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2022 Medicare Advantage Stars Primary Care Incentive Program: Clinical Quality Measures

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Agenda

1. **Overview of the 2022 Stars program.**
   Measures Included
   General Guidelines

2. **Descriptions of each Measure**

   Best Practices, Supplemental Data Submissions, Member Benefits, Additional Information

3. **Profiled Measures**

   Best Practices

2022 Medicare Advantage Stars Primary Care Incentive Program: Clinical Quality Measures

C01: Breast Cancer Screening
C02: Colorectal Cancer Screening
C12: Osteoporosis Management in Women who had a Fracture
C13: Eye Exam for Patients With Diabetes
~~**C14:** Comprehensive Diabetes Care: Medical Attention for Nephropathy~~
C15: Hemoglobin A1c Control for Patients With Diabetes
C16: Controlling High Blood Pressure
C21: All Cause Readmission Rate – Medicare Advantage
C22: Statin Therapy for Patients with Cardiovascular Disease
C23: TRC Medication Reconciliation Post-Discharge
C24: TRC Patient Engagement After Inpatient Discharge
C25: Follow Up ED for People with Multiple Chronic Conditions
HOS1: Screening for Future Fall Risk

D10: Medication Adherence for Diabetes Medications
D11: Medication Adherence for Hypertension (RASA)
D12: Medication Adherence for Cholesterol (Statins)
D13: Medication Therapy Management
D14: Statin Use in Persons with Diabetes

C51: Annual Wellness Visit Rate (AWV)*

Profiled

DMC14: Kidney Health Evaluation for Patients With Diabetes

***Not a CMS measure.**

C14 – Measure retired as of April 26, 2022

Measure Design

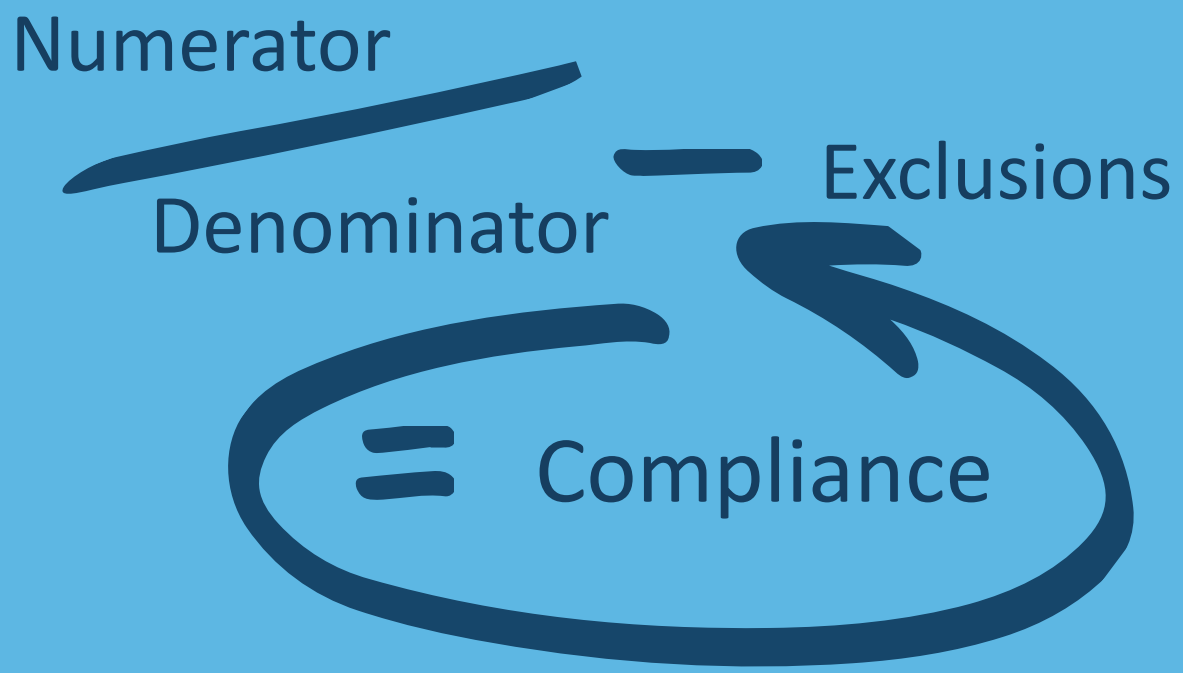
A HEDIS®[1] or PQA measure specification consists of defined sets and subsets of criteria needed to identify and calculate the concept being measured.

Each measure includes:

- **Numerator**- A description of services counted.
- **Denominator**- The definition of an eligible population.
- **Exclusion**- Removes a member from the denominator.

Also defined for each measure:

- Value Set
- Reporting Instructions
- Calculation Logic



1. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

General Guidelines

Hospice	Continuous Enrollment & Anchor Dates	Palliative Care	Race and Ethnicity Data
• Members who use hospice benefits any time during the measurement year, regardless of when the services began, are excluded. • Documentation that a member is near the end of life (e.g., comfort care, DNR, DNI) or is in palliative care does not meet criteria for the Hospice exclusion. • Members may be identified using various methods, which may include but are not limited to enrollment data, claims/encounter data.	• Each measure has an enrollment period with gap defined by HEDIS Part C or PQA Part D specifications. This helps ensure adequate time to render services. • Members must be enrolled and have benefits through anchor dates Identified within each measure specification. • Death and disenrollment will not remove a member from a measure if the continuous enrollment criteria is met.	• Exclusions for palliative care are specified in HEDIS measures where the services being captured may not be of benefit for this population or may not be in line with patients' goals of care. • Members receiving palliative care are captured and excluded via claims as defined by the HEDIS Value sets (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year • Codes for Palliative Care G9054; M1017; Z51.5	• **NEW for 2022 for Health Plan Reporting** • NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Race and ethnicity is intended to be used to further understanding of racial and ethnic disparities in care • The following measures instruct the organization to categorize race and ethnicity stratification: ✓ Colorectal Cancer Screening. ✓ Controlling High Blood Pressure. ✓ Hemoglobin A1c Control for Patients With Diabetes ***Stratification is not applied to scoring.***

STAR Measures with Advanced Illness and Frailty Exclusions

Source: HEDIS® 2022

Frailty	Advanced Illness

• Per HEDIS guidelines Frailty exclusions are determined via administrative claim data only.
 	
• For exclusion to be captured at least one claim that includes frailty (Frailty Value set) must be submitted during the measurement year.
 	
• For Osteoporosis, the diagnosis must be captured during the intake period of July1, 2021-June 30, 2022 through the end of the measurement year December 31, 2022.
	• Per HEDIS guidelines Advanced Illness exclusions are determined via administrative claims data only These can be submitted with telemedicine visit claims.
	
	• For exclusion, any of the following during the measurement year or year prior to the measurement year will be applied:
	  • At least two outpatient visits (OBs, ED, or non acute inpatient on different date of service with an advanced illness diagnosis
	  • At least one acute inpatient encounter with an advanced illness diagnosis
	  • A dispensed dementia medication

	Exclusion if claim submission on file reflects the diagnosis of one of the below categories	
Measure Description	Must have both elements of Frailty AND Advanced Illness in population 66 yrs. of age or older	Can qualify under Frailty alone in population 81 yrs. of age or older
Controlling High Blood Pressure	Yes	Yes
Breast Cancer Screening	Yes	
Colorectal Cancer Screening	Yes	
CDC: HbA1c Controlled	Yes	
CDC: Retinal Eye Exam	Yes	
~~CDC: Medical Attention for Nephropathy~~**	~~Yes~~	
Statin Therapy for Patients with Cardiovascular Disease	Yes	
Osteoporosis Management in Women Who Had a Fracture	Yes	Yes

**Measure Retired 4/26/2022

C01: Breast Cancer Screening

Source: HEDIS® MY 2022 (BCS)

Measure weight: 1 5 .5 Star 86%

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

Numerator	Denominator	Exclusions
One or more mammograms during the measurement year or the 15 months prior to the measurement year. (OCT 1, 2020 – DEC 31, 2022)	Female members 52–74 years of age as of the last date of the measurement year (female members who were 50 years of age or older as of OCT 2020).	• Those who had a bilateral mastectomy any time during the member's history through the last day of the measurement year • Unilateral mastectomy with a bilateral modifier (same procedure) • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)*

C01: Breast Cancer Screening

Source: HEDIS® MY 2022 (BCS)

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

Supplemental Data Submission

Clinical Quality Feedback (CQF) function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and permitted exclusionary data for Highmark members.

Best Practice

- Take the opportunity to cover personal review of member preventive screening needs through the Annual Wellness Visit/Initial Preventive Physical Exam (Welcome to Medicare). Make most of this opportunity to communicate preventive care.
- Supply members with an order to enable flexibility in scheduling through walk in centers and breast cancer screening events.
- Issue member letters from your practice to non-compliant member to explain why regular breast cancer screening is important.

Note: If screening events are free, claim may not be submitted through our member's insurance. Please advise members if they are able to attend a free screening event to list the PCP so that copies of the results may be obtained for submission via the CQF.

Note: As we move into 2022, COVID will still play a crucial role in quality measures. Please make sure to schedule all Mammograms as soon as possible in 2022 as appointments may once again be limited.

Medicare Advantage Member Benefits

Medicare Advantage denotes screening mammography as a covered in full benefit.
Limits: One screening during a calendar year.
Please distinguish between screening and diagnostic testing.

C02: Colorectal Cancer Screening

Source: HEDIS® MY 2022 (COL)

Measure weight: 1 5.5 Star: 89%

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

Numerator	Denominator	Exclusions
One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the five criteria below: • **FOBT** – During the Measurement Year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (FIT), assume that the required number of samples were returned. • **Flexible Sigmoidoscopy** – During the Measurement Year or the four years prior to the measurement year. • **Colonoscopy** – During the Measurement Year or the nine years prior to the measurement year. • **CT colonography** during the measurement year or the four years prior to the measurement year. • **FIT-DNA** during the measurement year or the two years prior to the measurement year. ***Please refer to the Primary Care Incentive Measure Guide for testing compliance dates of service**	Percentage of members 51–75 years of age who had appropriate screening for colorectal cancer.	• Those with a diagnosis of colorectal cancer • Those with evidence of a total colectomy • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)*

C02: Colorectal Cancer Screening

Source: HEDIS® MY 2022 (COL)

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

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and permitted exclusionary data for Highmark members.

Best Practice

- The use of Fecal Occult Blood detection testing is accepted as a HEDIS numerator compliant form of non-invasive colorectal screening. This testing is required to be completed annually. Many practices have distributed home testing kits to gain compliance. Information on how a practice can work with a supplier to purchase and distribute FOBT kits can be found on the Provider Resource Center under Practice Tools for Colorectal Cancer.
- Initiate screening for members beginning at age 45 following guidelines from US Preventive Services Task Force and Highmark benefits
- If your practice does not distribute kits, encourage members to complete FOBT tests distributed by Highmark Health Plan and its partners. Members may call Highmark's customer service anytime after April 1st and request a home FIT Kit be directly shipped.

Medicare Advantage Member Benefits

Medicare Advantage denotes screening colonoscopy, sigmoidoscopy, CT colonography, and fecal occult blood detection testing as a covered in full benefit.
Screening benefit schedule limits:
FOBT Limit 1 per calendar year.
FIT-DNA (Cologuard) Limit 1 every 3 calendar years
Colonoscopy once every 10 years, or 48 months after a previous flexible sigmoidoscopy.
Sigmoidoscopy: Every 48 months.
CT colonography: Limit once every 5 calendar years

Please distinguish between screening and diagnostic testing.

C12: Osteoporosis Management in Women who had a Fracture

Source: HEDIS® MY 2022 (OMW) Measure weight: 1 5 .5 Star: 82%

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis within 180 days of the fracture date.

Numerator	Denominator	Exclusions
Those female members age 67-85 who had suffered a fracture and who had one of the below: • A BMD test, in any setting (including inpatient stays), within 180 days of the fracture date. • Osteoporosis therapy, or long-acting Osteoporosis therapy within 180 days of the fracture date. • A dispensed prescription to treat osteoporosis filled the day of fracture or 180 days after the fracture date. *The drug classifications of Estrogen and Sex Hormone combinations are not included in numerator compliance*	Female members, 67–85 yrs. of age by the end of the measurement year who suffered a fracture. Fractures of finger, toe, face and skull are not included in this measure. Intake period is defined as a 12-month window that begins 6 months prior to the measurement year and ends after 6 months into the measurement year. The intake period is used to capture the first fracture. Intake Period: JULY 1, 2021 – JUNE 30, 2022 * *Remember this measure no longer has a minimum denominator requirement. All members will be scored for this measure.*	• Those who had a BMD test 24 months (730 days) prior to the earliest date of service during the index period with diagnosis of fracture (index episode start date) • Those who had a claim encounter for osteoporosis therapy during the 365 days prior to the episode date • Those who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the index episode start date • Those without pharmacy benefits through Highmark • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)*

C12: Osteoporosis Management in Women who had a Fracture

Source: HEDIS® MY 2022 (OMW)

Best Practice

- Proper coding is essential in correctly identifying members who have recently suffered a fracture. Recent or new fractures are fractures that are not yet healed and should be coded as such. However, if a fracture is healed, coding should indicate that the member has a history of fracture. In this case, providers are encouraged to use the appropriate z-code from the list below* when coding for “History of Fracture”.
  - Example ICD 10 Codes:
    - Z87.310 Personal history of (healed) osteoporosis fracture
    - Z87.311 Personal history of (healed) other pathological fracture
    - Z87.312 Personal history of (healed) stress fracture
    - Z87.81 Personal history of (healed) traumatic fracture

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

Fracture Prevention/Assess Contributing Factors:

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

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

* Alendronate is a Tier 1 low cost option on all Highmark Medicare formularies (Fosamax and Binosto)

Note: Monotherapy with calcium supplements or Vitamin D supplements (cholecalciferol or ergocalciferol) will not meet compliance for this measure.

C12: Osteoporosis Management in Women who had a Fracture

Source: HEDIS® MY 2022 (OMW)

Percentage of female members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis within 180 days of the fracture date.

Best Practice

- Patients with current fractures maybe under an orthopedic specialist care. Discuss with the orthopedic provider a timeline for required X-ray testing (monitoring of healing) and request DEXA scan be completed during the same outing; or discuss the opportunity of prescribing an osteoporosis medication after the four-month healing process.
- Select Medicare Advantage female members who have a fracture between 1/1/22 – 12/31/22 are eligible for a $100 reward for completing a Bone Mineral Density Test.
  - Cohort 1 – Fracture between 1/1/2022 – 6/30/2022 – Must complete BMD by 12/31/2022 to earn the reward.
  - Cohort 2 – Fracture between 7/1/2022 – 12/31/2022 – Must complete BMD by 4/30/2023 to earn the reward.

Supplemental Data Submission

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

Please maintain documentation within the member's medical record for future submission.

Medicare Advantage Member Benefits

Covered in full. Office visit or site of service co-pay may apply.
Medicare Advantage preventive schedule limit: One BMD test every 24 months

Diabetes Care Measures

Source: HEDIS® MY 2022

Measures will now be separated into separate categories:

- Eye Exam for Patients With Diabetes
- ~~Medical Attention for Nephropathy~~**
- Hemoglobin A1c Control for Patients with Diabetes ≤9

Diabetics are defined by:

Pharmacy data: members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or the year prior on an ambulatory basis

Note: Monotherapy glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA has posted a complete list of medications and NDC codes to www.ncqa.org

OR

Claim/encounter data*:* members who had either of the following during the measurement year or year prior

-Two outpatient encounters including outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, ED visits or non-acute inpatient encounters (without telehealth) on different dates of service with a dx of diabetes

-One face-to-face encounter in an acute inpatient setting OR one acute inpatient discharge with a diagnosis of diabetes

**Measure Retired 4/26/2022

C13: Eye Exam for Patients With Diabetes

Source: HEDIS® MY 2022 (EED) (prior CDC measure - No spec changes) Measure weight: 1 5.5 Star: 87%

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

Numerator	Denominator	Exclusions
Screening or monitoring for diabetic retinal disease identified through one of the following: • Diabetics who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation any time during the member's history through December 31st *Eye exam claims submitted by optometrist or ophthalmologist with the corresponding E11.9 Dx code are recorded as negative for retinopathy*	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 16 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year • Diagnosis of polycystic ovarian syndrome during the measurement year or the year prior to the measurement year *To remove a member with any of the above from the denominator, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.* • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)* • Members with ESRD

C13: Eye Exam for Patients With Diabetes

Source: HEDIS® MY 2022) (prior CDC measure - No spec changes)

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

Best Practice

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

Supplemental Data Submission

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

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

Medicare Advantage Member Benefits

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

C14: Comprehensive Diabetes Care – Medical Attention for Nephropathy

Source: HEDIS® 2021 (prior CDC measure - No spec changes) Measure weight: 1 5 .5 Star: 99%

Identifies adult diabetic members who had medical attention for nephropathy.

Numerator	Denominator	Exclusions
Those with evidence of nephropathy or a nephropathy screening test during the measurement year. • A claim encounter with a code to indicate evidence of treatment for nephropathy. • A nephrologist visit during the measureme year. • Evidence of ACE inhibitor or ARB therapy the measurement year. • Lab claim for a urinalysis that included microalbumin	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year.	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year • Diagnosis of Polycystic Ovarian Syndrome during the measurement year or the year prior to the measurement year *emove a member with any of the above from the ominator, member must not have a face-to-face ounter in any setting, with a diagnosis of diabetes, during measurement year or year prior to the measurement r.* • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)* • Members with ESRD

Retired Measure as of 4/26/22

Note: Documentation of ACEI/ARB medication regimen in current measurement year results as numerator compliance for this measure.

C14: Comprehensive Diabetes Care – Medical Attention for Nephropathy

Source: HEDIS® 2021 (prior CDC measure - No spec changes)

Identifies adult diabetic members who had medical attention for nephropathy.

Best Practice

- Complete AWV and assessment of diabetic member preventive care/disease progression indicators for all Highmark quality incentive programs.
- Hardwire EHR to trigger preventive schedules- this is an annual test requirement.
- Assure processes are in place to submit appropriate test billing.
- Report when appropriate the CPTII code 4010F - ACE inhibitor or ARB therapy prescribed or currently being taken.
- Review recent hospitalizations within the measurement year for urine screens while member was in the inpatient setting. Services billed in an inpatient setting will be billed as a bundle
- Issue member letters from your practice n why regular micro albumin screening is important.

Retired Measure as of 4/26/22

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data for Highmark members who have evidence of ACEI/ARB therapy recorded appropriately in the medical record or have study micro albumin study completed outside of claim submission.

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

Medicare Advantage Member Benefits

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

C15: Hemoglobin A1c Control for Patients With Diabetes ≤9%

Source: HEDIS® MY 2022 (HBD) (prior CDC measure - No spec changes) Measure weight: 3 5.5 Star: 92%

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

Numerator	Denominator	Exclusions
Diabetic members who received at least one HbA1c screening during the measurement year with the last HbA1c test result for the measurement year ≤ 9%. Control is demonstrated by CPTII Codes: 3044F HbA1c: < 7.0% 3051F HbA1c: ≥ 7.0 and < 8.0% 3052F HbA1c: ≥ 8.0 and ≤ 9.0%	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 16 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year • Diagnosis of Polycystic Ovarian Syndrome during the measurement year or the year prior to the measurement year *To remove a member with any of the above from the denominator, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.* • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)* • Members with ESRD

C15: Hemoglobin A1c Control for Patients With Diabetes ≤9%

Source: HEDIS® MY 2022 (HBD) (prior CDC measure - No spec changes)

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

Best Practice

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

Supplemental Data Submission

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

Medicare Advantage Member Benefits

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

C16: Controlling High Blood Pressure

Source: HEDIS® MY 2022 (CBP)

Measure weight: 1

5.5 Star: 88%

Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year (systolic <140 and diastolic <90 mm Hg).

Numerator	Denominator	Exclusions
A representative systolic BP of <140 mm Hg and a representative diastolic BP of <90 mm Hg AND is the most recent BP reading during the measurement year (occurring on or after the second diagnosis of hypertension) during an outpatient office visit billed to Highmark. *** as defined by Hedis, TOC visits are not able to be used in reporting values for blood pressure measurement.*** If no BP is recorded during the measurement year, assume that member is "not controlled". **Codes used to identify numerator compliance.** ***Most recent Systolic:*** 3074F :<130 mm Hg 3075F: 130-139 mm Hg ***Most recent Diastolic:*** 3078F: <80 mm Hg 3079F: 80-89 mm Hg	Members who had at least two visits on different dates of service with a diagnosis of hypertension during the first 6 months of the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits.	• Female members with a diagnosis of pregnancy • Members receiving palliative care during the measurement year. • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted).* • Members with ESRD • Exclude BPs taken in an acute inpatient setting or during an ED visit **Do not include BP readings on the following:** • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or a change in medication on one day before the day of the test or procedure (with the exception of fasting blood tests) • Taken by the member using a non-digital device such as a manual blood pressure cuff and a stethoscope.

C16: Controlling High Blood Pressure

Source: HEDIS® MY 2022 (CBP)

Percentage of members 18-85 years of age who had a diagnosis of HTN and whose BP was adequately controlled (systolic <140 and diastolic <90 mm Hg) during the measurement year.

Best Practice

- Identify patients 65 years and older who had at least two significant diagnoses of hypertension.
- This is an outcome control measure which requires disease management and the demonstration of controlled values. HEDIS (CMS) requires the last result of the year to be the determinant of compliance and control. 1500 clam submission of CPTII codes must match the date of service of an outpatient office visit claim.
- Develop and implement evidenced based guidelines to treat members identified with high blood pressure.
- Ensure that practice is submitting the appropriate CPTII code to Highmark for both systolic and diastolic values. Compliance for this measure requires both values to be within range.
- Provide ongoing outreach to non-compliant members.
- Implement care coordination to manage patients with values greater than 140mm Hg or values greater than 90 mm Hg diastolic.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance for services that are not submitted via claims such as nursing visits that are not billed to Highmark, or Specialist Visits where the PCP cannot submit matching claim data via NaviNet 1500 claims*.

If the most recent blood pressure value occurred during a nursing visit only and a claim was not submitted to Highmark, or through a specialist visit not within the PCP practice, the CQF is available to submit the EMR visit note along with numerator compliant systolic and diastolic values.

C23: TRC Medication Reconciliation Post-Discharge

Source: HEDIS® MY 2022 (TRC)

Measure weight: 1 5.5 Star 97%

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

Numerator	Denominator	Exclusions
Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days) in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.	Acute or nonacute inpatient discharges on or between January 1st and December 1st of the measurement year. *Measure is based on discharges, not members. If members have more than one discharge, include all discharges.*	• If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care settings on the date of discharge through 30 days after discharge, count only the last discharge. • If the member remains in an acute or nonacute facility through December 1st of the measurement year. *Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after DEC 1 of the measurement year.*

Note: Medication Reconciliation Post-Discharge measure is now a component of the Transitions of Care Measure

C23: TRC Medication Reconciliation Post-Discharge

Source: HEDIS® MY 2022 (TRC)

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

Best Practice

- Track Medication Reconciliation completion by downloading the MA Monthly Stars Gap Report.
- Review the weekly Discharge summary reports on NaviNet to identify patients that have recently been discharged from an inpatient setting.
- Partner/coordinate with other providers in the care continuum that have held a patient visit within 30 days of discharge to obtain medication reconciliation information for inclusion in the outpatient record.
- Coordinate with hospital partners for SNF discharges/transfers.

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

Note: A medication reconciliation performed without the member present meets criteria.

Claims Submission

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

C23: TRC Medication Reconciliation Post-Discharge

Source: HEDIS® MY 2022 (TRC)

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

Medical Record Documentation Requirements

Any of the following will meet criteria:

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

Note: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. Please make sure documentation reflects that the Med Reconciliation is being completed after discharge.

C21: All-Cause Readmission Rate

Source: HEDIS® MY 2022 (PRC)

Measure weight: 1 5 Star 0.83

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

Numerator	Denominator	Exclusions

Medicare Advantage members with an unplanned acute inpatient readmission or observation stay for any diagnosis within 30 days of a previous inpatient or observation index discharge date	Count of Index Hospital Stays or Observation Stays for Medicare Advantage members 18 years of age and older with an acute inpatient stay or observation stay with a discharge on or between the first day of the measurement year and 31 days prior to the last day of the measurement year.	• Hospital stays where the Index Admission Date is the same as the Index Discharge Date
		• Inpatient stays and Observation stays with discharges for death
		• Acute inpatient discharges or Observation stays with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period
		• *Outlier (Excluded from scoring) Members with 4 or more index hospital stays (including both inpatient and observation). Stays must occur between the first day of the measurement year and Dec 1st of the measurement year.
		• Discharged inpatient or observation (index hospital) stays if the admission date of the first planned hospital stay is within 30 days and includes any of the following:
		  • Principal dx of maintenance chemotherapy or rehabilitation
		  • An organ transplant
		  • A potentially planned procedure w/out a principal acute diagnosis

All-Cause Readmission Rate

Source: HEDIS® MY 2022 (PCR)

Performance Metrics

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

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

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

Examples

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

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

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C22: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® MY 2022 (SPC) Measure weight: 1 5.5 Star 94.5%

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

Numerator	Denominator	Exclusions
Members who filled at least one ambulatory prescription for high or moderate-intensity statin medication. *Note: **Because this is a Part C Measure**, prescriptions filled under commercial coverage will transition to numerator compliance for members that become newly enrolled in Medicare Advantage.*	Male members ages 21–75 and females age 40–75 identified by event or diagnosis during the year prior to the measurement year who were: -Discharged from an inpatient setting with myocardial infarction -Had a CABG, PCI or other revascularization procedure in any setting OR -*By Diagnosis*, as having Ischemic Vascular Disease during both the measurement period and the year prior. Criteria need not be the same across both years but meet at least one of the following criteria: -at least one acute inpatient encounter with an IVD diagnosis without telehealth -at least one outpatient visit, telephone, e-visit, or virtual check in with an IVD diagnosis -at least one acute inpatient discharge with an IVD diagnosis	• Those with a diagnosis of cirrhosis in the measurement year or year prior • Those with a diagnosis of myalgia, myositis, myopathy or rhabdomyolysis during the measurement year • Those with a diagnosis of pregnancy during the measurement year or year prior • Those who have In vitro fertilization in the measurement year or year prior • Those who filled at least one prescription for clomiphene during the measurement year or year prior • Those without pharmacy benefits through Highmark. • Members receiving palliative care during the measurement year • Members with ESRD • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted*)

C22: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® MY 2022 (SPC)

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

Description	Prescription (one Pharmacy claim required)	
High-Intensity Statin Therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-Intensity Statin Therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg	• Pravastatin 40-80 mg • Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by NOV 1, 2022.

C22: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® MY 2022 (SPC)

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

Best Practice

- Educate diabetic members on the increased risk of cardiovascular disease, so that they may understand the benefits of statin therapy in reducing their risk of stroke, heart attack and cardiovascular death
- Only select diagnoses can be submitted if statin therapy is contraindicated which would include myalgia, myositis, myopathy, and rhabdomyolysis (most popular listed below). Claim must be submitted within the measurement year with the appropriate diagnosis codes. Documentation in chart must be clear in stating symptoms. Phrasing of “intolerance", "reaction”, and “cannot take” are not evidence enough for an exclusion.

G72.0	Drug-induced myopathy	ICD10CM
G72.2	Myopathy due to other toxic agents	ICD10CM
G72.9	Myopathy, unspecified	ICD10CM
M62.82	Rhabdomyolysis	ICD10CM
M79.1	Myalgia	ICD10CM
M60.9	Myositis, unspecified	ICD10CM

- Review monthly gap reports and assure the member is on correct moderate or high dose medication to meet compliance

C22: Statin Therapy for Patients with Cardiovascular Disease

Source: HEDIS® MY 2022 (SPC)

Statin Intolerance and Statin-Induced Rhabdomyolysis

- Patient counseling:
  - *Educate patient on the following:*
    - ASCVD risk score and rationale behind statin therapy
    - Risk factors associated with statin-induced rhabdomyolysis
    - Signs/symptoms of rhabdomyolysis
- Additional Considerations:
  - Studies show that almost half of patients can tolerate the same statin upon rechallenge.
  - Rosuvastatin, Pravastatin, and Fluvastatin are the least likely to have drug interactions.
- Alternative Dosing Options to Consider:
  - Lipitor (Atorvastatin): QOD (every other day)
  - Crestor (Rosuvastatin): QOD (every other day), twice weekly, OR once weekly

****If considering use of an alternate dosing schedule, please be sure the prescription is written and dispensed at the pharmacy with these directions. This will allow adherence to be measured properly – important for future measure if SUPD or SUPC moves to a denominator for statin adherence measure.*

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C23: TRC Patient Engagement After Inpatient Discharge

Source: HEDIS® MY 2022 (TRC)

Measure weight: 1 5.5 Star 89%

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.

Numerator	Denominator	Exclusions
Documentation of patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. One of the following must be met, • An outpatient visit (including home visits) • A telephone visit • Transitional care management services • A synchronous telehealth visit • An e-visit or virtual check-in *** Requires claim submission for numerator compliance**	An acute or non acute inpatient discharge on or between January 1 and December 1 of the measurement year. *Measure is based on discharges, not members. If members have more than one discharge, include all discharges.*	• If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care settings on the date of discharge through 30 days after discharge, count only the last discharge. • If the member remains in an acute or nonacute facility through December 1st of the measurement year. *Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after DEC 1 of the measurement year.*

C23: Patient Engagement After Inpatient Discharge

Source: HEDIS® MY 2022 (TRC)

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

Best Practice

- Review the weekly Discharge summary reports on NaviNet to identify patients that have recently been discharged from an inpatient setting.
- Schedule post-discharge appointments within three to seven days as best practice to meet other measure requirements if possible.
- Educate members about their condition and provide extensive ongoing member outreach to manage chronic conditions.
- Provide extensive ongoing member outreach to manage potential admissions and ED usage.
- Partner/coordinate with other providers in the care continuum that have held a patient visit within 30 days of discharge to information for inclusion in the outpatient record.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance for services that are not submitted via claims such as bundled services after surgery or other visits that may have not been submitted to Highmark.

C24: Follow Up ED for People with Multiple Chronic Conditions

Source: HEDIS® MY 2022 (FMC) Measure weight: 1 5.5 Star 73%

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.

Numerator	Denominator	Exclusions
A follow up service within 7 days after the ED visit (8 days total days). Include visits that occur on the date of the ED visit. Visits can meet criteria in any of the following settings: • Outpatient Visit • A telephone Visit • Transitional Care Management • Case Management Visits • Complex Care Management Services • An outpatient or telehealth behavioral health visit • An intensive outpatient encounter or partial hospitalization *** Requires claim submission for numerator compliance**	An ED visit on or between Jan 1 and Dec 24th of the measurement year where the member was 18 years or older on the date of the visit and had at least two or more chronic conditions listed below within the measurement year or year prior to the measurement year: • COPD and Asthma • Alzheimer's disease and related disorders • Chronic Kidney Disease • Depression • Heart Failure • Acute Myocardial Infarction • Atrial Fibrillation • Stroke and Transient Ischemic Attack *Measure is based on ED visits, not members. If members have more than one ED visit, include all ED visits during appropriate time frame listed above.*	• Exclude ED visits that result in an inpatient stay, regardless of the principal diagnosis for the admission • Exclude ED visits followed by admission to an acute or nonacute inpatients care setting on the e date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for the admission

C24: Follow Up ED for People with Multiple Chronic Conditions

Source: HEDIS® MY 2022 (FMC)

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.

Best Practice

- Review the weekly Discharge summary reports on NaviNet to identify patients that have recently been discharged from an inpatient setting.
- Schedule post-discharge appointments within three to seven days
- Educate members about their condition and provide extensive ongoing member outreach to manage chronic conditions.
- Provide extensive ongoing member outreach to manage potential admissions and ED usage.
- Partner/coordinate with other providers in the care continuum that have held a patient visit.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliance for services that are not submitted via claims such as bundled services after surgery or other visits that may have not been submitted to Highmark.

D14: Statin Use in Persons with Diabetes

Source: PQA 2021 (SUPD) Measure weight: 1 5.5 Star 93%

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

Numerator	Denominator	Exclusions
Members who receive a prescription fill for a statin or statin combination during the measurement year. ***Members that turn 76 within the measurement year require a Part D statin fill prior to turning 76 for Health Plan compliance.***	Members aged 40–75* as of the first day of the measurement year who were dispensed two or more prescription fills on different dates of service for a hypoglycemic agent during the measurement year. *The index prescription for the first hypoglycemic medication must occur at least 90 days prior to the end of the measurement year for denominator inclusion.*	• Members with rhabdomyolysis or myopathy • Members with a diagnosis of pregnancy, lactation, or fertility (identified via a prescription claim for clomiphene) • Members with a diagnosis of Cirrhosis • Members with a diagnosis of pre-diabetes • Members with a diagnosis of Polycystic Ovarian Syndrome (PCOS) • ESRD

D14: Statin Use in Persons with Diabetes

Source: PQA 2021 (SUPD)

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

PQA Table: Statin Medications

Statin Medications			
• lovastatin • rosuvastatin	• fluvastatin • atorvastatin	• pravastatin • pitavastatin	• simvastatin

Statin Combination Products		
• niacin & lovastatin • atorvastatin & amlodipine	• niacin & simvastatin	• ezetimibe & simvastatin

D14: Statin Use in Persons with Diabetes

Source: PQA 2021 (SUPD)

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

Best Practice

- Educate diabetic members on the increased risk of cardiovascular disease, so that they may understand the benefits of statin therapy in reducing their risk of stroke, heart attack and cardiovascular death
- **Only select diagnoses can be submitted if statin therapy is contraindicated which would include myopathy and rhabdomyolysis. Claim must be submitted within the measurement year with the appropriate diagnosis codes. Phrasing of "intolerance", "reaction", and "cannot take" are not evidence enough for an exclusion.**
- **Review members chart for other exclusions that can be submitted to exclude member from the measure.**
- Consider statins with fewer drug interactions such as rosuvastatin, pravastatin, and fluvastatin to reduce risk of adverse events
- Members who do not tolerate one statin may be able to tolerate a different statin
- Review monthly gap reports and assure the member is on correct medication to meet compliance

D10: Medication Adherence for Diabetes Medications

Source: PQA 2021 Measure weight: 3 5.5 Star 94%

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

Numerator	Denominator	Exclusions
Those members with a prescription for diabetes medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medications. * **Derived from the prescription daily dosage.*	Members 18 years of age or older as of the first day of the measurement year with at least two fills on different dates of medication(s) across any of the drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	• Those without pharmacy benefits through Highmark. • Members who take insulin • ERSD

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

D11: Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA)

Source: PQA 2021 Measure weight: 3 5.5 Star 94%

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

Numerator	Denominator	Exclusions
Those members with a prescription for recommended hypertension medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medications. * **Derived from the prescription daily dosage.*	Members18 years of age or older as of the first day of the measurement year with at least two fills on different dates of medication(s) across either the same medication or medications (s) in the drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	• Those without pharmacy benefits through Highmark. • Members who take sacubitril/valsartan. • ESRD

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

D12: Medication Adherence for Cholesterol: Statins

Source: PQA 2021 Measure weight: 3 5.5 Star 94%

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

Numerator	Denominator	Exclusions
Those members with a prescription for a cholesterol medication (a statin drug or statin combination) who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medications.* **Derived from the prescription daily dosage.*	Members18 years of age or older as of the first day of the measurement year with at least two fills on different dates of either the same medication or medication(s) in the drug classes during the measurement period. Members are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the measurement period.	• Those without pharmacy benefits through Highmark. • ESRD

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

D10, D11, D12: Medication Adherence Measures

Source: PQA 2021

Percentage of members who were dispensed a medication who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking the medication.

Best Practice

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

D10, D11, D12: Medication Adherence Measures

Source: PQA 2021

Highmark offers one of the most comprehensive drug formularies in the market. This includes several Preferred Generic Medications which are the lowest cost medications offered. During the Initial Coverage Phase, Preferred Generics can be as low as a $0 copay when filled at a Preferred Pharmacy for members with the Preferred Pharmacy benefit.

The chart below includes several commonly prescribed Preferred Generics that are covered on all Highmark Medicare Formularies.

	Cholesterol	Diabetes	Hypertension	
Preferred Generics	Atorvastatin Lovastatin Pravastatin Rosuvastatin Simvastatin	Glimepiride (prior Auth required) Glipizide Glipizide Er Glipizide-Metformin Metformin Metformin Er (generic Glucophage Xr) Nateglinide Pioglitazone	Amlodipine-Benazepril Benazepril Benazepril-Hctz Candesartan Candesartan-Hctz Captopril Enalapril Enalapril-Hctz Fosinopril Fosinopril-Hctz Irbesartan	Lisinopril Lisinopril-Hctz Losartan Losartan-Hctz Moexipril Quinapril Quinapril-Hctz Ramipril Trandolapril Valsartan (excludes 320 mg)

D13: Medication Therapy Management (MTM)

Source: CMS 2022 & Highmark developed measure. Measure weight: 1 5.5 Star 96%

Percentage of MTM eligible members who received a Comprehensive Medication Review (CMR) during the measurement year.

Numerator	Denominator	Exclusions
Eligible members who complete a CMR by an approved CMS vendor during the measurement year.* **While Highmark understands medication reconciliation is often completed by our network providers, this is a Medicare program that requires CMRs be conducted by a prior CMS approved party*	Members who meet eligibility requirements: Those with three or more chronic conditions, who take a minimum of seven Part D medications, and are likely to incur annual costs of at least $4,696 for all covered Part D drugs. Targeted chronic conditions include: Bone Disease – Arthritis – Osteoporosis Bone Disease – Arthritis – Rheumatoid Arthritis Chronic Heart Failure Diabetes Dyslipidemia Mental Health – Depression Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD	• Those that opt out within 60 days of program eligibility** **Opt outs as determined by internal review will be reflected in member detail reports upon confirmation. • Those enrolled less than 60 days of eligibility date and not active with Highmark (deceased or dis-enrolled per ECS) are excluded provided that no CMR is completed. If a CMR is completed during the member's enrollment, then member is not excluded.

Note: Members in long-term care facilities are not excluded from the denominator.

D13: Medication Therapy Management (MTM)

Source: CMS 2022

Percentage of MTM eligible members who received a Comprehensive Medication Review (CMR) during the measurement year.

Reporting Developed to Track Numerator/Denominator

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

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

Best Practice

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

D13: Medication Therapy Management (MTM)

Source: CMS 2022

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

Program Specifics

- Medicare Part D covered benefit
- Designed to provide assistance to members with certain disease states who take many medications and have high prescription costs.
- Providers members access to a health care professional who can help support their health and safety and complement the care they receive by having a pharmacist work with them and their doctor.
- This program is free, and members are automatically enrolled if eligible.
- They will receive information on how to access the program and will be contacted to schedule/complete a CMR.

CMR/TMR

- During this one-on-one telephone consultation with a pharmacist or nurse, the member's entire medication profile is reviewed (CMR – Comprehensive Medication Review), including prescriptions, over-the-counter (OTC) medications, herbal supplements, and samples. The pharmacist or nurse will check for appropriateness of therapy and potential interactions. They will also discuss therapy goals, medication-related problems and any specific questions the member may have. Targeted Medication Reviews (TMR) are also conducted focusing on identifying cost savings, safety concerns, prescribing adherence to national treatment guidelines and whether members have been following their medication regimens.
- CMR Follow-up Letter - This letter includes a Personal Medication List and Medication Action Plan detailing the member's conversation with the pharmacist or nurse.
- Member / Doctor Outreach - If an issue is found during a medication review (CMR or TMR), the team may contact the member and/or doctor via phone, fax, or mail to discuss recommendations for adding or changing drug therapy, potential drug interactions or safety issues.

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Health Outcomes Survey (HOS)

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

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

Some things that may be suggested:

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

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

Best Practice Recommendations:

Complete during Annual Wellness Visits: Falls Risk Assessment; Improving Bladder Control; and Monitoring Physical Activity

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HOS1: Screening for Future Fall Risk

Source: NCQA (NQF: 0101) Measure weight: 1 5.5 Star 73%

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

Numerator	Denominator	Exclusions
Completed assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure. 3288F - Falls risk assessment documented 1100F - Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year 1101F - Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year **New for 2022** G0438 - Initial AWV G0439 - Subsequent AWV G0402 - IPPE (Welcome to Medicare) G0468 - FQHC IPPE or AWV	Members 65 years of age or older by the end of the measurement year who had a visit with an eligible provider* during the measurement year. **Any clinician with appropriate skills and the experience may preform the screening assessment.*	• Those with documentation of medical reason(s) for not screening for fall risk (i.e., patient is not ambulatory) **1100F-1P, 1101F-1P** – Patient not screened for future fall risk for medical reasons *Use of 8P Modifier – Will not result patient as numerator compliant and will also cause other submissions to be voided for the measurement year.*

HOS1: Screening for Future Fall Risk

Source: NCQA (NQF: 0101)

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

Best Practice

Fracture Prevention/Assess Contributing Factors:

- Remember that Fall Risk Assessments are part of the Annual Wellness Visit. If the requirements of the AWV are completed, then the requirements of for Fall Risk have been completed and a CPTII can be dropped with the AWV visit.
- Screen members at risk for osteoporosis (bone mineral density test)
- Assess Risk of Falls
- Screen for Urinary Incontinence
- Review and evaluate Use of High Risk Medications

Important Fact about Falls

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

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

C51: Annual Wellness/Initial Preventive Physical Rate

Source: Highmark developed measure *

No weight assigned

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

Numerator	Denominator	Exclusions
Members who completed the annual wellness visit after the first 12 months of enrollment in Medicare Part B. OR Members who completed the Initial Preventive Physical Examination (IPPE) during the first 12 months of enrollment in Medicare Part B. **Numerator Visit codes**: G0402, G0438, G0439, G0468 (FQHC)	Members 65 years of age or older by the end of the measurement year.	Member must be continuously enrolled during the measurement year Member may not exceed more than a 45 day gap in enrollment Member must be enrolled in the plan at the end of the year

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

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

C51: Annual Wellness/Initial Preventive Physical Rate

Source: Highmark developed measure *

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

Reporting Developed to Track Numerator/Denominator

Highmark follows established CMS policy guidance on the billing/payment of AWV codes. The only exception is that Highmark allows the AWV to be billable once a calendar year.

CMS provides guidance on provider documentation requirements, and appropriate coding/billing. Reference sites have been attached below.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/downloads/awv_chart_icn905706.pdf

This means edits are in place to assure Highmark is :

- Paying for "Welcome to Medicare Visit" (G0402, Initial preventive physical exam) only when billed within the first 12 months of a member being enrolled in Medicare Part B.
- Not paying for multiple Annual Wellness Visits being billed within the same year.

As of 1-1-19 OSCAR benefits had coding put in place to pay for G0438 (AWV, initial) once per lifetime per provider practice and G0439 (AWV, subsequent) once per calendar year per provider practice.

Profiled/Informational Measures

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

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DMC14: Kidney Health Evaluation for Patients With Diabetes

Source: HEDIS® MY 2022 (KED) No weight assigned 5.5 Star 65%

Percentage of members 18-85 years of age with diabetes (Type1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Numerator	Denominator	Exclusions
Members who received both and eGFR and a uACR during the measurement year on the same or different dates of service. • At least one eGFR (blood test) • At least one uACR identified by either of the following (urine): -Both a quantitative urine albumin test **AND** a urine creatinine test **with** service dates four days or less apart (can be before or after) OR -A uACR urine screen	Diabetic members age 18–75 years by the end of the measurement year and who were enrolled in the plan at the end of the measurement year. *Please refer to Diabetic member definitions on Slide 16 – also applicable to this measure.*	• Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year • Diagnosis of Polycystic Ovarian Syndrome during the measurement year or the year prior to the measurement year *To remove a member with any of the above from the denominator, member must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.* • Members receiving palliative care during the measurement year • Frailty and Advanced Illness exclusions apply (*supplemental data cannot be accepted)* • Members with ESRD

DMC14: Kidney Health Evaluation for Patients With Diabetes

Source: HEDIS® MY 2022 (KED)

Identifies adult diabetic members who received a kidney health evaluation.

Best Practice

- Complete AWV and assessment of diabetic member preventive care/disease progression indicators for all Highmark quality incentive programs.
- Hardwire EHR to trigger preventive schedules- this is an annual testing requirement.
- Assure processes are in place to submit appropriate testing coding.
- Review recent hospitalizations within the measurement year for urine screens while member was in the inpatient setting. Services billed in an inpatient setting will be billed as a bundle and may not be recorded for gap closure.
    - Example: eGFR (CPT 80053) is a component of the CMP (comprehensive metabolic panel) that is completed during most hospital inpatient stays and ED visits.

Supplemental Data Submission

CQF function is available through the Provider Portal on NaviNet and accepts submission of numerator compliant screening tests and exclusionary data.

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

Medicare Advantage Member Benefits

Thank you for your participation!