2021 MEDICARE ADVANTAGE STARS PRIMARY CARE INCENTIVE PROGRAM

PROGRAM MANUAL

This Program Manual is applicable to the following health plans: Highmark Inc., and Highmark West Virginia Inc. (Highmark WVA). Each such health plan is referred to herein as "Highmark".

Proprietary and Confidential

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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 2021 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. Practices contracted under another Highmark value-based incentive program that monitors quality performance on the Medicare Advantage population are not eligible for participation in this Program.

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 2021 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:

1. Care Gap Closure
2. Performance Level (Star Rating) Results

Practice Participation and Reimbursement

Program reporting, performance assessments, and subsequent incentive payments are based upon the submitted claims and approved supplemental data paths. 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. Participants 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.

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").

In order for Program payments to be made to Participants, 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 by completing the Program Acknowledgement and Agreement located on NaviNet. Acknowledgement can

be received by Highmark, via NaviNet, at any time during the 2021 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.

Attribution

Members who are active in a Highmark Medicare Advantage plan as of January 1, 2021 are included in the attribution process. Members who are deceased or have changed payer after January 1, 2021 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, 99495- 99496
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, 2021 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, 2021 attribution run will be noted as new-not scored.

Attribution does not utilize continuous enrollment criteria or include a membership check for active Highmark coverage. As such, Program Members who expired or changed payers will remain in attribution and may impact Program performance until they fall outside the parameters of an individual metric.

PROGRAM OVERVIEW, Continued

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.

Performance Measurement Requirements

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

Highmark will evaluate Member claims data for Participants for the measurement period of January 1, 2021 through December 31, 2021 for the following 16 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 Care 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.
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 (≤9%)** - The percentage of Members age 18 - 75 with diabetes (type 1 or type 2) whose most recent Hemoglobin A1C is ≤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).
C21:	**Plan All-Cause Readmissions -** For Members age 18 and older, the number of acute inpatient stays and observation 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.)
C22:	**Statin Therapy for Patients With Cardiovascular Disease** - The percentage of male Members age 21 - 75 and female Members age 40 - 75 as of the first day of the measurement year, 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. Members who turn 76 prior to the end of the measurement year must have a statin fill prior to turning 76 for compliance.

PROGRAM OVERVIEW, Continued

Performance Measurement Requirements (Continued)

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. All diabetic medications with the only exclusion being insulin products.
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).
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.
DMC19:	**TRC 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).
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.
	The following clinical quality measures will be shown in reporting for informational purposes and in anticipation of future measure development.
HOS2:	**Bladder Control** – The percent of Members 65 years and older who had a discussion regarding the presence or absence of urinary incontinence.
HOS3:	**Improving Physical Activity** – Percent of Members 65 years and older who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
DMC18:	**Follow Up ED for People with Multiple Chronic Conditions** – The percentage of emergency department (ED) visits for Members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
DMC21:	**TRC Patient Engagement After Inpatient Discharge** – The percentage of discharges for Members 18 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

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"). 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.

Ten 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
HOS1:	Monitoring for Future Fall Risk
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)

DMC19:	TRC 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, 2021 and December 31, 2021 will be noted to be eligible for the Care Gap Closure incentive payment. Care Gap Closure incentive payments will be distributed quarterly in June 2021, September 2021, December 2021 and May 2022.

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, 2021 through December 31, 2021 to assess performance measurement on the Performance Level Program component. All claims for consideration must be submitted to Highmark and adjudicated by January 31, 2022.

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 3.75 Stars overall. Payments will be distributed in June 2022.

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PERFORMANCE MEASUREMENT, Continued

Components (continued)

Participant's completion of an AWV (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 AWVs. Please see Table 2: 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 December 31, 2021. 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 December 31, 2021 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
- Statin Measures details pharmacy claims and outcomes data at the time of the report run out
- Member Contact Information populates the current member demographic on file and provides the opportunity to supply Highmark with the most up to date member contact information

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 16 CMS Star clinical quality measures for the Program measurement year ending December 31, 2021. Highmark will calculate the compliance percentage or ratio for each of the 16 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 & INCENTIVE PAYMENT

Component Results, Scoring and Incentive Payment

Care Gap Closure

Each of the static CMS Star measures with care gaps closed by date of service December 31, 2021 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, 2021 or year-end 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 and will be paid quarterly.
- Each care gap closed for Breast Cancer Screening will receive a care gap payment of $50 per gap closed per quarter.
- 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 each quarter.
- Participants reaching the 5-Star cut-point performance rating on D14: Statin Use in Persons with Diabetes (SUPD) and in combination with C22: Statin Therapy for Cardiovascular Disease (both measures) will receive $30 per numerator in each measure.*
- 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 91% compliance, with a minimum of 10 denominators, a $20 per denominator payment.*

**To be paid after final year-end performance calculation.*

Performance Level (Star Rating)

- A minimum of a 3.75 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 2022, 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 quali measure, that measure is excluded from results scoring, with an exception fo Osteoporosis Management in which all members will be scored.
    - 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 2 under Results and Scoring for incentive tiering.

RESULTS & SCORING, Continued

Component Results and Scoring (continued)

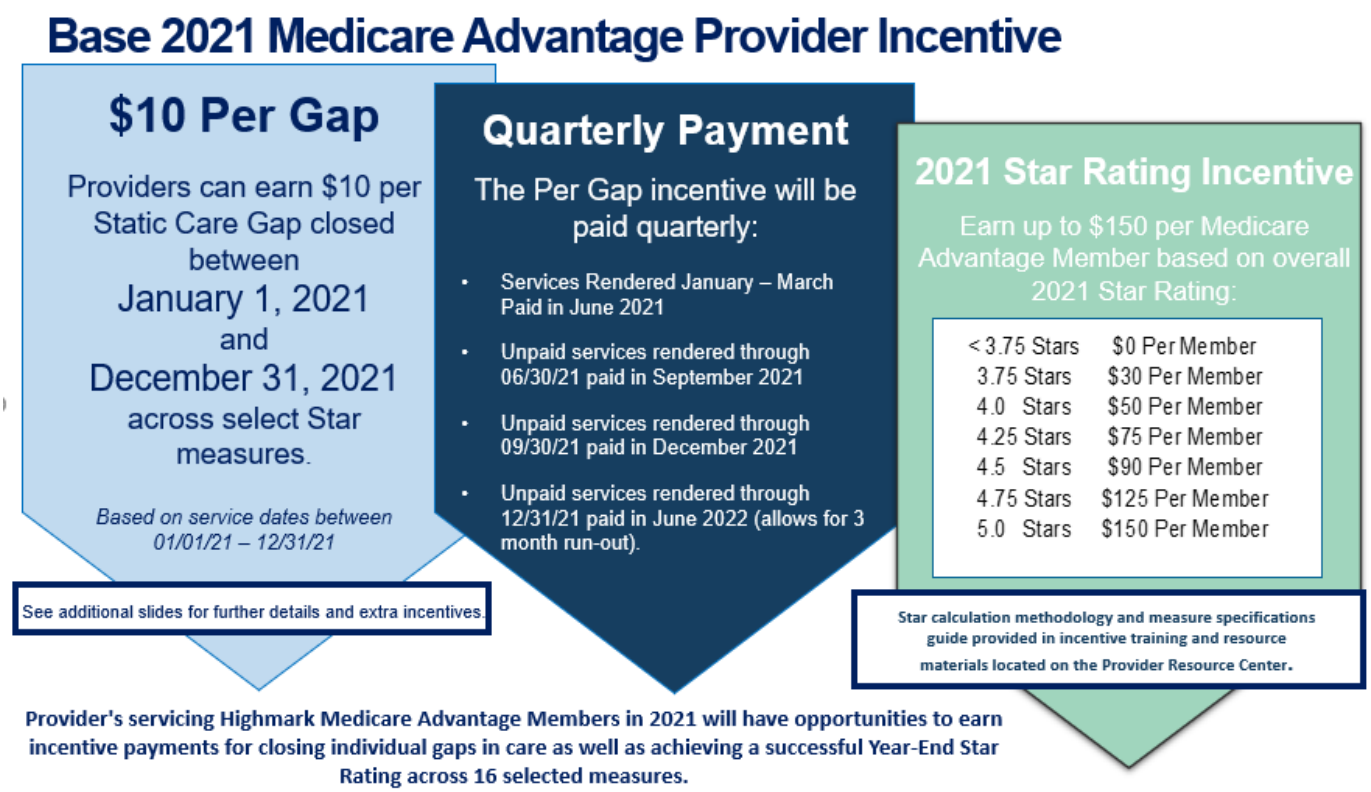
A lump-sum performance level results incentive payment will be made to eligible Participants based upon overall Star score as detailed below:

Table 2: Incentive Payment

Overall Stars Rating	Incentive per Medicare Advantage 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	$30	$36	$45
<3.75	$0	$0	$0

Reference Appendix E for an example of Star Rating calculations

APPENDIX A: Component Incentive Payment Cycle



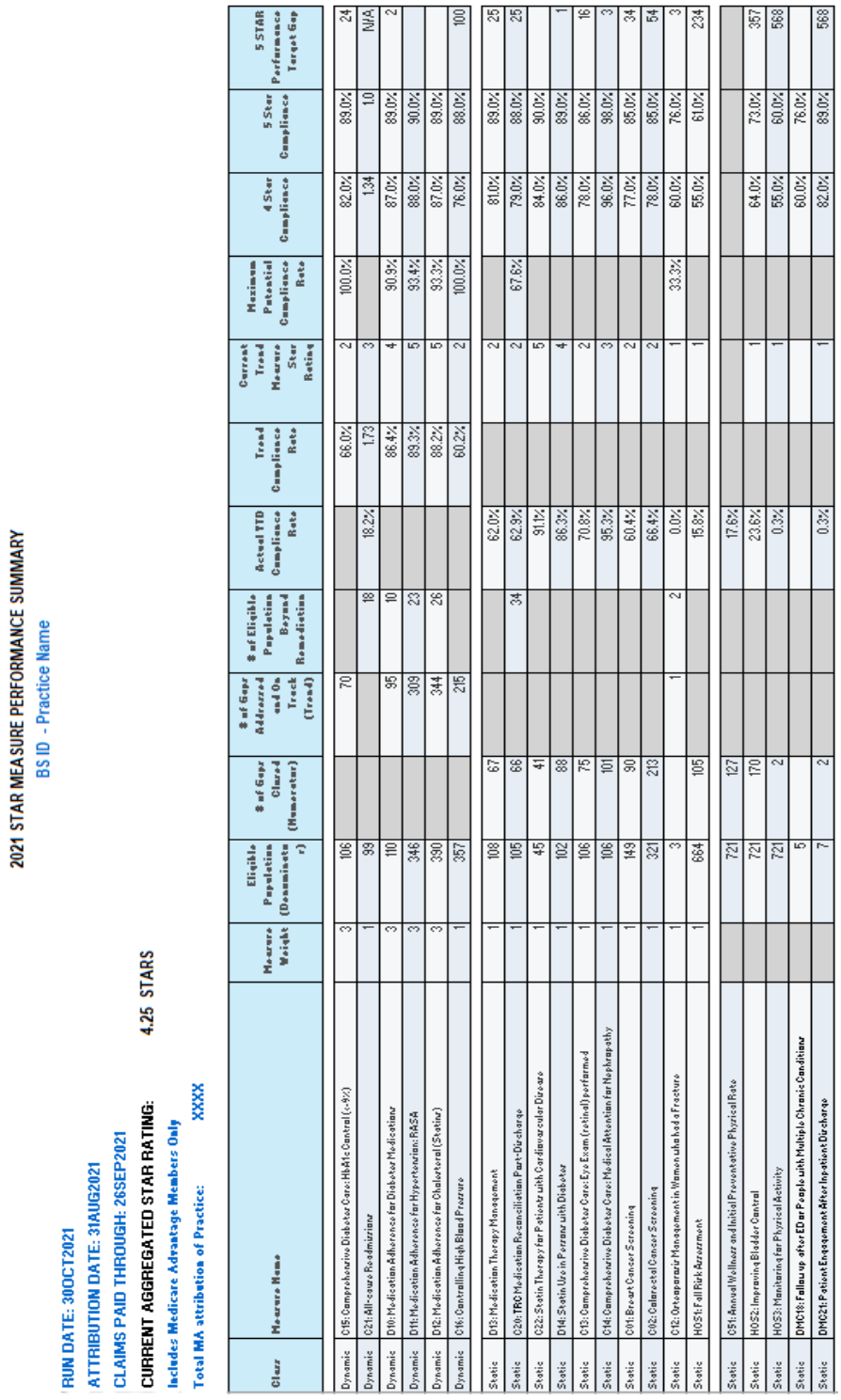
APPENDIX B: Program Reporting Schedule

Report Distribution Date	18-Month Time Period For Attribution	Enrollment Period Date	Capturing Claims Paid
3/25/2021	August 1, 2019 – January 31, 2021	February 15, 2021	January 1, 2021 – February 27, 2021
4/26/2021	September 1, 2019 – February 28, 2021	March 15, 2021	January 1, 2021 – March 27, 2021
5/25/2021	October 1, 2019 – March 31, 2021	April 15, 2021	January 1, 2021– April 24, 2021
6/25/2021	November 1, 2019 – April 30, 2021	May 15, 2021	January 1, 2021 – May 29, 2021
7/26/2021	December 1, 2019 – May 31, 2021	June 15, 2021	January 1, 2021 – June 26, 2021
8/25/2021	January 1, 2020 – June 30, 2021	July 15, 2021	January 1, 2021 – July 31, 2021
9/24/2021	February 1, 2020 – July 31, 2021	August 15, 2021	January 1, 2021 – August 28, 2021
10/25/2021	March 1, 2020 – August 31, 2021	September 15, 2021	January 1, 2021 – September 25, 2021
11/25/2021	April 1, 2020 - September 30, 2021	October 15, 2021	January 1, 2021 – October 30, 2021
12/22/2021	May 1, 2020 – October 31, 2021	November 15,2021*	January 1, 2021 – November 27, 2021
1/25/2022	June 1, 2020 – November 30, 2021	December 15, 2021*	January 1, 2021 – December 25, 2021
2/25/2022	July 1, 2020 - December 31, 2021	January 15, 2022*	January 1, 2021 – January 29, 2022
4/25/2022	September 1, 2020 – February 28, 2022	January 15, 2022*	January 1, 2021 – March 26, 2022

* **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



2021 STAR MEASURE PERFORMANCE SUMMARY

BS ID - Practice Name

RUN DATE: 30OCT2021

ATTRIBUTION DATE: 31AUG2021

CLAIMS PAID THROUGH: 26SEP2021

CURRENT AGGREGATED STAR RATING: 4.25 STARS

Includes Medicare Advantage Members Only

Total MA attribution of Practice: XXXX

Class	Measure Name	Measure Weight	Eligible Population (Denominator)	# of Gaps Closed (Numerator)	# of Gaps Addressed and On Track (Treated)	# 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	5 STAR Performance Target Gap
Dynamic	C15: Comprehensive Diabetes Care: HbA1c Control (<9%)	3	106		70			66.0%	2	100.0%	82.0%	89.0%	24
Dynamic	C21: Adherence to Ondansetron	1	99			18	18.2%	1.73	3		134	10	N/A
Dynamic	D10: Medication Adherence for Diabetes Medications	3	110		95	10		86.4%	4	90.9%	87.0%	89.0%	2
Dynamic	D11: Medication Adherence for Hypertension: RASA	3	346		309	23		89.3%	5	93.4%	88.0%	90.0%	
Dynamic	D12: Medication Adherence for Cholesterol (Statins)	3	390		344	26		88.2%	5	93.3%	87.0%	89.0%	
Dynamic	C16: Controlling High Blood Pressure	1	357		215			60.2%	2	100.0%	76.0%	88.0%	100
Static	D13: Medication Therapy Management	1	108	67			62.0%		2		81.0%	89.0%	25
Static	C20: TRC Medication Reconciliation Post-Discharge	1	105	66		34	62.9%		2	67.6%	79.0%	88.0%	25
Static	C22: Statin Therapy for Patients with Cardiovascular Disease	1	45	41			91.1%		5		84.0%	90.0%	
Static	D14: Statin Use in Persons with Diabetes	1	102	88			86.3%		4		86.0%	89.0%	1
Static	C13: Comprehensive Diabetes Care: Eye Exam (retinal) performed	1	106	75			70.8%		2		78.0%	86.0%	16
Static	C14: Comprehensive Diabetes Care: Medical Attention for Nephropathy	1	106	101			95.3%		3		96.0%	98.0%	3
Static	C01: Breast Cancer Screening	1	149	90			60.4%		2		77.0%	85.0%	34
Static	C02: Colorectal Cancer Screening	1	321	213			66.4%		2		78.0%	85.0%	54
Static	C12: Osteoporosis Management in Women who had a Fracture	1	3		1	2	0.0%		1	33.3%	60.0%	76.0%	3
Static	HOS1: Fall Risk Assessment	1	664	105			15.8%		1		55.0%	61.0%	234
Static	C51: Annual Wellness and Initial Preventative Physical Exam		721	127			17.6%						
Static	HOS2: Improving Bladder Control		721	170			23.6%		1		64.0%	73.0%	357
Static	HOS3: Maintaining Physical Activity		721	2			0.3%		1		55.0%	60.0%	568
Static	DMC18: Follow up after ED for People with Multiple Chronic Conditions		5								60.0%	76.0%	
Static	DMC21: Patient Engagement After Inpatient Discharge		7	2			0.3%		1		82.0%	89.0%	568

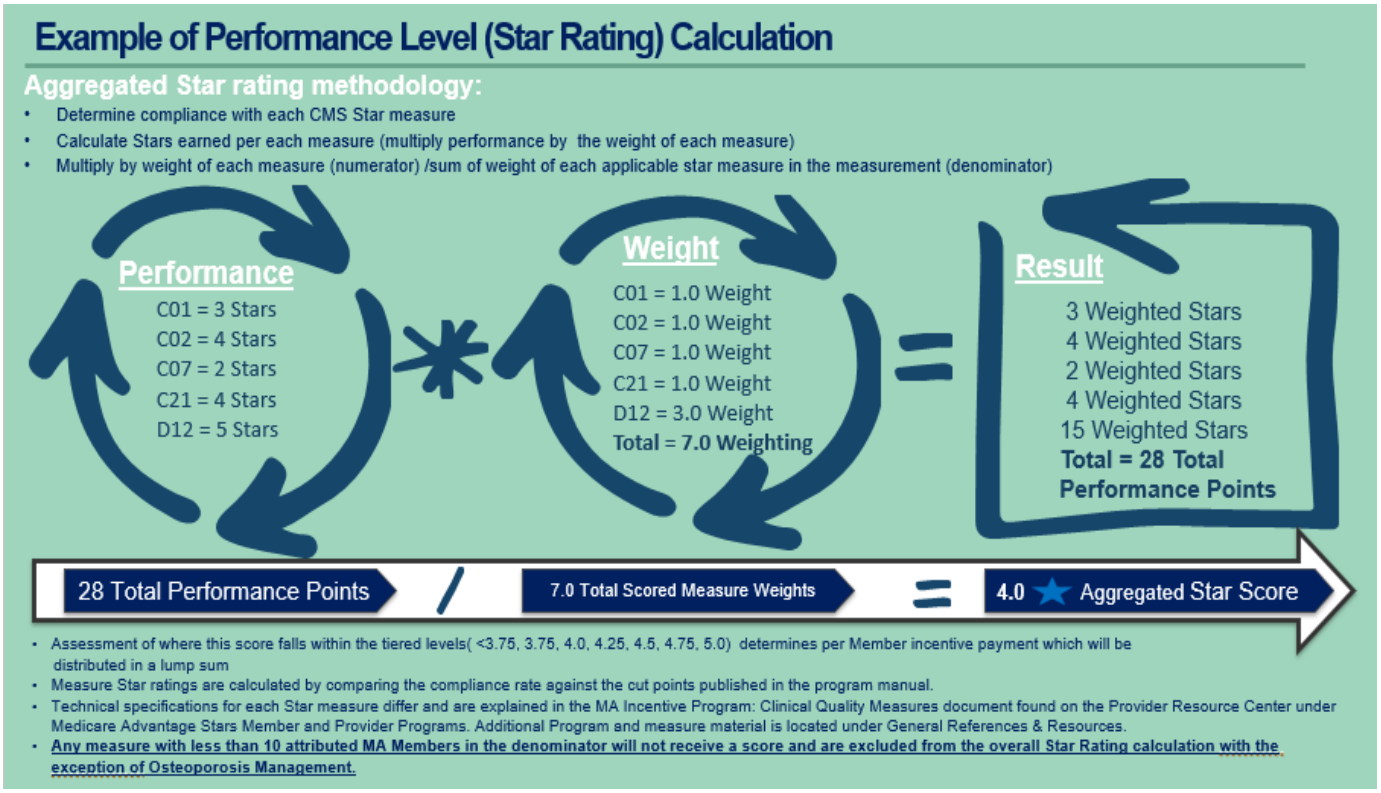
This is an example and individual reports may vary.

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	53%	68%	77%	85%
Colorectal Cancer Screening	1.0	57%	69%	78%	85%
Osteoporosis Management in Women w/Fracture	1.0	35%	47%	60%	76%
Diabetes Care - Eye Exam	1.0	60%	71%	78%	86%
Statin Therapy for patients with CV disease	1.0	75%	80%	84%	90%
Statin Use in Persons with Diabetes	1.0	78%	83%	86%	89%
Medication Therapy Management	1.0	59%	74%	81%	89%
Medication Reconciliation Post-Discharge	1.0	50%	66%	79%	88%
Diabetes Care- Blood Sugar Controlled $\leq$ 9	3.0	57%	73%	82%	89%
Plan All-Cause Readmissions	1.0	2.03	1.76	1.34	1.00
Medication Adherence for Diabetes Meds	3.0	78%	83%	87%	89%
Medication Adherence for Hypertension	3.0	79%	84%	88%	90%
Medication Adherence for Cholesterol	3.0	78%	83%	87%	89%
Controlling High Blood Pressure	1.0	50%	63%	76%	88%
Screening for Future Fall Risk	1.0	45%	49%	55%	61%
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).



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 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. Dyslipidaemia
    f. Mental Health – Depression
    g. Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD)
4) Drug spend based on drug claims for qualifying medications – $4,376

B. Numerator Compliance Requirements:

Attributed MTM Program eligible Members must complete an interactive, person-to-person, CMR, 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 telephonic 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.