



2019 MEDICARE ADVANTAGE STARS PRIMARY CARE INCENTIVE PROGRAM PROGRAM MANUAL

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PROGRAM OVERVIEW

Objective	The purpose of the Medicare Advantage Stars Primary Care Incentive Program (hereafter, "Program") is to evaluate the delivery of care and the effectiveness of improvement strategies for the Highmark Medicare Advantage (MA) Member population using the Centers for Medicare & Medicaid Services (CMS) Stars measures.
Intent	The 2019 Program is structured to assess and improve the process of care for Primary Care practices serving Highmark's Medicare Advantage Members (hereafter, "Members") using CMS Stars measures as the basis of clinical quality performance measurement.
Data Transparency	Highmark Members, our customers, seek insight into physician quality as one factor in determining their selection of their care givers. Highmark monitors physician practice performance through many channels. Unique to the Medicare Advantage network, the Program provides a view of physician practice quality that allows for determination of practice performance against nationally monitored measures. Highmark will publish the results of the 2019 Program at both the overall performance rating level and measure specific level on our Member Provider Directory. Providers are given a 60-day review period. Access Highmark's Provider Directory site to review your practices' comparative data.
Program Data Criteria	Primary care practices participating in the Program (hereafter, "Participants") will be assessed on their performance on defined metrics in two components of the Program and will be eligible for unique incentive opportunities: <ol style="list-style-type: none"> <li data-bbox="500 1094 760 1129">1. Care Gap Closure <li data-bbox="500 1129 1024 1161">2. Performance Level (Star Rating) Results
Practice Participation and Reimbursement	<p data-bbox="431 1199 1433 1444">Program reporting, performance assessments, and subsequent incentive payments are based upon the submitted claims and approved supplemental data paths of the practice. Claims submitted to Highmark are required to include accurate and complete coding with documentation to support the claim appropriately captured in the patient's medical record. Providers are required to submit the patient's principal diagnoses, as well as all complications and comorbid diagnoses with each claim. Highmark reserves the right to audit any and all claims or data submitted.</p> <p data-bbox="431 1482 1433 1623">Participants shall provide, free of charge, requested medical records or other documentation for the purposes of reporting to external agencies, such as National Committee for Quality Assurance ("NCQA") Healthcare Effectiveness Data and Information Set ("HEDIS") and Centers for Medicare and Medicaid Services ("CMS").</p> <p data-bbox="431 1661 1433 1896">Participants are required to agree to participate in the Program and to acknowledge review of the Program requirements and conditions, which includes program intent, measurement, scoring and incentive structure details. Acknowledgement can be received by Highmark, via NaviNet, at any time during the 2019 calendar year; however, quarterly gap closure payments will not be retroactively paid. No Program payments will be made outside of the established payment cycle. Please reference Appendix A Component Incentive Payment Cycle.</p>

Attribution

Medicare Advantage Members who are active in a Highmark Medicare Advantage plan as of January 1, 2019 are included in the attribution process. Members who are deceased or have changed payer after January 1, 2019 will remain in attribution and may impact Program performance unless they fall outside the parameters of an individual measure. Participants managed these Members as patients during the period they were attributed to them; therefore, these Members will count in the Participant's score.

Attribution will identify a Member's primary source of medical treatment based on the history of evaluation and management (E&M) claims associated with the Member.

The E&M codes included in the attribution process are detailed in Table 1. E&M codes will be reviewed and updated at least annually. Codes may be adjusted based on national programming in order to obtain a common attribution algorithm.

Table 1: Attribution E&M Codes

E&M Category	Codes
Office/Outpatient Services	99201–99205, 99211–99215
Outpatient Consultations	99241–99245
Nursing Facility Services	99304–99310, 99315–99316, 99318
Domiciliary, Rest Home or Custodial Care Services	99324–99328, 99334–99337
Domiciliary, Rest Home or Home Care Plan Oversight Services	99339–99340
Home Services	99341–99345, 99347–99350
Care Plan Oversight Services	99374–99375, 99377–99380
Preventive Medicine Services	99381–99387, 99391–99397, 99401–99404
Medicare Preventive Services	G0402, G0438, G0439
Federally Qualified Health Center (FQHC) Visits	G0466, G0467, G0468

Members are assigned, or "attributed," to the Practice with eligible Program providers (PCPs, CRNPs, and PAs) with whom they had the highest number of visits (based on E&M codes in Table 1) during an 18-month time period. Members who had Evaluation & Management ("E&M") billed under POS (Place of Service) code 31 (Skilled Nursing) will be excluded from attribution.

To allow Participants sufficient time to respond to Members' identified gaps and impact performance measurement, attribution will be locked down as of August 31, 2019 for scoring of the Program. Members will continue to be added and removed from reporting throughout the calendar year based upon attribution logic. Members who are first included in reports after the August 31, 2019 attribution run will be noted as not scored.

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PROGRAM OVERVIEW, Continued**Performance
Measurement
Requirements**

The following clinical quality measures will be used to assess Participant's performance in the Program and are applicable to the Care Gap Closure and/or Performance Level Results Program components to determine if Participants will be eligible for Program incentive payments.

CMS Stars Measures & Annual Wellness Visit ("AWV")

Highmark will evaluate Member claims data for Participants for the measurement period of January 1, 2019 through December 31, 2019 for the following 17 CMS Stars measures and AWV measure. *Highmark reserves the right to remove, amend, or supplement the Health Plan Stars measures from program monitoring and scoring upon receipt of notice for the CMS retirement thereof or as Highmark deems necessary. Any applicable Gap closure payment will be made for all services completed prior to notification.*

Measure ID	Measure Name and Description
C01:	Breast Cancer Screening - The percentage of female Members age 50 - 74 years who had a mammogram to screen for breast cancer.
C02:	Colorectal Cancer Screening - The percentage of Members age 50 - 75 who had appropriate screening for colorectal cancer.
C07:	Adult BMI Assessment - The percentage of Members age 18 - 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement period or the year prior to the measurement period.
C12:	Osteoporosis Management in Women Who Had a Fracture - The percentage of female Members age 67 - 85 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.
C13:	Comprehensive Diabetes Care: Eye Exam (retinal) performed - The percentage of diabetic Members age 18 - 75 who received an eye screening for diabetic retinal disease.
C14:	Comprehensive Diabetes Care: Medical Attention for Nephropathy - The percentage of diabetic Members age 18 - 75 who had medical attention for nephropathy.
C15:	Comprehensive Diabetes Care: HbA1c Control ($\leq 9\%$) - The percentage of Members age 18 - 75 with diabetes (type 1 or type 2) whose most recent Hemoglobin A1C is $\leq 9.0\%$.
C16:	Controlling High Blood Pressure - The percentage of Members 18-85 years of age who had two diagnoses of hypertension (HTN) and whose most recent BP was adequately controlled ($<140/90$ mm HG).
C17:	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis - The percentage of Members age 18 and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
C20:	Medication Reconciliation Post-Discharge - The percentage of discharges from January 1-December 1 of the measurement year for Members 18 years of age and older from whom medication were reconciled on the date of discharge through 30 days after discharge (31 total days).
C21:	All-Cause Readmissions - For Members age 18 and older, the number of acute inpatient stays during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days over the predicted probability of an acute readmission. (Displayed as a ratio.)

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PROGRAM OVERVIEW, Continued

Performance Measurement Requirements (Continued)

C22:	Statin Therapy for Patients With Cardiovascular Disease - The percentage of male Members age 21 - 75 and female Members age 40 - 75 during the measurement period, who were identified as having clinical atherosclerotic cardiovascular disease and were dispensed at least one high or moderate-intensity statin medication during the measurement period.
D14:	Statin Use in Persons with Diabetes The percentage of Members age 40-75 who were dispensed a medication for diabetes that receive a statin medication.
D10:	Medication Adherence for Diabetes Medication - The percentage of Members age 18 and older with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication. The six classes of diabetes medication include: biguanides, sulfonyleureas, thiazolidinediones, DPP-IV inhibitors, incretin mimetic, and meglitinide.
D11:	Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA) - The percentage of Members age 18 and older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication. Blood pressure medication includes: ACE (angiotensin converting enzyme) Inhibitor, ARB (angiotensin receptor blocker), and a direct renin inhibitor.
D12:	Medication Adherence for Cholesterol (Statins) - The percentage of Members age 18 and older with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication.
D13:	MTM Program Completion Rate for CMR -The percentage of Members age 18 and older enrolled in the Medication Therapy Management (MTM) program who received a Comprehensive Medication Review (CMR) during the measurement period. (CMR must be completed and reported by the CMS approved vendor - Refer to Supplement A for more MTM program information).
C51:**	Annual Wellness Visit and Initial Preventive Physical Exam Rate - The percentage of Members 65 and older who had an annual wellness visit or an initial preventive physical exam during the measurement year. **Not a CMS measure. Not included in aggregate Stars score calculation.
<i>The following clinical quality measures will be shown in reporting for informational purposes and in anticipation of future measure development.</i>	
HOS1:	Screening for Future Fall Risk - The percentage of Members 65 years and older who were screened for future fall risk at least once during the measurement year.

PERFORMANCE MEASUREMENT

Components Performance measurement requirements for the two Program components are outlined below and will be used to determine whether Participants will be eligible for Program incentive payments.

1. Care Gap Closure Component

Program care gaps are identified as Members who have not yet received the expected care as indicated by the NCQA HEDIS® or CMS measurement requirements. Members may have more than one identified care gap based on their measure eligibility as determined by the clinical quality measure specifications. Technical specifications for claim-based metrics can be found in a separate Medicare Advantage Incentive Program Masthead Measure Guide located on the Provider Resource Center under Medicare Advantage Stars – Medicare Advantage Stars Program. The Guide is provided as an educational resource for Participants to gain an understanding of numerators, denominators and exclusions used in performance measurement. Some reporting logic used by NCQA HEDIS (and its licensed vendors) is leveraged by Highmark to result the Program and may not be included in the Guide due to the complexity of calculations or proprietary limitations. Please consult your Provider Account Liaison, Clinical Transformation Consultant or call the Provider Service Center if you have questions on measure specifications.

CMS Star measures will be classified as either “static” or “dynamic” based upon whether or not care gaps can definitively be closed during the Program measurement year. Gap closure results from a one-time activity (static), or final year end submission activity (dynamic). Static measures are closed for a Member when the expected care is provided to that member once during the measurement year. Dynamic measures may require ongoing member monitoring and population management to ensure that Members have received the expected care for a clinical quality measure.

Eleven static CMS Star measures and the AWV/Initial Prevention Physical measure will be eligible for inclusion and assessed for the Care Gap Closure Program component:

Static Measure ID	
C01:	Breast Cancer Screening
C02:	Colorectal Cancer Screening
C07:	Adult BMI Assessment
C12:	Osteoporosis Management in Women Who Had a Fracture
C13:	Comprehensive Diabetes Care: Eye Exam (retinal) performed
C14:	Comprehensive Diabetes Care: Medical Attention for Nephropathy

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PERFORMANCE MEASUREMENT, Continued

Components (continued)

C17:	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
C20:	Medication Reconciliation Post-Discharge
C22:	Statin Therapy for Patients with Cardiovascular Disease
D14:	Statin Use in Persons with Diabetes
D13:	Medication Therapy Management
AWV Completion	
C51:	Annual Wellness Visit (AWV) and Initial Preventive Physical Exam Rate

Each gap in care that is closed on an eligible static or AWV measure-set between January 1, 2019 and December 31, 2019 -will be noted to be eligible for the care gap closure incentive payment. Care gap closure incentive payments will be distributed quarterly in June 2019, September 2019, December 2019 and May 2020.

Participants will receive a monthly Member listing report to support care gap closure efforts. These lists will update based upon claims received by Highmark throughout the course of the measurement year.

NOTE: Care gaps can open anytime during the measurement year based upon measure specification requirements and the measurement window.

2. Performance Level (Star Rating) Component

Highmark will calculate a practice level Star rating using administrative claims data reflecting a date of service of January 1, 2019 through December 31, 2019 to assess performance measurement on the Performance Level Program Component. All claims for consideration must be submitted to Highmark and adjudicated by January 31, 2020.

At the conclusion of the measurement period, performance will be assessed and the Participant will receive a lump sum incentive payment. Incentives will be made for performance levels greater than or equal to 3.5 Stars overall. Payments will be distributed in June 2020.

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PERFORMANCE MEASUREMENT, Continued

Components (continued)

Participant's completion of an AWW (initial, subsequent or Initial Preventive Physical Exam ("IPPE")) will be assessed on attributed Members to determine an overall compliance rate. Additional incentive opportunities will be made available to Participants with AWWs. Please see Table A: Incentive Payment under Results and Scoring.

NOTE: Eligible Participants will have the opportunity to include supplemental data submitted into the Clinical Quality Feedback function by January 31, 2020. Submissions must demonstrate numerator compliance and/or denominator exclusion for one of the CMS Star measures to impact Program performance. Highmark reviews each submission to the Clinical Quality Feedback function, following NCQA HEDIS® requirements for the supplemental data documentation. Submissions must be reviewed and accepted by Highmark prior to the January 31, 2020 date to impact Program performance. Clinical Quality Feedback Guidelines are posted on the Provider Resource Center under Medicare Advantage Stars – Medicare Advantage Stars Program.

Component Monitoring

Highmark will provide Participants with summary reports and care gap member listing reports on a monthly basis to aid in care gap closure and population management.

Highmark will also supply monthly event based reports:

- Osteoporosis Management based on fracture data available at time of report run out
- Medication Adherence based on Pharmacy claims available at time of report run out
- HbA1c results based on claim and lab results available at time of report run out
- Medication Therapy Management Comprehensive Medication Review data available at time of report run out
- Medication Reconciliation Post Discharge outcomes data available at time of report run out
- Readmission member detail outcomes data available at time of report run out
- Controlling High Blood Pressure outcomes data available at time of report run out

Reference Appendix B & C for Program Reporting Schedule and Report Example.

PERFORMANCE MEASUREMENT, Continued

**Star Measure
Cut Points &
Weighting**

Numerator/denominator data will be captured using attributed Member claims data for each Participant practice for each of the 17 CMS Star clinical quality measures for the Program measurement year ending December 31, 2019. Highmark will calculate the compliance percentage or ratio for each of the 17 measures and compare those to each measure's Star cut-points to determine a Star rating by measure. Participant's Star ratings earned by measure will be multiplied by the assigned measure weight to calculate an overall performance level (Star rating) for each practice. (Please reference Appendix D for Star measure cut points and measure weight allocation.) **Participant's performance level (Star rating) component is the sum of the individual measure weighted Star ratings divided by the sum of the applicable Star measure weights. The AWV measure is NOT included in this calculation.**

RESULTS & SCORING

Component Results and Scoring

Care Gap Closure

Each of the static CMS Star measures with care gaps closed by date of service December 31, 2019 is eligible to receive a \$10 incentive per gap closed.

In addition to the foregoing, note the following payment enhancements for specific CMS Star measures with care gaps closed by the date of service December 31, 2019 or yearend performance rating.

- Each care gap closed for Osteoporosis Management in Women Who Had a Fracture will receive a care gap payment of \$100 per gap closed.
- Each care gap closed for Rheumatoid Arthritis Management will receive a care gap payment of \$50 per gap closed.
- AWV (C51) will also be monitored and paid as a “static” measure in the Care Gap Closure Component and paid as a \$10 incentive per completion.
- Participants reaching the 5-Star cut-point performance rating on D14: Statin Use in Persons with Diabetes (SUPD) will receive \$30 per SUPD gap closed.*
- A \$10 payment per acute care hospital discharge that does not have an associated readmission for Participants achieving at least a 4-Star cut-point rating on C19: All-Cause Readmissions.*
- For each Medication Adherence measure at or above 92% compliance, with a minimum of 10 denominators, a \$25 per denominator payment.*

**To be paid after final yearend performance calculation.*

Performance Level (Star Rating) Results

- A minimum of a 3.50 overall Star rating must be obtained by the Participant to be eligible to receive the performance level incentive payment.
 - To evaluate practice performance, Highmark examines the Participant’s practice aggregate Stars measure compliance percentages compared to the projected CMS Stars national cut-points. The practice performance level will be resulted by April 2020, following the calendar year end and a 90 day claims run out period.
 - If a practice has less than 10 Members in the denominator for a clinical quality measure, that measure is excluded from results scoring.
 - Star rating calculation will **NOT** be rounded.
 - The overall Stars rating calculation must meet or exceed the defined performance level incentive threshold.
 - AWV will not be associated with a Participant’s Star rating nor will compliance be used in determining year end results.
 - AWV completion will be calculated for the “payment multiplier” opportunity. Payment multiplier is defined by % AWV/IPPE completed for eligible Members for which Highmark has received appropriately submitted claims. Please reference Table A under Results and Scoring for incentive tiering.
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RESULTS & SCORING, Continued

Component Results and Scoring (continued)

A lump-sum performance level results incentive payment will be made to eligible Participants based upon overall Star score as detailed below:

TABLE A: Incentive Payment

Overall Stars Rating	Incentive per Member	Multiplier 120% (with 75% AWV)	Multiplier 150% (with 90% AWV)
5.00	\$150	\$180	\$225
4.75-4.9999	\$125	\$150	\$187.50
4.50-4.7499	\$90	\$108	\$135
4.25-4.4999	\$75	\$90	\$112.50
4.00-4.2499	\$50	\$60	\$75
3.75-3.9999	\$20	\$24	\$30
3.50-3.7499	\$10	\$12	\$15
<3.50	\$0	\$0	\$0

Reference Appendix E for an example of Star Rating calculations

APPENDIX A: Component Incentive Payment Cycle

Base 2019 Medicare Advantage Provider Incentive

Providers servicing Highmark Medicare Advantage Members in 2019 will have opportunities to earn incentive payments for closing individual gaps in care as well as achieving a successful Year-End Star Rating across 17 selected measures.

\$10 Per Gap

Providers can earn \$10 per Care Gap* closed between **January 1, 2019** and **December 31, 2019** across select Star measures.

Based on service dates between 01/01/19 – 12/31/19

*Osteoporosis Management \$100 per gap closure, Rheumatoid Arthritis Management \$50 per gap closure. See additional slides for further details and extra incentives.

Quarterly Payment

The Per Gap incentive will be paid quarterly:

- Services Rendered January – March Paid in June 2019
- Unpaid services rendered through 06/30/19 paid in September 2019
- Unpaid services rendered through 09/30/19 paid in December 2019
- Unpaid services rendered through 12/31/19 paid in May 2020 (allows for 3 month run-out).

2019 Star Rating Incentive

Earn up to \$150 per Medicare Advantage Member based on overall 2019 Star Rating:

< 3.5 Stars	\$0 Per Member
3.5 Stars	\$10 Per Member
3.75 Stars	\$20 Per Member
4.0 Stars	\$50 Per Member
4.25 Stars	\$75 Per Member
4.5 Stars	\$90 Per Member
4.75 Stars	\$125 Per Member
5.0 Stars	\$150 Per Member

Star calculation methodology and measure specifications guide provided in Incentive training and resource materials located on the Provider Resource Center.



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APPENDIX B: Program Reporting Schedule

Report Distribution Date	18-Month Time Period For Attribution	Enrollment Period Date	Capturing Claims Paid
3/25/2019	August 1, 2017 – January 31, 2019	February 15, 2019	January 1, 2019 – February 23, 2019
4/25/2019	September 1, 2017 – February 28, 2019	March 15, 2019	January 1, 2019 – March 30, 2019
5/27/2019	October 1, 2017 – March 31, 2019	April 15, 2019	January 1, 2019 – April 27, 2019
6/25/2019	November 1, 2017 – April 30, 2019	May 15, 2019	January 1, 2019 – May 25, 2019
7/25/2019	December 1, 2017 – May 31, 2019	June 15, 2019	January 1, 2019 – June 29, 2019
8/26/2019	January 1, 2018 – June 30, 2019	July 15, 2019	January 1, 2019 – July 27, 2019
9/25/2019	February 1, 2018 – July 31, 2019	August 15, 2019	January 1, 2019 – August 24, 2019
10/25/2019	March 1, 2018 – August 31, 2019	September 15, 2019	January 1, 2019 – September 28, 2019
11/25/2019	April 1, 2018 - September 30, 2019	October 15, 2019	January 1, 2019 – October 26, 2019
12/26/2019	May 1, 2018 – October 31, 2019	November 15, 2019*	January 1, 2019 – November 30, 2019
1/27/2020	June 1, 2018 – November 30, 2019	December 15, 2019*	January 1, 2019 – December 28, 2019
2/25/2020	July 1, 2018 - December 31, 2019	January 15, 2020*	January 1, 2019 – January 25, 2020
4/27/2020	September 1, 2018 – February 28, 2020	January 15, 2020*	January 1, 2019 – March 31, 2020

* **New Members will be removed from scoring**

Note: Dates noted on the reporting schedule may be subject to change. Any adjustments will be communicated to Participants via the Provider Portal on NaviNet.

APPENDIX C: Report Example - Star Practice Level Monthly Report Sample Summary Tab

2019 STAR MEASURE PERFORMANCE SUMMARY
1234567 - MOCK UP FOR 2019

RUN DATE: 28NOV2019

ATTRIBUTION DATE: 31AUG2019

CLAIMS PAID THROUGH: 27OCT2019

CURRENT AGGREGATED STAR RATING: 3.62 STARS

Includes Medicare Advantage Members Only

Class	Measure Name	Measure Weight	Eligible Population (Denominator)	# of Gaps Closed (Numerator)	# of Gaps Addressed and On Track (Trend)	# of Eligible Population Beyond Remediation	Actual YTD Compliance Rate	Trend Compliance Rate	Current Trend Measure Star Rating	Maximum Potential Compliance Rate	4 Star Compliance	5 Star Compliance	Number of Gaps Needed Closed for 5 Star Performance
Dynamic	C1: Comprehensive Diabetes Care: HbA1c Control (<=8%)	3	5	5	-	-	100.0%	0.0%	1	100.0%	80.0%	88.0%	88.0%
Dynamic	C2: All-cause Readmissions	3	3	3	-	1	33.3%	3.61	1	-	.57	.40	-
Dynamic	D1: Medication Adherence for Diabetes Medications	3	4	4	-	4	100.0%	100.0%	5	100.0%	84.0%	88.0%	88.0%
Dynamic	D1: Medication Adherence for Hypertension: RASA	3	19	16	-	2	84.2%	84.2%	3	89.5%	87.0%	89.0%	89.0%
Dynamic	D2: Medication Adherence for Cholesterol (Statins)	3	20	18	-	2	90.0%	90.0%	5	90.0%	85.0%	88.0%	88.0%
Dynamic	C1: Controlling High Blood Pressure	1	30	28	-	2	6.7%	6.7%	3	100.0%	76.0%	87.0%	87.0%
Static	D3: Medication Therapy Management	3	3	3	-	3	100.0%	100.0%	5	-	75.0%	85.0%	85.0%
Static	C2: Medication Reconciliation Post-Discharge	1	3	3	-	3	0.0%	0.0%	1	0.0%	72.0%	82.0%	82.0%
Static	C2: Statin Therapy for Patients with Cardiovascular Disease	1	1	1	-	1	0.0%	0.0%	1	-	83.0%	88.0%	88.0%
Static	D4: Statin Use in Persons with Diabetes	3	2	2	-	2	100.0%	100.0%	5	-	83.0%	87.0%	87.0%
Static	C1: Comprehensive Diabetes Care: Eye Exam (retinal) performed	1	5	2	-	2	40.0%	40.0%	1	-	77.0%	86.0%	86.0%
Static	C1: Comprehensive Diabetes Care: Medical Attention for Nephropathy	1	5	5	-	5	100.0%	100.0%	5	-	96.0%	98.0%	98.0%
Static	C01: Breast Cancer Screening	1	5	3	-	3	60.0%	60.0%	2	-	79.0%	85.0%	85.0%
Static	C02: Colorectal Cancer Screening	1	14	9	-	9	64.3%	64.3%	2	-	74.0%	83.0%	83.0%
Static	C07: Adult BMI Assessment	1	9	6	-	6	66.7%	66.7%	1	-	94.0%	96.0%	96.0%
Static	C1: Osteoporosis Management in Women who had a Fracture	1	1	1	-	1	0.0%	0.0%	-	0.0%	62.0%	81.0%	81.0%
Static	C17: Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	1	1	1	-	1	0.0%	0.0%	-	-	83.0%	89.0%	89.0%
Static	C5: Annual Wellness and Initial Preventative Physical Exam	-	31	10	-	10	32.3%	32.3%	-	-	45.0%	61.0%	61.0%
Static	H05: Screening for Future Fall Risk	-	31	31	-	31	0.0%	0.0%	1	-	-	-	-

This is an example and individual reports may vary.

APPENDIX D: Star Measure Weighting and Cut-points

Measure Description	Measure Weighting	Achieved 2 Stars	Achieved 3 Stars	Achieved 4 Stars	Achieved 5 Stars
Breast Cancer Screening	1.0	56%	71%	79%	85%
Colorectal Cancer Screening	1.0	55%	65%	74%	83%
Osteoporosis Management in Women w/Fracture	1.0	30%	45%	62%	81%
Diabetes Care - Eye Exam	1.0	51%	67%	77%	86%
Rheumatoid Arthritis Management	1.0	69%	76%	83%	89%
Statin Therapy for patients with CV disease	1.0	71%	78%	83%	89%
Statin Therapy For Diabetes	3.0	75%	79%	83%	87%
Medication Therapy Management	3.0	55%	65%	75%	85%
Medication Reconciliation Post-Discharge	1.0	45%	60%	72%	82%
Diabetes Care- Blood Sugar Controlled < 9	3.0	49%	69%	80%	88%
Plan All-Cause Readmissions	3.0	.97	0.81	0.57	0.40
Medication Adherence for Diabetes Meds	3.0	75%	81%	84%	88%
Medication Adherence for Hypertension	3.0	80%	84%	87%	89%
Medication Adherence for Cholesterol	3.0	74%	80%	85%	88%
Controlling High Blood Pressure	1.0	50%	63%	76%	88%
Adult BMI	1.0	76%	84%	94%	98%
CDC: Kidney Disease Monitoring	1.0	92%	94%	96%	98%

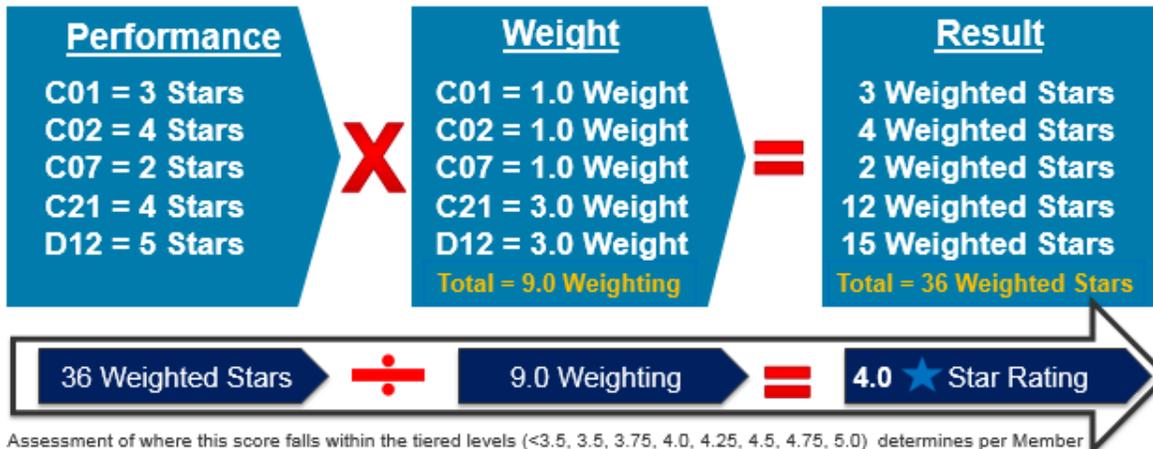
APPENDIX E: Practice Overall Star Rating Calculation Example

Practice Overall Stars Rating Calculation Determine compliance with each Star measure and determine the Star earned per each measure, multiply by weight of each measure to calculate weighted stars result. Numerator (total weighted stars) / Denominator (sum of weight of each applicable Star measure)

Example of Performance Level (Star Rating) Calculation

Aggregated Star rating methodology:

- Determine compliance with each CMS Star measure
- Calculate Stars earned per each measure (multiply performance by the weight of each measure)
- Multiply by weight of each measure (numerator) /sum of weight of each applicable star measure in the measurement (denominator)



- Assessment of where this score falls within the tiered levels (<3.5, 3.5, 3.75, 4.0, 4.25, 4.5, 4.75, 5.0) determines per Member incentive payment which will be distributed in a lump sum
- Measure Star ratings are calculated by comparing the compliance rate against the published cut points.
- Technical specifications for each Star measure differ and are explained in the MA Incentive Program: Clinical Quality Measures document found on the Provider Resource Center under Medicare Advantage Stars Member and Provider Programs. Additional Program and measure material is located under General References & Resources.
- Any measure with less than 10 attributed MA Members in the denominator will not receive a score and are excluded from the overall Star Rating calculation.

SUPPLEMENT A: Medication Therapy Management Program ("MTM Program")

The MTM Program is designed to support the health and safety of Members by optimizing drug therapy. MTM Program eligible Members are automatically enrolled into the Program and sent an Introduction Letter that welcomes them into the MTM Program and offers the opportunity to request a Comprehensive Medication Review (CMR).

Criteria for Eligibility in the MTM Program:

Only Attributed Members who meet the specified targeting criteria per CMS requirements will be included in the measure denominator. Eligibility is determined by multiple drugs covered under Part D. The criteria is as follows:

- 1) Minimum number of covered Part D drugs: 7
- 2) Type of covered Part D Drugs that apply: Chronic/Maintenance Drugs
- 3) Chronic Diseases as determined by drug claims (minimum of 3 chronic conditions from below):
 - a. Bone Disease-Arthritis- Osteoporosis
 - b. Bone Disease- Arthritis-Rheumatoid Arthritis
 - c. Chronic Heart Failure
 - d. Diabetes
 - e. Dyslipidemia
 - f. Mental Health – Depression
 - g. Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD)
- 4) Drug spend based on drug claims for qualifying medications - \$4,044

B. Numerator Compliance requirements:

Attributed MTM Program eligible Members must complete an Interactive, Person to Person, Comprehensive Medication Review, annually. The CMR must be completed as outlined by the CMS approved MTM Program description.

C. Additional Requirements:

- 1) The CMR must be an interactive, person to person or telehealth consultation: Conducted by phone or face to face using an authorized software program.
 - 2) The post CMR materials must be an individualized, written summary of CMR in CMS' standardized format (includes beneficiary cover letter, medication action plan, and personal medication list).
 - 3) Delivery of individualized written summary of CMR in CMS' Standardized format: via mail or in person after the completion of CMR.
 - 4) A targeted medication review (TMR) is performed by an authorized vendor on a quarterly basis. This is an automated process that is executed using the vendor's software program. A TMR identifies opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. Provider outreach via phone, mail or fax as appropriate for review of potential therapy changes is conducted by the vendor.
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