2016 MEDICARE ADVANTAGE STARS PRIMARY CARE INCENTIVE PROGRAM

PROGRAM MANUAL

Revised 04/13/2016

Proprietary and Confidential

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PROGRAM OVERVIEW

Objective

To evaluate the delivery of care and the effectiveness of improvement strategies in the Highmark Medicare Advantage member population using the CMS Stars measures.

Intent

The 2016 Medicare Advantage Stars Primary Care Incentive Program (hereafter, the "Program") is structured to assess and improve the process of care for Primary Care practices serving Highmark's Medicare Advantage Members ("Members") using CMS Stars measure as the basis of clinical quality performance measurement.

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 that will be eligible for unique incentive opportunities:

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

Attribution

Highmark Medicare Advantage Members' claims will establish the data set for both Participant performance measurement and attribution.

Members are assigned, or "attributed," to the practice with eligible Program providers (PCPs and CRNPs) with whom they had the highest number of visits during a rolling 18-month time period. If a member had the same number of visits with multiple practices, the member is attributed to the practice visited most recently. PCPs include: internal medicine, family practice, general practice, CRNP PCP, and geriatric medicine. When the provider billing specialty is multi-specialty, the practitioners are only included when the performing specialty is one of the PCP specialties listed above. Please note that it is within Highmark's discretion to update the definition of eligible Primary Care Providers.

Attribution is updated monthly, using no run-out period for claims processing, which could result in membership attribution changes throughout the course of the calendar year.

Members who had Evaluation & Management ("E&M") claims for skilled nursing facilities (as determined by Place of Service code) but no other PCP E&M claims in the 18-month attribution period will be excluded from attribution.

Members who expired or changed payer will remain in attribution and may impact Program performance until they fall outside the parameters of an individual measure. Participants managed these patients during the period they were attributed to them; therefore, these members will count in the Participant's score.

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PROGRAM OVERVIEW, Continued

Attribution (continued)

To allow Participants sufficient time to respond to members identified gaps and impact performance measurement, attribution will be locked down as of August 31, 2016 for the resulting of the Medicare Advantage Incentive program. Members will continue to be added and removed from reporting throughout the calendar year based upon attribution logic. Members that are first included in reports after August 31, 2016 will be flagged and adjusted out of final scoring.

Practice Participation and Reimbursement

Participants are required to acknowledge review of the Highmark 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 2016 calendar year; however, Program payments will not be disbursed until this acknowledgement is received. No Program payments will be made outside of the established payment cycle. Please reference Appendix D– Incentive Payment Cycle.

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

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PROGRAM OVERVIEW, Continued

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, 2016 through December 31, 2016 for the following 16 CMS Stars measures and Annual Wellness Visit measure:

Measure ID	Measure Name and Description
C01:	**Breast Cancer screening** Percentage of female Members aged 52-74 who had a mammogram during the past 2 years.
C02:	**Colorectal Cancer screening** Percentage of Members aged 50-75 who had appropriate screening for colon cancer.
C07:	**Adult BMI Assessment** Percentage of Members with an outpatient visit who had their 'Body Mass Index" calculated from their height and weight and recorded in their medical records as indicated through submission of the appropriate diagnosis code
C12:	**Osteoporosis Management in Women who had a fracture** Percentage of female Members who broke a bone and got screening or treatment for osteoporosis within 6 months.
C13:	**Comprehensive Diabetes Care: Eye Exam (retinal) performed** Percentage of Members with diabetes who had an eye exam to check for damage from diabetes during the year.
C14:	**Comprehensive Diabetes Care: Medical Attention for Nephropathy** Percentage of Members with diabetes who had a kidney function test during the year.
C15:	**Comprehensive Diabetes Care: HbA1c Control (≤9%)** Percentage of Members with diabetes who had an HbA1c lab test during the year that showed their average blood sugar is under control.
C17:	**Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis** Percentage of Members with rheumatoid arthritis (RA) who got one or more prescriptions for an anti-rheumatic drug.

PROGRAM OVERVIEW, Continued

Performance Measurement Requirements (Continued)

C19:	**All cause readmissions: Medicare Advantage** Ratio of observed to expected Members discharged from a hospital stay who were readmitted to a hospital within 30 days, regardless of readmission diagnosis. *NOTE: Participants observed percentage of Members readmitted to a hospital within 30 days, regardless of readmission diagnosis readmission (readmission rate) will also be provided for informational purposes*.
DMC 20:	**Statin Therapy for Patients with Cardiovascular Disease** Percentage of males 21 to 75 years of age and females 40 to 75 years of age who were identified as having atherosclerotic cardiovascular disease and were dispensed at least one high or moderate-intensity statin medication
DMC 21:	**Medication Management for People with Asthma** The percentage of members age 18 to 85 years of age who were identified as having persistent asthma and were dispensed appropriate medications and achieved a proportion of days covered of at least 75%
DMC 22:	**Statin Therapy for Patients with Diabetes** The percentage of members 40 and 75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease who were dispensed at least one statin medication
D12:	**Medication Adherence for Diabetes Medications** Percentage of Members with a prescription for a diabetes medication who fill their prescription often enough to demonstrate medication adherence.
D13:	**Medication Adherence for High Blood Pressure Renin Angiotensin System Antagonists** Percentage of Members with a prescription for a blood pressure medication who fill their prescription often enough to demonstrate medication adherence.
D14:	**Medication Adherence for Cholesterol (Statins)** Percentage of Members with a prescription for a cholesterol medication who fill their prescription often enough to demonstrate medication adherence.
D15:	**Medication Therapy Management** The percentage of Medication Therapy Management eligible members who received a Comprehensive Medication review (CMR must be completed and reported by the CMS approved vendor-Refer to AppendixG for more MTM program information).
C51:*	**Annual Wellness Visit and Initial Preventive Physical Exam Rate** Percentage of Members 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

PERFORMANCE MEASUREMENT

Components

Performance measurement requirements for both Program components are outlined below and will be used to determine whether Participants will be eligible for Program incentive payments. There are two independent Program components eligible for incentives.

1. Care Gap Closure Component

Program care gaps are identified as Medicare Advantage Members who have not yet received the expected care as indicated by the national 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 Relations Representative or Clinical Transformation Consultant 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 be definitively closed during the Program measurement year. 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. (One service or procedure may not ensure that a Member's care gap is closed.)

Ten static CMS Star measures and the Annual Wellness Visit /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
DMC20:	Statin Therapy for Patients with Cardiovascular Disease
DMC 22:	Statin Therapy for Patients with Diabetes
D15:	Medication Therapy Management
AWV Completion	
C51:	Annual Wellness Visit and Initial Preventive Physical Exam Rate

Each gap in care that is closed on an eligible static or Annual Wellness Visit measure- set between January 1, 2016 and December 31, 2016 -will be noted to be eligible for the care gap closure incentive payment. Care gap closure incentive payments will be distributed quarterly in June 2016, September 2016, December 2016 and May 2017.

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, 2016 through December 31, 2016 to assess performance measurement on the Performance Level Program Component. All claims for consideration must be submitted to Highmark and adjudicated by January 31, 2017.

At the conclusion of the measurement period, performance will be assessed and the Participant will receive a per Highmark Medicare Advantage lump sum incentive payment based upon the practice level overall Star rating. Incentives will be made for performance levels greater than or equal to 3.5 Stars overall. Payments will be distributed in June 2017.

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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 AWV /eAWV. Please see Incentive Payment Table under Results and Scoring.

NOTE: Eligible participants will have the opportunity to include supplemental data submitted into the Clinical Quality Feedback function by November 25, 2016 in the assessment of the Performance Level (Star rating) Component. 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 approved by Highmark prior to the November 25th, 2016 date to impact Program performance.

Component Monitoring

Highmark will provide Participants 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

Reference Appendix C for the Report Tool Guide.

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, 2016. 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 A for Star measure cut points and Star 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, 2016 is eligible to receive a $10 incentive per gap. Note the following payment enhancements.

- Each care gap closed for Osteoporosis Management in Women who had a Fracture will receive a care gap payment of $100 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.

- Enhanced Annual Wellness Visits, completed through Vatica, will be monitored and paid as a "static" measure in the Care Gap Closure Component as a $200 incentive per completion.

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 practice aggregate Stars measure compliance percentages compared to our projected CMS Stars national cut-points. The practice performance level will be resulted by April 2016, 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 level thresholds.

- AWV will not be associated with a Participant's Star rating nor will the compliance be used in determining year end results.
- AWV completion will be calculated for the "payment multiplier" opportunity. Payment multiplier is defined by type of AWV completed and % of eligible Medicare Advantage members for which Highmark has received appropriately submitted claims. Please reference Table A 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 A:

Overall Stars Rating	Incentive per Medicare Member	Multiplier 120% (with 50% AWV)	Multiple 150% (with 75% AWV)	Multiplier 125% (with 30% eAWV)	Multiplier 160% (with 60% eAWV)
5.00	$150	$180	$225	$187.50	$240
4.75-4.9999	$125	$150	$187.50	$156.30	$200
4.50-4.7499	$90	$108	$135	$112.50	$144
4.25-4.4999	$75	$90	$112.50	$93.75	$120
4.00-4.2499	$50	$60	$75	$62.50	$80
3.75-3.9999	$20	$24	$30	$26	$32
3.50-3.7499	$10	$12	$15	$12.50	$16
<3.50	$0	$0	$0	$0	$0

Reference Appendix B for an example of Star Rating calculations

APPENDIX A: Star Measure Weighting and Cut-points

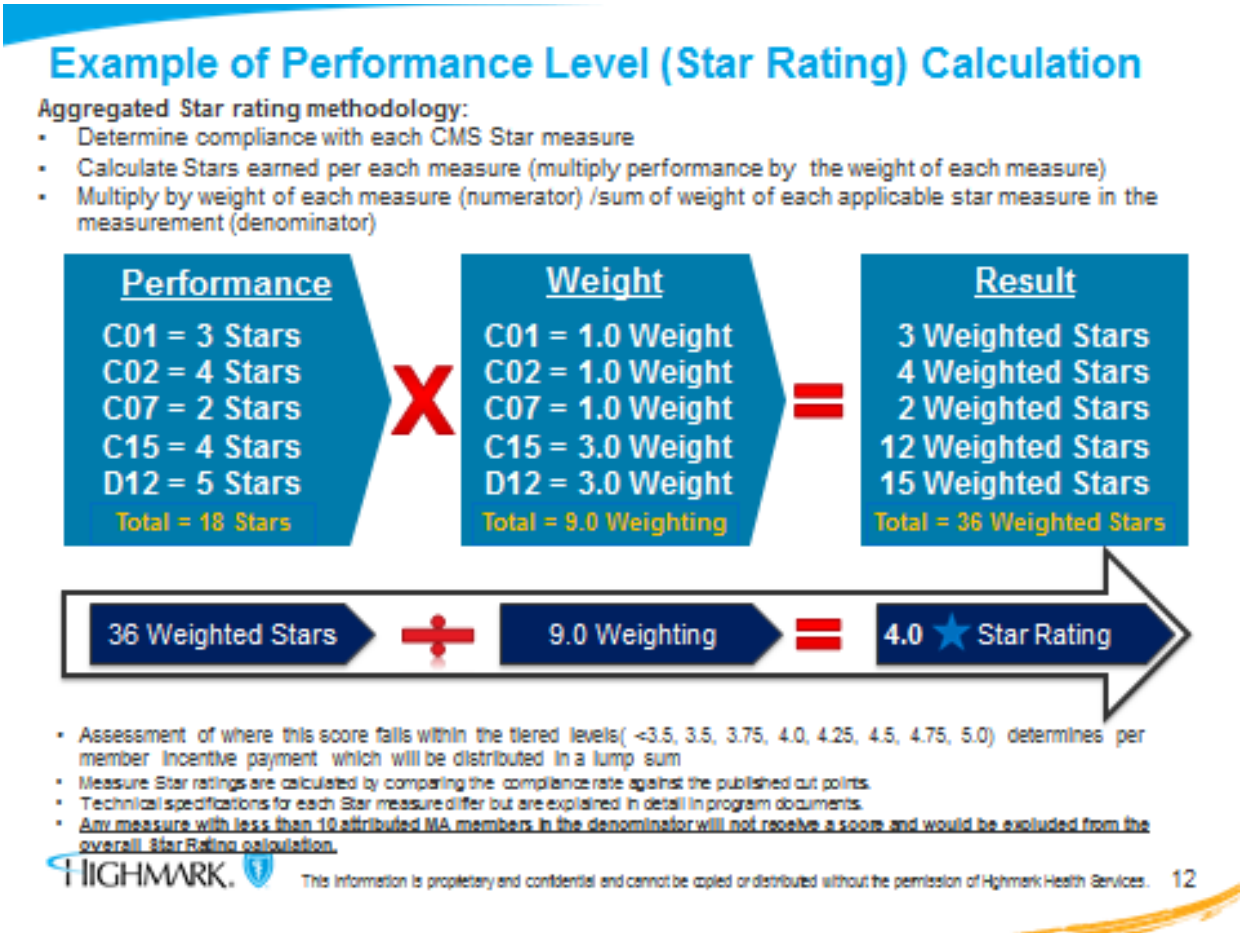
Star ID	Measure Name	Measure Weighting	Achieved 2 Stars	Achieved 3 Stars	Achieved 4 Stars	Achieved 5 Stars
C01	Breast Cancer Screening	1.0	50%	67%	77%	83%
C02	Colorectal Cancer Screening	1.0	51%	62%	74%	82%
C07	Adult BMI Assessment	1.0	75%	84%	94%	97%
C12	Osteoporosis Management in Women who had a Fracture	1.0	21%	37%	56%	77%
C13	Comprehensive Diabetes Care: Eye Exam (retinal) performed	1.0	53%	65%	76%	85%
C14	Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	85%	89%	94%	98%
C15	Comprehensive Diabetes Care: HbA1c Control (≤9%)	3.0	52%	66%	74%	85%
C17	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	1.0	66%	76%	83%	88%
C19	All-Cause Readmissions	3.0	0.92	0.85	0.75	0.66
DMC 20	Statin Therapy for Patients with Cardiovascular Disease	1.0	61%	70%	78%	84%
DMC 21	Medication Management for People with Asthma	1.0	57%	64%	72%	81%
DMC 22	Statin Therapy For Patients with Diabetes	1.0	61%	70%	76%	83%
D12	Medication Adherence for Diabetes Medications	3.0	65%	71%	78%	84%
D13	Medication Adherence for Hypertension Renin Angiotensin System Antagonists	3.0	69%	75%	82%	85%
D14	Medication Adherence for Cholesterol (Statins)	3.0	59%	68%	77%	83%
D15	Medication Therapy Management	3.0	21%	39%	55%	81%

APPENDIX B: Practice Overall Star Rating Calculation Example

Practice Overall Stars Rating Calculation (A)

Practice Overall Stars Rating Calculation (A):

(A) 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)



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

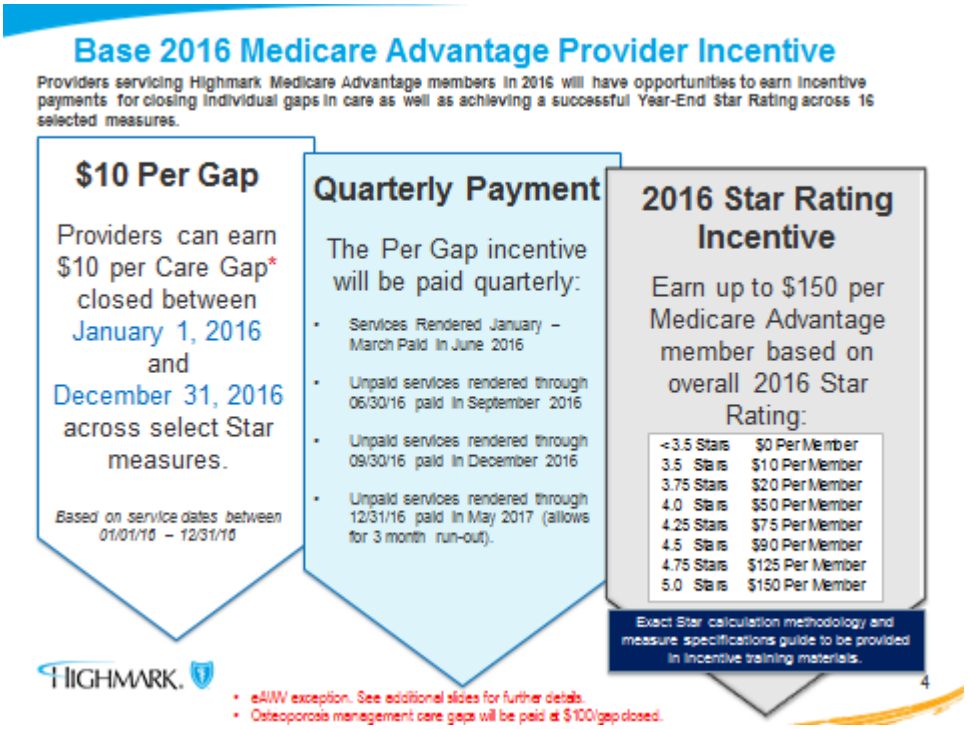
Attribution Date: 31DEC2015
Claims Paid Through: 30JAN2015
Current Aggregated Star Rating: 2.42 Stars

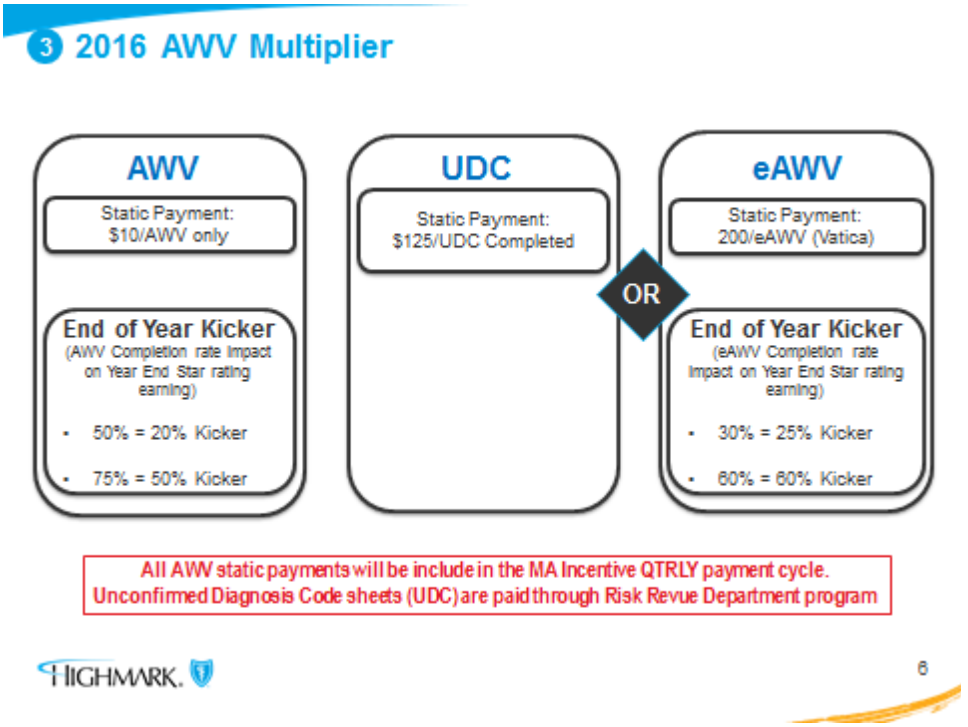
Class	Measure Name	Measure Weight	Eligible Population (Den.)	# of Gaps Closed (Num.)	# of Gaps Addressed and On Track (Trend)	# of Eligible Population Beyond Remediation	Actual YTD Compliance Rate	Trend Compliance Rate	Current Trend Measure Star Rating	Maximum Potential Compliance Rate	4 Star Compliance	5 Star Compliance
Dynamic	C15: Comprehensive Diabetes Care: HbA1c Control (<=8%)	3.0	19		0			0.00%	1		74.00%	85.00%
Dynamic	C19: All-cause Readmissions	3.0	4		4			.0			.75	.66
Dynamic	D12: Medication Adherence for Diabetes Medications	3.0	2		2	0		100.00%		100.00%	78.00%	84.00%
Dynamic	D13: Medication Adherence for Hypertension: RASA	3.0	2		1	0		50.00%		100.00%	82.00%	85.00%
Dynamic	D14: Medication Adherence for Cholesterol (Statins)	3.0	2		2	0		100.00%		100.00%	77.00%	83.00%
Dynamic	DMC21: Medication Management for People with Asthma	1.0	0	0							72.00%	81.00%
Static	D15: Medication Therapy Management	3.0	32	32			100.00%		5		55.00%	81.00%
Static	C01: Breast Cancer Screening	1.0	42	29			69.00%		3		77.00%	83.00%
Static	C02: Colorectal Cancer Screening	1.0	88	61			69.30%		3		74.00%	82.00%
Static	C07: Adult BMI Assessment	1.0	75	59			78.70%		2		94.00%	97.00%
Static	C12: Osteoporosis Management in Women who had a Fracture	1.0	0	0		0					56.00%	77.00%
Static	C13: Comprehensive Diabetes Care: Eye Exam (retinal) performed	1.0	19	1			5.30%		1		76.00%	85.00%
Static	C14: Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	19	5			26.30%		1		94.00%	98.00%
Static	Arthritis	1.0	0	0							83.00%	88.00%
Static	DMC20: Statin Therapy for Patients with Cardiovascular Disease	1.0	6	3			50.00%				78.00%	84.00%
Static	DMC22: Statin Therapy for Patients with Diabetes	1.0	15	6			40.00%		1		76.00%	83.00%
Static	C5t: Annual Wellness and Initial Preventative Physical Rate		247	9			3.60%					
Static	C5t: Enhanced Annual Wellness and Initial Preventative Physical Rate		247	0			0.00%					

Please Note the Following
- Aggregate Star Rating: Includes only measures with 10 or more eligible members
- Measurement Period: The reports are produced to reflect claims adjudicated at a point in time; the reports reflect claims incurred and paid by the report measurement end date.
- Measures are divided into two classes: 'Dynamic' measures cannot be 'closed' prior to year's end due to last visit or continuous care monitoring requirements; and 'Static' measures that have a one time compliance fulfillment requirement.
- Provider Issues: Providers can be terminated from Highmark networks or their identification information could be reassigned. Providers can experience significant change in the number of members that are attributed to them.
- Various factors can affect which members appear in the denominators for each measure and can cause the denominators to change from one report to the next:
  Factors such as new diagnosis, membership attribution, members moving into or leaving a practice, measure exclusion events, continuous enrollment requirements; member age, member deaths, etc.
- Gaps are defined as 'member-measure' gaps because one member might have gaps for more than one measure.
- Most Recent Encounter: A number of measures require the use of the most recent date of service as the encounter to be used for compliance determination. Because of this constraint a compliance status for a member can change from one measurement period to a subsequent measurement period. Impacted measures include Comprehensive Diabetes Care (CDC) test for HbA1c.
- Beyond Remediation: This value represents gaps that cannot be 'closed' based on the remaining time in the measurement period.
(See also the 'Stars - Column Definitions' tab for more detail on each of the columns)

This is an example and individual reports may vary.

APPENDIX D: Component Incentive Payment Cycle





APPENDIX E: Program Reporting Schedule

Report Distribution Date	18-Month Time Period For Attribution	Enrollment Period Date	Capturing Claims Paid
3/20/2016	July 1, 2014 – January 31, 2016	February 15 , 2016	January 1, 2016 – February 27, 2016
4/20/2016	August 1, 2014 –February 29,2016	March 15 , 2016	January 1, 2016 – March 26, 2016
5/20/2016	September 1, 2014 – March 31,2016	April 15 , 2016	January 1, 2016– April 30, 2016
6/20/2016	October 1, 2014 – April 30, 2016	May 15 , 2016	January 1, 2016 – May 28, 2016
7/20/2016	November 1, 2014 – May 31, 2016	June 15 , 2016	January 1, 2016 – June 25, 2016
8/20/2016	December 1, 2014 – June 30, 2016	July 15 , 2016	January 1, 2016 – July 30, 2016
9/20/2016	January 1, 2015 – July 31, 2016	August 15 , 2016	January 1, 2016 – August 27, 2016
10/20/2016	February 1 , 2015 – August 31, 2016	September 15 , 2016	January 1, 2016 – September 24, 2016
11/21/2016	March 1, 2015 - September 30, 2016	October 15 , 2016	January 1, 2016 – October 29, 2016
12/20/2016	April 1, 2015 – October 31, 2016	November 15 ,2016*	January 1, 2016 – November 26,2016
1/23/2017	May 1 , 2015 – November 30, 2016	December 15 , 2016*	January 1, 2016 – December 31, 2016
2/20/2017	June 1, 2015 - December 31, 2016	January 15, 2017 *	January 1, 2016 – January 28, 2017
4/21/2017	August1, 2015 – February 28, 2017	January 15, 2017*	January 1, 2016 – March 31, 2017

* **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 User Interface and/or Provider Resource Center.*

APPENDIX F: Enhanced Annual Wellness

Highmark is pleased to announce that the Enhanced AWV (eAWV) Program will be continued in 2016. Providers participating in the eAWV Program using the Vatica tool should continue conducting eAWVs as the new year begins. New contracts will be required for 2016—see below for more information.

The 2016 Highmark Enhanced AWV (eAWV) Program includes several updates.

Additional compensation: An expanded compensation structure is being introduced in 2016, with two tiers of additional compensation.

Tier One:	Providers receive a base of $200 additional compensation for each eAWV completed
Tier Two:	Providers that reach an aggregated Stars score of 3.5 or above are eligible for additional compensation after completing at least 30% of eAWVs for their attributed Medicare Advantage population. More details will follow in the 2016 eAWV and Stars training.

Full-year timeframe: eAWVs may be performed at any time between Jan. 1, 2016 and Dec. 31, 2016.

Regular quarterly payments: tier one additional compensation will be paid quarterly in alignment with the Stars payment schedule. Tier two compensation will be paid after year-end 2016.

The additional compensation and corresponding requirements will be further described in the new eAWV Program Manual.

New Highmark contracts are required: New Highmark eAWV Program contracts are required for all Providers participating in the 2016 eAWV Program. The new contracts are required due to the change in additional compensation. The old incentive structure will be phased out as of Dec. 31, 2015.

APPENDIX G: Medication Therapy Management

The MTM Program is designed to support the health and safety of members by optimizing drug therapy. MTM eligible members are automatically enrolled into the program and sent an Intro Letter that welcomes them into the program, provides the opportunity to opt-out, and offers the opportunity to request a Comprehensive Medication Review (CMR)

A. Targeting Criteria for Eligibility in the MTM Program:

Only Attributed member who meet the specified targeting criteria per CMS requirements with be included in the measure denominator.

1) Multiple Covered Part D Drugs:

a) Minimum number of covered Part D drugs: 7

b) Type of covered Part D Drugs that apply: Chronic /maintenance Drugs apply

Chronic Diseases that apply include:

1. Bone Disease-Arthritis- Osteoporosis
2. Chronic Heart Failure (HF)
3. Dyslipidemia
4. Hypertension
5. Diabetes
6. End-Stage Renal Disease
7. Mental Health- Depression
8. Respiratory Disease – Asthma
9. Respiratory Disease- Chronic Obstructive Pulmonary Disease (COPD)

c) Determinate: Drug Claims

B. Numerator Compliance requirements:

Attributed members must complete an Interactive, Person to Person, Comprehensive Medication Review, annually, by a pre-approved program specific CMS approved resource. **Must be completed by *Highmark vendor (until further notice) Pharm MD***

Vendor Requirements:

a. *Interactive, Person to Person or telehealth consultation: Means Phone*
b. *Individualized, written summary of CMR in CMS' standardized format (includes beneficiary cover letter, medication action plan, and personal medication list)*
c. *Delivery of individualized written summary of CMR in CMS' Standardized format : via Mail*
d. *Vendor must conduct Prescriber interventions in the form of phone consultation, mailed consultation or faxed consultation to resolve medication-related problems or optimize therapy.*

APPENDIX H: Clinical Measures Applicable CPTII Codes

Clinical Measures Applicable CPT II codes, BMI Diagnosis Codes and AWV G codes

CMS Star Measures: CPT II /Diagnosis / G codes ACCEPTED by HEDIS Specifications		
C01: BREAST CANCER SCREENING-NOT APPLICABLE		
C02: COLORECTAL CANCER SCREENING-NOT APPLICABLE		
C07: ADULT BMI ASSESSMENT Must use highest level of specificity when applying DX code		
	Z 68.1	BMI < 19
	Z 68.20	BMI 20.0 - 20.9
	Z 68.21	BMI 21.0 - 21.9
	Z 68.22	BMI 22.00-22.9
	Z 68.23	BMI 23.0 - 23.9
	Z 68.24	BMI 24.0 - 24.9
	Z 68.25	BMI 25.0-25.9
	Z 68.26	BMI 26 - 26.9
	Z 68.27	BMI 27.0-27.9
	Z 68.28	BMI 28.0-28.9
	Z 68.29	BMI 29.0-29.9
	Z 68.30	BMI 30-30.9
	Z 68.31	BMI 31-31.9
	Z 68.32	BMI 32-32.9
	Z 68.33	BMI 33-33.9
	Z 68.34	BMI 34-34.9
	Z 68.35	BMI 35-35.9
	Z 68.36	BMI 36-36.9
	Z 68.37	BMI 37-37.9
	Z 68.38	BMI 38-38.9
	Z 68.39	BMI 39-39.9
	Z 68.41	BMI 40.0-44.9
	Z 68.42	BMI 45.0-49.9
	Z 68.43	BMI 50.0-59.9
	Z 68.44	BMI 60.0-69.9
	Z 68.45	BMI 70.0 and over
	Z68.51	<5th Percentile for age, Pediatric
	Z68.52	5th Percentile to <85 th Percentile, Pediatric
	Z68.53	85th Percentile to less than 95th Percentile, Pediatric
	Z68.54	95th Percentile or greater for age, Pediatric
C12: OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE- NOT APPLICABLE		
C13: COMPREHENSIVE DIABETES CARE-EYE EXAM (RETINAL) PERFORMED		
	2022F	Dilated Retinal Exam with interpretation by an ophthalmologist or optometrist documented and reviewed (N)
	2024F	Seven field photos with interp by ophthalmologist or an optometrist documented and reviewed (N)
	2026F	Eye image validated to match diagnosis from seven standard field photo result (N)
	3072F	Low risk for retinopathy (no evidence of retinopathy the prior year) (N) **NOTE**: CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the code definition itself indicates results were negative, an automated result is not required.
C14: COMPREHENSIVE DIABETES CARE-MEDICAL ATTENTION FOR NEPHROPATHY- NOT APPLICABLE		
C15: COMPREHENSIVE DIABETES CARE- HbA1c CONTROL (≤9%)		
	3044F	Most recent hemoglobin A1c level <7% (N)
	3045F	Most recent hemoglobin A1c level 7%-9% (N)
C17: DISEASE MODIFYING ANTI-RHEUMATIC THERAPY FOR RHEUMATOID ARTHRITIS- NOT APPLICABLE		
C51: ANNUAL WELLNESS AND INITIAL PREVENTIVE PHYSICAL RATE (not a CMS measure)		
	G0402	Initial Preventive Physical Exam (member first 12 months of enrollment in Medicare Part B) (N)
	G0438	Annual Wellness Visit, Initial (can be completed after first 12 months of enrollment in Medicare Part B) (N)
	G0439	Annual Wellness Visit, subsequent (can be completed on annual basis after initial AWV, Highmark recognizes on a calendar year basis) (N)
	(N) = Numerator Inclusion - Indicates that when a code is used, member will be considered compliant for care, also referred to as 'numerator compliant'	