes	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year. For exclusions to remove member from the denominator, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.

Note: Bilateral eye enucleation added to CDC Retinal Eye Exam measure specifications for eye exam compliance.

C13: Comprehensive Diabetes Care – Eye Exam (retinal)

Source: HEDIS® 2018 (portion of CDC)

Identifies adult diabetic members who received an eye screening for diabetic retinal disease.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

** The code 3072F which indicates a member has had a negative retinal eye exam last year can be resulted via the clinical feedback loop. This data point must be submitted using the current year (date documentation reviewed) to indicate the eye exam results were negative in the prior year. The negative eye exam report must be secured within the member's medical record.

Best Practice

- Complete AWV and assessment of diabetic member preventive care/disease progression indicators for all Value Based Reimbursement quality programs.
- Provide script or referral to ophthalmologist or optometrist to complete the exam. Use referral form with results to be faxed/emailed back to the PCP. Reference Diabetic retinal eye preventive screening requirement on referral sheet.
- Reference measure specifications for appropriate CPT2 code application. For measure specific educational material on CPT2 codes, please contact your Clinical Transformation Consultant or Provider Account Liaison

Medicare Advantage Member Benefits

Covered in full. Office visit or site of service co-pay may apply.
Routine vision exam covered every calendar year.

C14: Comprehensive Diabetes Care – Medical Attention for Nephropathy

Source: HEDIS® 2018 (portion of CDC) **Measure weight: 1** **5 Star: 98%**

Identifies adult diabetic members who had medical attention for nephropathy.

Numerator	Denominator	Exclusions
Those with evidence of nephropathy or a nephropathy screening test during the measurement year.	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 15 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year. For exclusions, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.

Note: Sacubitril-valsartan was added to Antihypertensive combinations in the ACE Inhibitor/ARB Medications List for Medical Attention for Nephropathy CDC measure specifications.

C14: Comprehensive Diabetes Care – Medical Attention for Nephropathy Source: HEDIS® 2018 (portion of CDC)

Identifies adult diabetic members who had medical attention for nephropathy.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

Note: Specifications denote testing as numerator compliance; therefore, results of urine protein test do not need to be submitted.

Best Practice

- Complete AWV and assessment of diabetic member preventive care/disease progression indicators for all Highmark quality incentive programs.
- Hardwire EHR to trigger preventive schedules- this is an annual test requirement
- Assure processes are in place to submit appropriate test billing.

Medicare Advantage Member Benefits

Covered in full. Office visit or site of service co-pay may apply.

C15: Comprehensive Diabetes Care – HbA1c Control (≤9%)

Source: HEDIS® 2018 (portion of CDC) **Measure weight: 3** **5 Star: 86%**

Percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent Hemoglobin A1C is ≤9.0%. The measure is reported as an inverted rate [1-(numerator/eligible population)]. Higher rate of compliance demonstrates better performance.

Numerator	Denominator	Exclusions
Members whose most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Control is demonstrated by CPTII Codes: 3044F HBA1c: <7.0% 3045F HbA1c: 7.0-9.0% The service date for the Category II code and the test result must follow the requirements outlined in general Guideline 36: the dates of service for the code and the test result must be no more than seven days apart.	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 15 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year. For exclusions, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.

Note: CDC Hba1c Control measure specifications have not changed from the 2017 measurement year.

C15: Comprehensive Diabetes Care – HbA1c Control (≤9%)

Percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent Hemoglobin A1C is ≤9.0%.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance and exclusionary data unavailable through claims or for Highmark members who had services prior to being a Highmark carrier.

Best Practice

- Review HbA1c Reporting that is made available on the User Interface. Highmark will issue an ad hoc HbA1c report which will indicate whether Highmark has received a claim indicating an HbA1c has been drawn – Y/N and if drawn if that test has been resulted to date. If a result has been received, the report will reflect the value received in the format it has been received (either CPT2 code or the actual lab value). All ad hoc reports are directional only and do not take into consideration continuous enrollment and other factors that determine a member's inclusion into program resulting.
- This is an outcome control measure which requires disease management and the demonstration of controlled HbA1c lab values. **HEDIS (CMS) requires the last result of the year to be the determinant of compliance and control**.
- Highmark is required to submit all member claims data. Lab providers (outpatient labs and facilities) submit claims for payment, which influences the last test of the year. All "draw" claims without a resulting lab value are seen as non-compliant.
- Submit zero dollar (performance reporting only) CPT2 claims on every result received or result via CPT2 codes with next patient visit.
- Encourage partner facilities to include lab results with procedure claims submission.

Medicare Advantage Member Benefits

- Covered in full. Office visit or site of service co-pay may apply.
- Limits: 4 per calendar year

C17: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Source: HEDIS® 2018 (ART) Measure weight: 1 5 Star: 88%

Percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Numerator	Denominator	Exclusions
Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year HEDIS provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are only provided in NOV of the year prior and may not be reflected at the start of reporting; additionally any updates received in NOV 2018 will be applied to resulting upon programming updates.	Members 18 years and older as of the last day of the measurement year with diagnosis of rheumatoid arthritis identified by **two** of the following claims (with different dates of service) on or between day one of the measurement year and 32 days prior to the end of the measurement year: • Outpatient visit • Non-acute inpatient discharge, with any diagnosis of rheumatoid arthritis	• Those with a diagnosis of HIV • Those with a diagnosis of pregnancy any time during the measurement year. • Those without pharmacy benefits through Highmark.

Note: Rheumatoid Arthritis Management measure specifications have not changed from the 2017 measurement year, however numerator compliant medications and the NDC codes associated with these medications are progressive.

C17: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Source: HEDIS® 2018 (ART)

Percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Best Practice

- Take the proper steps to ensure all members are being coded properly for office visits. Assure appropriate diagnosis coding of Rheumatoid arthritis. Please reference the Masthead Measure Guide located on the Provider Resource Center under Medicare Advantage Stars – Medicare Advantage Stars Program for instructions on obtaining details on the diagnosis codes that pull a member into this measure.

- Assure that a patient's diagnosis is appropriate which is fundamentally important not only to this measurement but to your patient's shared medical record, course of treatment and history data. The diagnosis of Rheumatoid Arthritis should not be applied for patients with the following:
  - Patient-reported or Personal History of RA
  - Family History of Arthritis
  - Screening for RA
  - Unspecified Inflammatory Polyarthropathy
  - Osteoarthritis
  - Unspecified Polyarthritis or Polyarthropathy
  - Unspecified Inflammatory Spondylopathy
  - Polymyalgia Rheumatica

- Consult specialist prior to application of patient's first RA diagnosis.

- Apply RA Dx during routine annual visit when assessing: progression of disease, RA drug tolerance, etc.

C17: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Source: HEDIS® 2018 (ART)

Percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Ad Hoc Suspicious Diagnosis Reports Available

In the months APR, JULY and OCT, suspicious diagnosis reports will be released via the User Interface. These reports show practices members whom have had claims submitted to Highmark indicating a diagnosis of Rheumatoid Arthritis without any claims indicating that a Rheumatologist is involved in the member's care. Additional factors that serve as filters to this report are whether or not a pharmacy claim for a DMARD has been submitted in the measurement year and whether claims have been submitted in the prior year denoting Rheumatoid Arthritis. Please review this report for those members who may require claims correction. Contact your Provider Account Liaison or Clinical Transformation Consultant for claims correction process.

Note: **All** claims indicating Rheumatoid Arthritis must be corrected in order for the member to not appear in the denominator.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator and exclusionary data for Highmark members who had services prior to being a Highmark carrier.

Medicare Advantage Member Benefits

Medicare Advantage members have a specialist co-pay of $10-$50 dependent on specific plan

C20: Medication Reconciliation Post-Discharge

Source: HEDIS® 2018 (MRP) **Measure weight: 3** **5 Star: 72%**

Percentage of discharges in the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge.

Numerator	Denominator	Exclusions
Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).	Acute or nonacute inpatient discharges on or between JAN 1 and DEC 1 of the measurement year. *Measure is based on discharges, not members. If members have more than one discharge, include all discharges.*	*If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care settings on the date of discharge through 30 days after discharge, count only the last discharge.* *Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after DEC 1 of the measurement year.*

Note: Medication Reconciliation Post-Discharge measure specifications have not changed from the 2017 measurement year.

C20: Medication Reconciliation Post-Discharge

Claims Submission

Discharge medications reconciled with the current medication list in outpatient medical record:
CPTII Code 1111F or Transition of Care CPT Codes 99495 or 99496

Medical Record Documentation Requirements

Any of the following meets criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Note: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

C20: Medication Reconciliation Post-Discharge

Source: HEDIS® 2018 (MRP)

Percentage of discharges in the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge.

Best Practice

- Review your patient's admissions and discharges through the Admission/Discharge Query on NaviNet > Newest Reports to monitor patient activity to schedule and complete medication reconciliations post discharge.
- Track Medication Reconciliation completion by downloading the MA Monthly Stars Gap Report.
- Coordinate with hospital partners for SNF discharges/transfers.

Note: If a member is admitted within 30 days of a discharge or transferred directly to a skilled nursing facility, the medication reconciliation is required after the SNF discharge.

C21: All-Cause Readmission Rate

Source: HEDIS® 2018 (PCR) **Measure weight: 3** **5 Star: .41**

The ratio of observed to expected acute inpatient stays during the measurement year that were followed by an *unplanned* acute readmission for any diagnosis within 30 days. Members may be readmitted to the same hospital or different one.

Numerator	Denominator	Exclusions
Medicare Advantage members with an unplanned acute inpatient readmission for any diagnosis within 30 days of a previous index hospital stay discharge date.	Count of Index Hospital Stays for Medicare Advantage members 18 years of age and older with an acute inpatient stay with a discharge on or between the first day of the measurement year and 31 days prior to the last day of the measurement year. Includes acute admissions to behavioral health facilities. Readmissions can serve as a potential index admission.	• Hospital stays where the Index Admission Date is the same as the Index Discharge Date • Inpatient stays with discharges for death • Acute inpatient discharges with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period • Discharged inpatient (index hospital) stays if the admission date of the first *planned* hospital stay is within 30 days and includes any of the following: – Principal dx of maintenance chemotherapy or rehabilitation – An organ transplant – A potentially planned procedure w/out a principal acute dx

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Note: All Cause Readmission measure specifications have not changed from the 2017 measurement year.

C21: All-Cause Readmission Rate

Source: HEDIS® 2018 (PCR)

Performance Metrics

Stars Monthly Practice reports will again this year reflect both the: actual readmission rate (readmissions/admissions) and then the trend compliance ratio value. The trend compliance calculation is the determinate of the Star rating

The trend compliance data will be represented as a ratio: Observed Readmissions/Expected Readmission.

The expected readmission value is a complex risk adjusted model supplied by NCQA/HEDIS specifications. Incorporated risk adjustment categories are based on presence of surgeries, discharge condition, comorbidity, and age.

Example:

A. Your practice has 100 acute inpatient discharges of which 20 were unplanned readmissions. Based on the application of the expected model to those 100 patients, 10 were expected to be readmitted. Your ratio is 20/10 or 2.00

B. Your practice has 100 acute inpatient discharges of which 20 were unplanned readmissions. Based on the application of the expected model to those 100 patients, 30 were expected to be readmitted. Your ratio is 20/30 or 0.66

Note: All Cause Readmission measure specifications have not changed from the 2017 measurement year.

Accuracy of Diagnosis Coding – a Key to Accurate Readmissions Expected Ratio

USE All DATA AVAILABLE

- Identified Unconfirmed diagnosis codes (Chart Prep)
- Monthly gap reports (Chart Prep)
- EMR History and Problem lists

ACT

- Submit the patient's principal diagnoses, as well as, all complications and comorbid diagnoses with each visit **claim** – this includes AWV
- Follow coding principals in assessing chronic conditions, persistent diagnosis conditions, and suspected diagnosis conditions: Industry standard guideline MEAT (Monitor, Evaluate, Assess and/or Treat (plan))

DMC17: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® 2018 (SPC) **Measure weight: 1** **5 Star: 84%**

Percentage of members who had at least one dispensing event for a high or moderate-intensity statin medication in the measurement year.

Numerator	Denominator	Exclusions
Members who filled at least one ambulatory prescription for high or moderate-intensity statin medication. HEDIS provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are only provided in NOV of the year prior and may not be reflected at the start of reporting; additionally any updates received in NOV 2018 will be applied to resulting upon programming updates.	Male members ages 21–75 and females age 40–75 identified by event during the year prior to the measurement year who were: -discharged from an inpatient setting with myocardial infarction OR -Had a CABG, PCI or other revascularization procedure in any setting OR -By Diagnosis, as having IVD who met at least one of the following criteria during both the measurement period and the year prior. Criteria need not be the same across both years: -at least one inpatient encounter with an IVD diagnosis OR -at least one outpatient encounter with an IVD diagnosis	• Those with a diagnosis of ESRD, or cirrhosis in the measurement year or year prior. • Those with a diagnosis of myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. • Those with a diagnosis of pregnancy during the measurement year or year prior. • Those who have In vitro fertilization in the measurement year or year prior. • Those who filled at least one prescription for clomiphene during the measurement year or year prior. • Those without pharmacy benefits through Highmark**.**

Note: Statin Therapy for Patients with Cardiovascular Disease measure specifications have not changed from the 2017 measurement year.

DMC17: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® 2018 (SPC)

Percentage of members who had at least one dispensing event for a high- or moderate-intensity statin medication in the measurement year.

Description	Prescription (one pharmacy claim required)	
High-Intensity Statin Therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-atorvastatin 40-80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-Intensity Statin Therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Ezetimibe-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Niacin-simvastatin 20-40 mg • Sitagliptin–simvastatin 20-40 mg	• Pravastatin 40-80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2-4 mg

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by NOV 1, 2018.

DMD15: Statin Use in Persons with Diabetes

Source: PQA 2017 (SUPD) **Measure weight: 3** **5 Star: 86%**

Percentage of members who were dispensed a medication for diabetes that receive a statin medication.

Numerator	Denominator	Exclusions
Members who receive a prescription fill for a statin or statin combination during the measurement year. PQA provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are updated and will be applied to resulting upon programming updates.	Members aged 41–75 as of the last day of the measurement year who were dispensed two or more prescription fills for a hypoglycemic agent during the measurement year.	Members with ESRD or in Hospice

Note: Statin Use in Persons with Diabetes measure specifications have not changed from the 2017 measurement year.

DMD15: Statin Use in Persons with Diabetes

Source: PQA 2017 (SUPD)

Percentage of members who were dispensed a medication for diabetes that receive a statin medication

PQA Table: Statin Medications

Statin Medications			
• lovastatin • rosuvastatin	• fluvastatin • atorvastatin	• pravastatin • pitavastatin	• simvastatin
Statin Combination Products			
• niacin & lovastatin • atorvastatin & amlodipine	• niacin & simvastatin • sitagliptin & simvastatin	• ezetimibe & simvastatin • ezetimibe & atorvastatin	

Statin Therapy

Best Practice

- Educate diabetic patients on the increased risk of cardiovascular disease, so that they may understand the benefits of statin therapy in reducing their risk of stroke, heart attack and cardiovascular death
- Consider statins with fewer drug interactions such as rosuvastatin, pravastatin, and fluvastatin to reduce risk of adverse events
- Patients who do not tolerate one statin may be able to tolerate a different statin
- Review monthly gap reports and assure patient is on correct medication to meet compliance

DMD16: Use of High Risk Medications in the Elderly

Source: PQA 2017 (HRM) modified **Measure weight: 1** **5 Star: 3%**

Percentage of members 65 years of age and older who had at least two dispensing events for the same high-risk medication classification.

Numerator	Denominator	Exclusions
Members who received at least two prescription fills for high-risk medications in the same **class** during the measurement period. Therapeutic categories include Estrogens and Nonbenzodiazepine hypnotics with cumulative day supply >90 days PQA provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are updated and will be applied to resulting upon programming updates.	Members 66 years and older as of the last day of the measurement year	• Those without pharmacy benefits through Highmark. • Members in Hospice • Do not include denied claims

Note: PQA Use of High Risk Medication in the Elderly measure specifications have been modified to include only Estrogens and Non-Benzodiazepine-GABA-Receptor Modulators.

DMD16: Use of High Risk Medications in the Elderly

Source: PQA 2017 (HRM) modified

Percentage of members 66 years of age and older who had at least two dispensing events for the same high-risk medication class.

Estrogens with or without progesterone (oral and topical patch products only)

- Conjugated estrogen
- Esterified estrogen
- Estradiol
- Estropipate

Includes combination products

Nonbenzodiazepine hypnotics (include when cumulative day supply is >90*

- Eszopiclone
- Zolpidem
- Zaleplon

**The cumulative calculation applies to the class of nonbenzodiazepine hypnotics and not for each individual medication. A patient is included in the numerator if he/she received at least two prescription fills for any medication in the class and if the cumulative days supply for any product is greater than 90 days during the measurement period. For example, if a patient received a 30 day supply of zolpidem, a second fill for 30 days supply of zolpidem and then a fill for 35 days supply eszopiclone (all during the measurement period), this would qualify for inclusion in the numerator.*

DMD16: Use of High Risk Medications in the Elderly

Best Practice

- Reference the Highmark formularies prior to initiating therapy
- Review high-risk medication first fill report to identify patients receiving a High-Risk Medication AND the medication being prescribed
- Evaluate medication to determine if a safer alternative is available
- If patients are switched to alternative medications with a safer profile assure they understand why the adjustment is being made
- Assure patients are aware to dispose of all medications that have been discontinued
- Highmark formulary updates include additional preauthorization requests for certain high risk medications
- A lower rate represents better performance

D11: Medication Adherence for Diabetes Medications

Source: PQA 2017

Measure weight: 3 **5 Star: 86%**

Percentage of members with a prescription for diabetes medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking the medication. The classes of diabetes medication includes: biguanides, sulfonylureas, thiazolidinediones, DDP_IV inhibitors, Incretin Mimetic Agents, Meglitinides , and SGLT2 Inhibitors.

Numerator	Denominator	Exclusions
Those members with a prescription for diabetes medication who fill their prescriptions often enough to cover 80% or more of the time they are suppose to be taking their medications. PQA provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are updated and will be applied to resulting upon programming updates.	Members 18 years of age or older as of the last day of the measurement year with at least two fills on different dates of medication(s) across any of the drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	• Those without pharmacy benefits through Highmark. • Members who take insulin • Members with ESRD

Note: Medication Adherence for Diabetes medications have been updated, and NDC codes are progressive.

D12: Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA)

Source: PQA 2017 **Measure weight: 3** **5 Star: 87%**

Percentage of members with a prescription for a blood pressure medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking the medication. Blood pressure medication includes: ACE (angiotensin converting enzyme) inhibitor, ARB (angiotensin receptor blocker), a direct renin inhibitor or combinations thereof.

Numerator	Denominator	Exclusions
Those members with a prescription for recommended hypertension medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medications. PQA provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are updated and will be applied to resulting upon programming updates.	Members18 years of age or older as of the last day of the measurement year with at least two fills on different dates of medication(s) across **either the same medication or medications (s) in the** drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	• Those without pharmacy benefits through Highmark. • Members with ESRD • Members who take sacubitril/valsartan.

Note: Medication Adherence for Hypertension medications have been updated, and NDC codes are progressive.

D13: Medication Adherence for Cholesterol: Statins

Source: PQA 2017 **Measure weight: 3** **5 Star: 86%**

Percent of plan members with a prescription for a cholesterol medication (a HMG CoA Reductase Inhibitor-statin drug or statin combination) who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator	Denominator	Exclusions
Those members with a prescription for a cholesterol medication (a statin drug or statin combination) who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medications PQA provides guidance on which medications are denoted as numerator compliant. NDC lists associated with these medications are updated and will be applied to resulting upon programming updates.	Members18 years of age or older as of the last day of the measurement year with at least two fills on different dates of **either the same medication or medication(s) in** the drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	Those without pharmacy benefits through Highmark.

Note: Medication Adherence for Cholesterol specifications have not changed from the 2017 measurement year; however, NDC codes are progressive.

Medication Adherence

Best Practice

- Identify all patients who are prescribed medication for these categories
- Prep chart to ensure that provider discusses importance of ongoing compliance
- Discuss with patients the benefits of adhering to medication - Nurse/Physician/Medical assistant/Physician extender
- Utilize medication adherence report to identify those trending poorly on compliance
- Provide ongoing patient outreach to those showing as non-compliant
- Identify reason for noncompliance and attempt to solve
- Educate patients about their condition and explain why the medication is being prescribed
- Use motivational interviewing to help patients commit to taking their medication and set goals for taking their medications
- Ask patients what routine they use to help them remember to take their medications (apps, alarms, pillboxes)
- Discourage “pill splitting” or taking medications every other day. If dosage changes, rewrite prescription to accurately show prescribed dose.
- Consider 90 day fills when writing prescriptions.
- Encourage patients to utilize their insurance card, as this may help to identify other services that may be beneficial to them. Samples, paying in cash and using discount cards will not generate an insurance claim, and Highmark will not be able to measure compliance. These patients will appear as non-compliant with the measure.
- Be proactive. Evaluate practice processes for opportunities to close gaps every time the patient is seen rather than reacting to gap closure reports

Medication Adherence

Available Resources to Improve Medical Adherence	Description	Call to Action
Automatic Refill Programs	• Service is offered by almost all retail chains • Tool facilitates automatic refills for prescriptions and notifies a patient that their medication is ready	Notify your patient of this program and warm transfer to their pharmacy to enroll them in this service.
Medication Synchronization	Tool that coordinates fill dates so that all medications for a 30-day supply can be obtained on the same day each month	Notify your patient of this program and warm transfer to their pharmacy to enroll them in this service.
Mail Order	Service that offers home delivery of 90-day supplies for maintenance medications	Contact Express Scripts at 1-800-903-6228 to set your patient up for mail order services.
Automated Reminders	Service offered by pharmacies that will send automated refill reminders in the form of text messages or IVR calls to notify patients that it is time to pick up their medication	Notify your patient of this program or even warm transfer to their pharmacy to enroll them in this service.
Highmark Mobile App	Highmark offers a mobile application that will help a patient manage their medications, such as automated refill reminders and even reminders to take their daily dose of medication	Refer patient to Highmark Member Service for assistance in downloading the application.

D14: Medication Therapy Management (MTM)

What is the MTM Program and how will it be conducted?

The Highmark MTM program is a free program that was designed in conjunction with Medicare to provide assistance to members with certain disease states who take many medications and have high prescription costs. It provides members access to the services of a health care professional who can help support their health and safety to get the most benefit from their medications. It is designed to complement the care they receive by having a pharmacist work with them and their doctor.

If a member is eligible to participate in this free program, they are automatically enrolled. They will receive information on how to access the program and will be contacted to schedule/complete a CMR.

CMR: During this one-on-one telephone consultation with a pharmacist or nurse, your patient's entire medication profile is reviewed, including prescriptions, over-the-counter (OTC) medications, herbal supplements, and samples. The pharmacist or nurse will check for appropriateness of therapy and potential interactions. They will also discuss therapy goals, medication-related problems and any specific questions the patient may have.

CMR Follow-up Letter - This letter includes a Personal Medication List and Medication Action Plan detailing the patient's conversation with the pharmacist or nurse.

Targeted Medication Reviews (TMR) - These reviews are performed at least quarterly. TMRs focus on identifying cost savings, safety concerns, prescribing adherence to national treatment guidelines and whether patients have been following their medication regimens.

Member / Doctor Outreach - If an issue is found during a medication review (CMR or TMR), the team may contact the patient and/or doctor via phone, fax, or mail to discuss recommendations for adding or changing drug therapy, potential drug interactions or safety issues.

D14: Medication Therapy Management (MTM)

Source: CMS 2018 **Measure weight: 3** **5 Star: 79%**

Percentage of MTM eligible members who received a Comprehensive Medication Review (CMR) during the measurement year. Source: Highmark developed measure.

Numerator	Denominator	Exclusions
Eligible members who complete a CMR by an approved CMS vendor during the measurement year.* *While Highmark understands medication reconciliation is often completed by our network providers, this is a Medicare program that requires CMRs be conducted by a prior CMS approved party.	Members who meet eligibility requirements: Those with three or more chronic conditions, who take a minimum of seven Part D medications, and are likely to incur annual costs of at least $3,967 for all covered Part D drugs. Targeted chronic conditions include: a. Bone Disease – Arthritis – Osteoporosis b. Bone Disease – Arthritis – Rheumatoid Arthritis c. Chronic Heart Failure d. Diabetes e. Dyslipidemia f. End Stage Renal Disease g. Mental Health – Depression h. Respiratory Disease – Asthma i. Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD)	Those under hospice care (per CMS reporting systems) Those that opt out within 60 days of program eligibility** ** Opt outs as determined by internal review will be reflected in member detail reports upon confirmation. Members in long-term care facilities are not excluded from the denominator.

D14: Medication Therapy Management (MTM)

Reporting Developed to Track Numerator/Denominator

Eligible members will be reflected on Monthly Stars Care Gap reports - CMR completion will be seen as compliant.

Eligible members may elect to opt out of CMR completion when contacted by the MTM Pharmacy Team; however, opt outs must be documented in the CMR system within 60 days of becoming MTM Program eligible to be removed from the denominator. Members who opt out after the 60 day time period will be denoted as non-compliant.
Validation of opt outs is determined by internal review and will be reflected in member detail reports upon confirmation.

Best Practice

- Review Monthly Star Care Gap MTM detail reports for members that have become eligible.
- Correct or add missing member information and notify Highmark Pharmacy Team to assist in contacting and scheduling CMRs for your patients.
- Develop process for timely patient contact and encourage completion of CMR with the MTM Pharmacy Team.
- Discuss the benefits of completing the CMR with your patients during AWV and other office visits
- To schedule a CMR on behalf of your patient, use the MTM Referral Request Form located on the Provider Resource Center > Value-Based Reimbursement Programs > Medicare Advantage Stars > Medication Therapy Management> Practice Tools and fax to (833) 887-4676.

C51: Annual Wellness/Initial Preventive Physical Rate/Annual Physical Exam

Source: Highmark developed measure *

No weight assigned

Percentage of Medicare Advantage members who had the Annual Wellness Visit, Initial Preventive Physical Exam or Annual Physical Exam within the measurement year.

Numerator	Denominator	Exclusions
Members who completed the annual wellness visit after the first 12 months of enrollment in Medicare Part B. ***OR*** Members who completed the Initial Preventive Physical Examination (IPPE) during the first 12 months of enrollment in Medicare Part B. ***OR*** Members receiving an Annual Preventive Physical Exam	Members 65 years of age or older by the end of the measurement year.	None

Note: An Annual Physical Exam has been added to the Annual Wellness/IPPE measure specifications for numerator compliance.

* Not a CMS Star measure. C51 is eligible for gap closure incentive payments as well as determining performance level incentive multiplier.

C51: Annual Wellness and Initial Preventive Physical Rate

Source: Highmark developed measure ** **No weight assigned**

The percentage of Medicare Advantage members who had the Annual Wellness Visit or the Initial Preventive Physical Exam within the measurement year.

Applicable Codes

CPT Code	Description
G0402	Initial Preventive Physical Exam (IPPE)
G0438	Annual Wellness Visit, Initial visit
G0439	Annual Wellness Visit, Subsequent visit

It may be appropriate to perform an Evaluation and Management (EM) (99201-99215) and an Annual Wellness Visit (G0438, G0439) on the same day, as these services do contain Different elements. A separate note is needed to support each service rendered. When the 25 modifier is reported, the patient's records must clearly document that separately identifiable medical care has been rendered.

Compliance Alert

Billing of a Preventive Medicine Visit (PMV) (99381-99397) and an Annual Wellness Visit (AWV) (G0438, G0439) together may not be appropriate on the same day as there is significant overlap in the elements of these two services.

Maximize Patient Encounter: You may only get one chance

USE All DATA AVAILABLE

- Identified Unconfirmed diagnosis codes (Chart Prep)
- Monthly gap reports (Chart Prep)
- EMR History and Problem lists

ACT

- Submit the patient's principal diagnoses, as well as, all complications and comorbid diagnoses with each visit **claim** – this includes AWV
- Follow coding principals in assessing chronic conditions, persistent diagnosis conditions, and suspected diagnosis conditions: Industry standard guideline MEAT (Monitor, Evaluate, Assess and/oR Treat (plan))

Profiled/Informational Measures

The following clinical quality measures will be shown in reporting for informational purposes and in anticipation of future measure development.

HIGHMARK.

HOS1: Screening for Future Fall Risk

Source: NCQA (NQF: 0101)

No weight assigned **5 Star: 61%**

Percentage of members aged 65 years and older who had a risk assessment for falls completed in the measurement year.

Numerator	Denominator	Exclusions
Members who were screened for future fall risk in the measurement year. **1100F** – Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year **1101F** – Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year ***Use of 8P Modifier – Patient not screened for future fall risk, reason not otherwise specified is not accepted as numerator compliance.***	Members 65 years of age or older by the end of the measurement year.	Those with documentation of medical reason(s) for not screening for fall risk (i.e., patient is not ambulatory) **1100F-1P**, **1101F-1P** – Patient not screened for future fall risk for medical reasons

HOS2: Plan of Care to Prevent Future Falls

Source: NCQA (NQF: 0101) **No weight assigned** **5 Star: 75%**

Percentage of Members 65 years and older with a history of falls who had a plan of care for falls documented in the measurement year.

Numerator	Denominator	Exclusions
Members with a plan of care for falls documented in the measurement year. A plan of care must include consideration of an appropriate assistance device and balance, strength, and gait training. **0518F** – Falls plan of care documented ***Use of 8P Modifier – Falls plan of care not documented, reason not otherwise specified is not accepted as numerator compliance.***	Members aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). **1100F** – Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year	Those with documentation of medical reason(s) why a plan of care is not documented **0518F-1P** – Falls plan of care not documented for medical reason **1100F-1P** – Patient not screened for future fall risk for medical reasons

Falls: Risk Assessment & Plan of Care

CMS uses the Medicare Health Outcomes Survey (HOS) to measure falls risk management for Medicare Advantage Members.

The survey asks about falls in the past 12 months, problems with balance or walking and whether their provider did anything to help prevent falls or treat problems with balance or walking.

Some things that may be suggested:

- Using a cane or walker
- Checking blood pressure lying or standing
- Exercising or physical therapy program
- Vision or hearing testing

The measures used in this Program (HOS1 & HOS2) serve as a proxy for the HOS measures. The rationale for development of these measures is to identify at-risk patients to target for comprehensive risk-assessment and intervention, which is identified as the most important part of falls prevention. Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama, 2011).

Falls: Risk Assessment & Plan of Care

Best Practice

Fracture Prevention/Assess Contributing Factors:

- Screen patients at risk for osteoporosis (bone mineral density test)
- Assess Risk of Falls
- Screen for Urinary Incontinence
- Review and evaluate Use of High Risk Medications

Osteoporosis Management (OMW):

Osteoporosis Medications: Bisphosphonates are a class of drugs that prevent the loss of bone density, used to treat osteoporosis and similar diseases. Bisphosphonates and other agents included as compliant as a drug to treat osteoporosis for HEDIS OMW: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid, calcitonin, denosumab, raloxifene, and teriparatide.

Note: Treatment with Vitamin D **does not** meet compliance for OMW.

Falls are Serious and Costly

Important Facts about Falls

- One out of five falls causes a serious injury such as broken bones or a head injury.
- Each year, 2.8 million older people are treated in emergency departments for fall injuries.
- Over 800,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture.
- Each year at least 300,000 older people are hospitalized for hip fractures.
- More than 95% of hip fractures are caused by falling, usually by falling sideways.
- Falls are the most common cause of traumatic brain injuries (TBI).
- Adjusted for inflation, the direct medical costs for fall injuries are $31 billion annually. Hospital costs account for two-thirds of the total.

https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

DMCP8: Comprehensive Diabetes Care: HbA1c Control (<8%) Source: HEDIS® 2018 (portion of CDC)

No weight assigned **5 Star: 75%**

Percentage of Members age 18-75 with diabetes (type 1 or type 2) whose most recent Hemoglobin A1C is <8.0%.

Numerator	Denominator	Exclusions
Members whose most recent HbA1c level is <8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Control is demonstrated by: CPTII Code: 3044F HBA1c: <7.0% The service date for the Category II code and the test result must follow the requirements outlined in general Guideline 36: the dates of service for the code and the test result must be no more than seven days apart.	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 15 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year. For exclusions, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.

Note: CDC Hba1c Control measure specifications have not changed from the 2017 measurement year.

DMCP8: Comprehensive Diabetes Care – HbA1c Control (<8%)

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance and exclusionary data unavailable through claims or for Highmark members who had services prior to being a Highmark carrier.

*The CPT Category II code (3045F) indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. Other sources (laboratory data, CQF submission) must be used to identify the actual value and determine if the HbA1c result was <8%.

Best Practice

- Review HbA1c Reporting that is made available on the User Interface. Highmark will issue an ad hoc HbA1c report which will indicate whether Highmark has received a claim indicating an HbA1c has been drawn – Y/N and if drawn if that test has been resulted to date. If a result has been received the report will reflect the value received in the format it has been received (either CPT2 code or the actual lab value). All ad hoc reports are directional only and do not take into consideration continuous enrollment and other factors that determine a members inclusion into program resulting.
- This is an outcome control measure which requires disease management and the demonstration of controlled HbA1c lab values. **HEDIS (CMS) requires the last result of the year to be the determinant of compliance and control**.
- Highmark is required to submit all member claims data. Lab providers (outpatient labs and facilities) submit claims for payment, which influences the last test of the year. All “draw” claims without a resulting lab value are seen as non-compliant.
- Submit zero dollar (performance reporting only) CPT2 claims on every result received or result via CPT2 codes with next patient visit.
- Encourage partner facilities to hardwire lab results within procedure claims submission.

Medicare Advantage Member Benefits

- Covered in full. Office visit or site of service co-pay may apply.
- Limits: 4 per calendar year

DMC16: Hospitalization for Potentially Preventable Complications (HPC) Source: 2018 HEDIS

Measure weight: 1 **5 Star: .73**

For Medicare Advantage members 67 years of age and older, the rate of discharges for ambulatory sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.

Numerator	Denominator
Acute Inpatient and Observation discharges for ACSC Chronic ACSC: a. Diabetes short-term complications b. Diabetes long-term complications c. Uncontrolled diabetes d. Lower-extremity amputation among patients with diabetes e. COPD f. Asthma g. Hypertension h. Heart failure Acute ACSC: i. Bacterial pneumonia j. Urinary tract infection k. Cellulitis l. Pressure ulcer	Medicare Advantage members 67 years of age and older as of DEC 31 of the measurement year

Note: HPC specifications have changed from 2017 most notably – addition of observation discharges and exclusion of outliers.

DMC16: Hospitalization for Potentially Preventable Complications (HPC) Source: 2018 HEDIS

Exclusions

Members enrolled in an Institutional Special Needs Plan any time during the measurement year or living long-term in an institution any time during the measurement year (as reported by CMS).

Chronic ACSC:

- **Lower Extremity Amputation among patients with diabetes:** Traumatic amputation of the lower extremity or toe amputation
- **COPD**
- **Asthma**
- **Acute Bronchitis w/COPD** } Cystic fibrosis and anomalies of the respiratory system
- **Hypertension:** Cardiac procedure codes; any diagnosis for Stage I-IV kidney disease, only if accompanied by a procedure code for dialysis
- **Heart failure:** Cardiac procedures
- **Chronic ACSC Outliers:** Members with three or more chronic ACSC discharges during the measurement year

Acute ACSC:

- **Bacterial Pneumonia:** Sickle cell anemia, HB-S disease or immunocompromised state
- **Urinary Infection:** Diagnosis of kidney/urinary tract disorder or immunocompromised state
- **Acute ACSC Outliers:** Members with three or more acute ACSC discharges during the measurement year

Ambulatory Care Sensitive Conditions (ACSCs)

AHRQ – Agency for Healthcare Research and Quality

ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

Example Circumstances for Preventable Events:

- Timely access to high quality care in outpatient settings
- Improved medication management
- Greater health and health system literacy
- Better coordination of care among providers across the system of care delivery and between patients, their families and health care providers.

Assess patient needs and the benefits of a care management resource/program.