Quality Indicator Reference for Physicians

Your guide to HEDIS, HOS, CAHPS and Patient Safety measures for the Medicare Star Rating Program

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Quality Indicator Reference Guide overview

The Centers for Medicare & Medicaid Services (CMS) created the Star Rating Program to raise the quality of care for Medicare enrollees electing Medicare Advantage (MA) coverage from health plans versus Original Medicare. The program is aligned with CMS' quality strategy goals to optimize health outcomes, improve members' experience and access to care, and maximize efficiency and cost savings. Star Ratings are released annually by CMS and help Medicare beneficiaries select the best Medicare Advantage plan for their healthcare needs. The ratings enable health plan performance comparison on an apples-to-apples basis and hold plans accountable for the care of their members by physicians, hospitals and other healthcare providers.

As many of the measures included in the Star Rating Program assess members' interaction with practitioners of the healthcare system, this guide outlines the Star quality and performance measures that CMS, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA™) use to evaluate the care and services provided to your Medicare Advantage patients. Humana strives to support you in providing quality services and improving the health outcomes of your Humana-covered patients. This guide does not include Star measures that are not directly influenced by physicians and are strictly assessing plan information, services or member experience with the plan.

The information offered in this guide is from the current Healthcare Effectiveness Data and Information Set (HEDIS®) Volume 2 Technical Specifications for Health Plans and its most current corresponding Value Set Directory, as well as the current CMS Medicare Part C & D Star Ratings Technical Notes available at www.cms.gov. This information is not meant to preclude clinical judgment. Treatment decisions should always be based on clinical judgment of the physician or other healthcare provider at the time of care.

For each measure, we've provided:

- Measure name and abbreviation
- Weight assigned by CMS that is used when calculating summary or overall Star ratings
- Definition of the measure, its eligible population and expected quality activity and/or outcome
- Best practices for addressing the measure with patients
- Applicable exclusions that will remove a patient from the eligible population for a measure
- Quality result percentage ranges (i.e., cut points) used to determine each of the measure's rating year Star level
- For HEDIS measures: The service(s) needed and coding guidance to ensure measure compliance
- For Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures: Applicable question(s) from the respective survey administered to Medicare Advantage-covered patients
- For Patient Safety measures: the prescription drug activity needed for compliance

You also will find information for display measures within this guide. These measures are not currently part of the Star Rating Program, but in some cases they may be recent Star measures that underwent substantive changes and have been temporarily moved to display. In many cases these are new measures being performance tested before they are designated as a Star measure. They could also be former Star measures that may be retired in the future. As we do not have access to the same details that are available for Star measures, we have provided any information available from CMS' Medicare current Part C & D Display Measure Technical Notes and HEDIS current Vol. 2 Technical Specifications.

The information in this guide is subject to change based on CMS regulatory guidance and technical specification changes from NCQA and/or PQA. Measure details can change annually (i.e., service needed for compliance, applicable codes). The coding information in this document is subject to changing requirements and should not be relied on as official

coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

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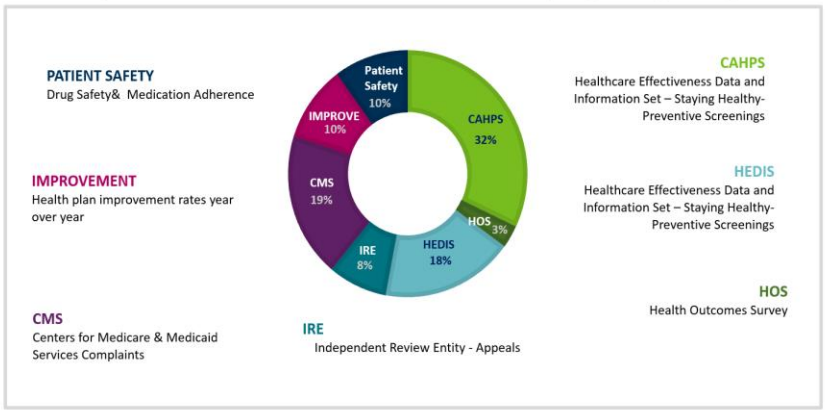
Measurement year (MY) 2023 Star measure category weighting and measures



MY2023/BY2026 Star measures[1] and weights[1]

Updated: 04/10/2023

HEDIS (measured Jan – Dec)	ABBR	Weight
Breast Cancer Screening	BCS	1x
Colorectal Cancer Screening	COL	1x
Controlling Blood Pressure	CBP	3x
COA[2] – Functional Status Assessment	FSA	*
COA[2] – Medication Review	MDR	1x
COA[2] – Pain Screening	PNS	1x
Diabetes – Blood Sugar Control	HBD	3x
Diabetes – Eye Exam	EED	1x
Diabetes - Kidney Health Evaluation	KED	*
Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions	FMC	1x
Medication Reconciliation Post-Discharge[3]	MRP	1x
Osteoporosis Management in Women who had a fracture	OMW	1x
Plan All-Cause Readmissions	PCR	3x
Statin Therapy for Cardiovascular Disease	SPC	1x
Transitions of Care[4] – NIA, RDI, PED, MRP	TRC	1x

Patient Safety (measured Jan – Dec)	ABBR	Weight
Medication Adherence: Cholesterol (statins)	MAC	3x
Medication Adherence: Diabetes Medication	MAD	3x
Medication Adherence: Hypertension (ACE/ARB)	MAH	3x
Statin Use in Persons with Diabetes	SUPD	1x

CAHPS (measured Feb – Jun of following year)	ABBR	Weight
Annual Flu Vaccine	FLU	1x
Care Coordination	CC	4x
Customer Service	CS	4x
Getting Appointments and Care Quickly	GACQ	4x
Getting Needed Care	GNC	4x
Getting Needed Prescription Drugs	GNRx	4x
Overall Rating of Drug Plan	RDP	4x
Overall Rating of Health Care Quality	RHCQ	4x
Overall Rating of Health Plan	RHP	4x

HOS (measured Aug – Nov)	ABBR	Weight
Improving Bladder Control	IBC	1x
Improving or Maintaining Mental Health [5]	IMPH	*
Improving or Maintaining Physical Health [5]	IMMH	*
Monitoring Physical Activity	MPA	1x
Reducing the Risk of Falls	FRM	1x

CMS (measured Jan – Dec)	ABBR	Weight
Call Center - Foreign Language Interpreter & TTY/TDD - Part C[6]	FLIC	4x
Call center - Foreign Language Interpreter & TTY/TDD - Part D[6]	FLID	4x
Complaints about the Health/Drug Plan [7]	CHPC/ CHPD	4x
Comprehensive Medication Review	CMR	1x
Medicare Plan Finder Accuracy [5]	MPF	1x
Members Choosing to Leave the Plan [7]	MLPC/ MLPD	4x
Special Needs Plan Care Management [2]	SNP	1x

IRE (measured Jan – Dec)	ABBR	Weight
Reviewing Appeals Decisions	RAD	4x
Timely Decisions about Appeals	PTD	4x

Improvement Measures	ABBR	Weight
Part C Improvement [5]	HPQI	5x
Part D Improvement [5]	DPQI	5x

Notes:
1. Measures and weights reflect Final Rate Notice as of 04/03/2023
2. Measures apply only to Special Needs Plans
3. Medication Reconciliation Post-Discharge stand alone measurestill active; CMS has confirmed it is calculated the same way as the TRC component measure version.
4. Transitions of Care– Average new to Star measures in MY22. It is an average of 4 components: NIA, RDI, PED, MRP
5. Measures that are NOT part of the Improvement calculation
6. TTY/FL measure data is collected through test calls made by a CMS vendor Feb-June of the following year
7. Part C and Part D performance calculated separately and apply only toward respective line of business

* Display measure but actively pursuing improvement in anticipation of Stars weighting in MY24

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Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is required by NCQA for compliance and accreditation. HEDIS measures are created for all types of health plans—commercial, Medicaid and Medicare. Listed here are those chosen by CMS to include in the Medicare Star Rating Program as they align with their domains of care for Medicare beneficiaries.

Measurement year (MY) 2023 priority HEDIS measures[1]

HEDIS (measured January–December)	ABBR	Weight
Breast Cancer Screening	BCS	1x
Controlling High Blood Pressure	CBP	3x
Colorectal Cancer Screening	COL	1x
COA[2] – Functional Status Assessment	FSA	*
COA[2] – Medication Review	MDR	1x
COA[2] – Pain Screening	PNS	1x
Diabetes Care – Eye Exam for Patients with Diabetes	EED	1x
Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes	HBD	3x
Diabetes Care – Kidney Health Evaluation	KED	*
Medication Reconciliation Post-Discharge[3]	MRP	1x
Osteoporosis Management in Women who had a Fracture	OMW	1x
Statin Therapy for Patients with Cardiovascular Disease	SPC	1x
Care Coordination measures		
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	FMC	1x
Plan All-Cause Readmissions	PCR	3x
Transitions of Care	TRC	1x
TRC – Notification of Inpatient Admission*	NIA	-
TRC – Receipt of Discharge Information*	RDI	-
TRC – Patient Engagement after Inpatient Discharge*	PED	-
TRC – Medication Reconciliation Post-Discharge*	MRP	-

CHANGES TO HEDIS MEASURES

NOTE: CHANGES APPLY TO MEASURE YEAR 2023 (MY2023) AND SUBSEQUENT MEASURE YEARS UNLESS OTHERWISE SPECIFIED.

Breast Cancer Screening (BCS)

Measure to be reported via Electronic Clinical Data Systems

Care for Older Adults

Functional Status Assessment (FSA) remains a display measure

Medication Reconciliation Post-Discharge (MRP)

MRP remains a stand-alone measure, in addition to being a component of the Transitions of Care (TRC) measure

BREAST CANCER SCREENING

Breast Cancer Screening (BCS) | Weight = 1

Overview

Percentage of women 52–74 years old who had a mammogram to screen for breast cancer

Service needed for compliance

- Mammogram between October 1 two years prior and December 31 of the current measurement year
- All types and methods of mammograms, including screening, diagnostic, film, digital or digital tomosynthesis

Note: Magnetic resonance imaging (MRI), ultrasound or biopsy do not count toward this measure.

BCS measure best practices

- Due to the unique 27-month measurement period, physician practices may want to consider ordering a mammogram every two years for their patients beginning at age 50, or sooner when risk factors such as family history exist.
- Educate patients about the importance of early detection, and encourage testing.
- Engage patients to discuss their fears about mammograms, and let women know that the test is less uncomfortable and uses less radiation than it did in the past.
- Provide female patients with a list of facilities that provide mammograms and schedule for them, if possible.
- Document date of service (at minimum month and year) of the most recent mammogram in the medical record.
- Document mastectomy status and date of service (minimum year performed) in the medical record.

Exclusions

- Patients who have had a bilateral mastectomy or who have had both a unilateral left and unilateral right mastectomy (a unilateral mastectomy code and bilateral modifier must be from the same procedure)
  - A single unilateral mastectomy does not count as a full exclusion.
- Patients in hospice, using hospice services or receiving palliative care
- Patients 66 years old and older who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
    and/or
  - Have frailty and advanced illness
    (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
    - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
    - Advanced illness can be diagnosed via any telehealth visits, including audio-only and online assessments.

BCS Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 43%	43% to less than 62%	62% to less than 70%	70% to less than 77%	77% and above

BCS codes

Code	Code type	Definition
77061–77063	CPT	Breast, mammography
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed

Note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing.

CPT: 77055, 77056 and 77057; HCPCS: G0202, G0204 and G0206; ICD-9 Procedure: 87.36 and 87.37

CARE FOR OLDER ADULTS

Eligible population

- Medicare Advantage patients 66 years old and older who are also enrolled in a Special Needs Plan (SNP)
- SNPs are a type of Medicare Advantage plan designed for certain people with Medicare.
- Some SNPs are for people with certain chronic diseases and conditions, who have both Medicare and Medicaid or who live in an institution such as a nursing home.

Exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year

CARE FOR OLDER ADULTS – FUNCTIONAL STATUS ASSESSMENT

COA–Functional Status Assessment (COA-FSA) | Weight = Display

Overview

Percentage of COA-eligible patients who have had a functional status assessment

Service needed for compliance

At least one complete functional status assessment performed in an outpatient setting in the current measurement year with dated notation in the patient's medical record, which may include:

- Assessment of activities of daily living (ADL) or instrumental activities of daily living (IADL)
- Results using a standardized functional assessment tool

Note: Functional status assessment is limited to an acute or single condition. An event or body system does not meet criteria.

COA–FSA measure best practices

- Perform a comprehensive functional status assessment with older patients as a part of an Annual Wellness Visit or physical exam. These can be conducted via all telehealth methods, including audio-only telephone visit, e-visit and virtual check-in.
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

COA–FSA Star measure cut points reminder:

COA–FSA has been a display measure from MY2020. Therefore, there are no cut points available in the 2023 Star Ratings Technical Notes.

COA–FSA codes

Code	Code type	Definition
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision-making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan.
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

CARE FOR OLDER ADULTS – MEDICATION REVIEW

COA – Medication Review (COA–MDR) | Weight = 1

Overview

Percentage of COA-eligible patients whose prescribing practitioner or clinical pharmacist reviewed all of the patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies

Service needed for compliance

At least one medication review conducted by a prescribing practitioner or clinical pharmacist in the current measurement year with a medication list present in the patient's medical record with a dated notation. Both of the following services must be included along with the appropriate codes:

- **CPT II 1160F** – At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.
- **CPT II 1159F** – A medication list signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist). The practitioner's signature is considered evidence that the medications were reviewed.
- If the patient is not taking any medicine, creating a dated notation in the medical record will address the measure.
- Transitional care management services that include medication review administered during the current measurement year will address the measure.

COA–MDR measure best practices

- A medication review and medication list code must be billed simultaneously for a patient to be compliant.
- A review of side effects for a single medication at the time of prescription alone is not sufficient.
- Medication reviews can be completed via all telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or member presence is not required.
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

COA–MDR Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 43%	43% to less than 70%	70% to less than 82%	82% to less than 93%	93% and above

COA–MDR codes

Code	Code type	Definition
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy.
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision-making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan.
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge.
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge.
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face to face with patient, with assessment and intervention if provided, initial 15 minutes, new patient.
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face to face with patient, with assessment and intervention if provided, initial 15 minutes, established patient.
1159F	CPT II	Medication list documented in medical record.
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record.
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route.

COA – PAIN SCREENING

COA – Pain Screening (COA–PNS) | Weight = 1

Overview

Percentage of COA-eligible patients who have had a pain screening or assessment

Service needed for compliance

- At least one pain assessment or screening performed in an outpatient setting in the current measurement year with a dated notation in the patient's medical record
- Documentation that the patient was assessed for pain
- May include positive or negative findings for pain
- Result of assessment using a standardized pain assessment tool
- Notation alone of the following activities does not meet criteria:
  - Pain management plan
  - Pain treatment plan
  - Screening for or presence of chest pain

COA–PNS measure best practices

- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.
- Pain screenings can be addressed via all telehealth methods, including audio-only telephone visit, e-visit and virtual check-in.

COA–PNS Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 50%	50% to less than 71%	71% to less than 85%	85% to less than 94%	94% and above

COA–PNS codes

Code	Code type	Definition
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present

COLORECTAL CANCER SCREENING

Colorectal Cancer Screening (COL) | Weight = 1

Overview

Percentage of patients 50–75 years old who had an appropriate screening for colorectal cancer

Note: Per CMS Final Rule April 5, 2023, the age range for the 2023 COL Star measure is 50–75 years old.

Service needed for compliance (any one of the following)

- Fecal occult blood test (FOBT) during the current measurement year
- Cologuard (fecal immunochemical test [FIT] DNA) test during the current measurement year or the two years prior
- Flexible sigmoidoscopy or CT colonography during the current measurement year or the four years prior
- Colonoscopy during the current measurement year or the nine years prior

COL measure best practices

- Clearly document administered screenings, total colectomy or colorectal cancer in the patient's medical record, including date of service.
- Ask patients if they've had a colorectal cancer screening, and update patient history annually.
- Encourage patients resistant to having a colonoscopy to perform and return at-home stool tests (FOBT).
- If testing of the patient's sample has unfavorable results, further diagnostic testing such as a colonoscopy is recommended.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients 66 years old and older who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **and/or**
  - Have frailty and advanced illness (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
- Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
- Advanced illness can be diagnosed via any telehealth visits, including audio-only and online assessments.
- Patients who have had total colectomy or colorectal cancer at any time during the patient's history through December 31 of the current measurement year
  - Partial colectomy is not an exclusion

Healthcare Effectiveness Data and Information Set (HEDIS)

COL Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 43%	43% to less than 60%	60% to less than 71%	71% to less than 79%	79% and above

COL codes

Fecal occult blood test (FOBT)

Code	Code type	Definition
82270	CPT	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, one determination
82274	CPT	Blood, occult, by fecal hemoglobin, qualitative, one to three simultaneous determinations
G0328	HCPCS	Colorectal cancer screening, fecal occult blood test, immunoassay, one to three simultaneous determinations
Flexible sigmoidoscopy		
45330	CPT	Sigmoidoscopy, flexible, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	CPT	Sigmoidoscopy, flexible, with biopsy, single or multiple
45332	CPT	Sigmoidoscopy, flexible, with removal of foreign body
45333	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	CPT	Sigmoidoscopy, flexible, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	CPT	Sigmoidoscopy, flexible, with directed submucosal injection(s), any substance
45337	CPT	Sigmoidoscopy, flexible, with decompression (for pathological distention) (e.g., volvulus, megacolon) including placement of decompression tube, when performed
45338	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45340	CPT	Sigmoidoscopy, flexible, with transendoscopic balloon dilation, one or more strictures
45341	CPT	Sigmoidoscopy, flexible, with endoscopic ultrasound examination
45342	CPT	Sigmoidoscopy, flexible, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

Code	Code type	Definition
45346	CPT	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed
45347	CPT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guidewire passage, when performed
45349	CPT	Sigmoidoscopy, flexible; with endoscopic mucosal resection
45350	CPT	Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0104	HCPCS	Colorectal cancer screening, flexible sigmoidoscopy

Note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing.

CPT: 45339 and 45345; ICD-9 Procedure: 45.24

Colonoscopy

Code	Code type	Definition
44388	CPT	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389	CPT	Colonoscopy through stoma, with biopsy, single or multiple
44390	CPT	Colonoscopy through stoma, with removal of foreign body
44391	CPT	Colonoscopy through stoma, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	CPT	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44394	CPT	Colonoscopy through stoma, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
44401	CPT	Colonoscopy through stoma; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)
44402	CPT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guidewire passage, when performed)
44403	CPT	Colonoscopy through stoma; with endoscopic mucosal resection
44404	CPT	Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	CPT	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	CPT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	CPT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent
44408	CPT	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45378		Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	CPT	Colonoscopy, flexible; with removal of foreign body(s)
45380	CPT	Colonoscopy, flexible; with biopsy, single or multiple

45381	CPT	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45382	CPT	Colonoscopy, flexible; with control of bleeding, any method
45384	CPT	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy
45385	CPT	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	CPT	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	CPT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	CPT	Colonoscopy, flexible, with endoscopic stent placement (includes pre- and post-dilation and guidewire passage, when performed)
45390	CPT	Colonoscopy, flexible, with endoscopic mucosal resection
45391	CPT	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	CPT	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45393	CPT	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398	CPT	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0105	HCPCS	Colorectal cancer screening, colonoscopy on individual at high risk
G0121	HCPCS	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk

Please note obsolete codes: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing.

CPT: 44393, 44397, 45339, 45345, 45355, 45383 and 45387; ICD-9 Procedure: 45.22, 45.23, 45.24, 45.25, 45.42 and 45.43

CT colonography

Code	Code type	Definition
74261	CPT	Computed tomographic (CT) colonography, diagnostic, including image post- processing; without contrast material
74262	CPT	Computed tomographic (CT) colonography, diagnostic, including image post- processing; with contrast material(s) including non-contrast images, if performed
74263	CPT	Computed tomographic (CT) colonography, screening, including image post-processing

FIT-DNA test		
Code	**Code type**	**Definition**
81528	CPT	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

CONTROLLING HIGH BLOOD PRESSURE

Controlling High Blood Pressure (CBP) | Weight = 3

Overview

Percentage of hypertensive patients 18–85 years old whose blood pressure (BP) was adequately controlled (< 140/90 mmHg) during the current measurement year

- Patients become eligible for this measure once they have had two visits with a diagnosis of hypertension.
  - Can occur during the prior year or first six months of the current measurement year
  - Must have two different dates of service
  - Can be any type of outpatient visit, telephone visit, virtual or e-visit and any combination of visit type applies

Service needed for compliance

- BP reading during the current measurement year on or after the second diagnosis of hypertension
- Most recent reading in the current measurement year must have a representative systolic BP of < 140 mmHg and a representative diastolic BP of < 90 mmHg to be measure compliant
- The adequately controlled result must be documented and reported administratively

Note: If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP.

CBP measure best practices

- BP readings can be collected in a number of ways—via outpatient and telehealth visits, including real-time, interactive audio/video visits, audio-only and online assessments, as well as remote monitoring devices that transmit results to your office. Your patients can also report their results to you.
- Advise patients not to smoke, drink caffeinated beverages or exercise within 30 minutes of their reading and allow at least five minutes of quiet rest before BP measurement.
- Patients should sit with their back straight and supported with feet flat on the floor, and their lower arm should be supported on a flat surface and upper arm should be at heart level.
- Document blood pressure readings at each visit. If the blood pressure (BP) is high (140/90 or greater), repeat the measurement after at least a one-minute wait. HEDIS allows the lowest systolic and lowest diastolic readings in the same day. Often, the second reading is lower. Do not round BP values. If using an automated machine, record exact values.

- Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed.
- Ensure submitted claims or encounters include the appropriate CPT Category II codes for BP readings.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant
- Patients with a diagnosis of pregnancy
- Patients 66 years old and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old with frailty and advanced illness or 81 years old and older with frailty only (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
- Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can be a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
- Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.

CBP Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 48%	48% to less than 63%	63% to less than 73%	73% to less than 80%	80% and above

CBP codes

Code	Code type	Definition
I10	ICD-10	Essential (primary) hypertension
3074F	CPT II	Most recent systolic blood pressure less than 130 mmHg (DM) (HTN, CKD, CAD)
3075F	CPT II	Most recent systolic blood pressure 130–139 mmHg (DM)
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mmHg (HTN, CKD, CAD) (DM)
3078F	CPT II	Most recent diastolic blood pressure less than 80 mmHg (HTN, CKD, CAD) (DM)
3079F	CPT II	Most recent diastolic blood pressure 80–89 mmHg (HTN, CKD, CAD) (DM)
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mmHg (HTN, CKD, CAD) (DM)
99457	CPT	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

DIABETES CARE

Overview

There are two weighted diabetes care measures: Hemoglobin A1c Control for Patients with Diabetes (HBD) and Eye Exam for Patients with Diabetes (EED). The Nephropathy (NPH) measure was retired in 2022 and is anticipated to be replaced by Kidney Health Evaluation for Patients with Diabetes (KED), which is currently on display.

The diabetes care measures include patients 18–85 years old with type 1 or type 2 diabetes.

Patients eligible for diabetes care measures are identified based on any of the following activity during the current or prior measurement year:

- Dispensed insulin, hypoglycemic or anti-hyperglycemic medication
- Claim(s) submitted with a diagnosis of diabetes for one acute inpatient encounter or discharge
- Two outpatient, telehealth, observation, emergency department or nonacute inpatient visits
  - Telehealth visits include real-time, interactive audio/video visits, audio-only and online assessments
  - Can be any combination of visit types that occurred on different dates of service

Exclusions

- Patients in hospice, using hospice services or receiving palliative care any time during the measurement year
- Patients who died any time during the measurement year
- Patients who did not have a diagnosis of diabetes during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year.
- Patients 66 years old and older who:
- Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **and/or**
- Have frailty and advanced illness
  (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
- Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
- Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.

DIABETES CARE – HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES

Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes (HBD)

Weight = 3

Overview

Percentage of eligible diabetic patients who have evidence of HbA1c test with a level of 9% or less

Service needed for compliance

- At least one HbA1c test in current measurement year for all eligible patients with the resulting level reported
- The most recent HbA1c test in the current measurement year must have a level of 9% or less to be measure compliant

HBD measure best practices

- Review recommendations for diabetes care at each office visit and order labs prior to patient appointments.
- Adjust therapy to improve HbA1c and BP levels. Follow up with patients to monitor changes.
- Encourage patients to perform and return in-home blood glucose test kits. Discuss results they receive.
- When point-of-care HbA1c tests are completed in-office, bill for service with results. Ensure submitted claims or encounters include the appropriate CPT Category II codes for the most recent HbA1c level.
- If result is more than 9%, order and document follow-up HbA1c testing, as appropriate.
- Ensure documentation in the medical record includes the date when the HbA1c test was performed, along with the result or finding.
- Finding must be in the format of a value (e.g., 7%). Missing values or results recorded in a format other than this example will result in noncompliance for the measure.

HBD Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 39 %	39% to less than 62%	62% to less than 75%	75% to less than 83%	83% and above

HBD Star measure codes

Code	Code type	Definition
83036	CPT	Hemoglobin; glycosylated (A1c)
83037	CPT	Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use
3044F	CPT II	Most recent hemoglobin A1c level less than 7%
3046F	CPT II	Most recent hemoglobin A1c level greater than 9%
3051F	CPT II	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7% and less than 8%
3052F	CPT II	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8% and less than or equal to 9%

Exclusions

Unless otherwise indicated, these apply to Medicare, Medicaid and commercial patients:

- Patients in hospice or using hospice services
- Patients receiving palliative care during the measurement year
- Patients 66 years old and older with frailty and advanced illness
- Medicare-covered patients 66 years old and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year
- Patients without a diagnosis of diabetes during or prior to the measurement year and who have had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes

DIABETES CARE – EYE EXAM FOR PATIENTS WITH DIABETES

Diabetes Care – Eye Exam for Patients with Diabetes (EED) | Weight = 1

Overview

Percentage of patients 18–75 years old with diabetes (type 1 or 2) who had a retinal eye exam in the measurement period

Service needed for compliance (any one of the following)

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the current measurement year
- A negative retinal or dilated eye exam (negative for diabetic retinopathy) by an eye care professional (optometrist or ophthalmologist) in the prior measurement year
- Bilateral eye enucleation any time during the member's history or the current measurement year

EED measure best practices

- Review diabetes services needed at each office visit.
- Encourage and/or refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during the current year.
- Document the date of most recent diabetic eye exam with results and name of eye care provider in the medical record.
- If possible, obtain records of eye exams performed in the prior or current measurement year by an ophthalmologist or optometrist. Retain a copy of exam results in the patient's medical record.
- Patients whose exams have negative results showing no evidence of retinopathy will be compliant with this measure for the year in which the screening occurred and the following measurement year.
- Ensure submitted claims include the appropriate coding for exam and results. Eye exams submitted with the most common CPT codes (see * in code chart below) are covered on all Medicare Advantage plans with $0 in-network cost share for Humana-covered patients with diabetes at all outpatient levels of service.
- Consider using fundus photography to capture an image of the retina with a camera that can be operated by healthcare provider staff after brief training. Results can be interpreted by an eye care professional, at a reading center with a retinal specialist serving as medical director or by a system with artificial intelligence.

EED Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 47%	47% to less than 61%	61% to less than 71%	71% to less than 79%	79% and above

EED Star measure codes

Code	Code type	Definition
65091	CPT	Evisceration of ocular contents; without implant
65093	CPT	Evisceration of ocular contents; with implant
65101	CPT	Enucleation of eye; without implant
65103	CPT	Enucleation of eye; with implant, muscles not attached to implant
65105	CPT	Enucleation of eye; with implant, muscles attached to implant
65110	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents only
65112	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
65114	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
67028	CPT	Intravitreal injection of a pharmacologic agent (separate procedure)
67030	CPT	Discussion of vitreous strands (without removal), pars plana approach
67031	CPT	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	CPT	Vitrectomy, mechanical, pars plana approach
67039	CPT	Vitrectomy, mechanical, pars plana approach, with focal endolaser photocoagulation
67040	CPT	Vitrectomy, mechanical, pars plana approach, with endolaser panretinal Photocoagulation
67041	CPT	Vitrectomy, mechanical, pars plana approach, with removal of preretinal cellular membrane (e.g., macular pucker)
67042	CPT	Vitrectomy, mechanical, pars plana approach, with removal of internallimiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil)
67043	CPT	Vitrectomy, mechanical, pars plana approach, with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil) and laser photocoagulation
67101	CPT	Repair of retinal detachment, one or more sessions, cryotherapy or diathermy, with or without drainage of subretinal fluid
67105	CPT	Repair of retinal detachment, one or more sessions, photocoagulation, with or without drainage of subretinal fluid
67107	CPT	Repair of retinal detachment, scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid

Healthcare Effectiveness Data and Information Set (HEDIS)

Code	Code type	Definition
67108	CPT	Repair of retinal detachment, with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling and/or removal of lens by same technique
67110	CPT	Repair of retinal detachment, by injection of air or other gas (e.g., pneumatic retinopexy)
67113	CPT	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling and/or removal of lens
67121	CPT	Removal of implanted material, posterior segment, intraocular
67141	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, cryotherapy, diathermy
67145	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, photocoagulation (laser or xenon arc)
67208	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, cryotherapy, diathermy
67210	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, photocoagulation
67218	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, radiation by implantation of source (includes removal of source)
67220	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photocoagulation (e.g., laser), one or more sessions
67221	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photodynamic therapy (includes intravenous infusion)
67227	CPT	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions, cryotherapy, diathermy
67228	CPT	Treatment of extensive or progressive retinopathy, one or more sessions (e.g., diabetic retinopathy), photocoagulation
92002*	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, intermediate, new patient
92004*	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits
92012*	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient
92014*	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, comprehensive, established patient, one or more visits
92018	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, complete

Healthcare Effectiveness Data and Information Set (HEDIS)

Code	Code type	Definition
92019	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, limited
92134*	CPT	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92225*	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, initial
92226*	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, subsequent
92227*	CPT	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228*	CPT	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report,unilateral or bilateral
92230*	CPT	Fluorescein angioscopy with interpretation and report
92235	CPT	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	CPT	Indocyanine green angiography with interpretation and report
92250*	CPT	Fundus photography with interpretation and report
92260*	CPT	Ophthalmodynamometry
99203	CPT	Office or other outpatient visit for evaluation and management of a new patient, 30 minutes
99204	CPT	Office or other outpatient visit for evaluation and management of a new patient, 45 minutes
99205	CPT	Office or other outpatient visit for evaluation and management of a new patient, 60 minutes
99213	CPT	Office or other outpatient visit for evaluation and management of an established patient, 15 minutes
99214	CPT	Office or other outpatient visit for evaluation and management of an established patient, 25 minutes
99215	CPT	Office or other outpatient visit for evaluation and management of an established patient, 40 minutes
99242	CPT	Office consultation for a new or established patient, 30 minutes
99243	CPT	Office consultation for a new or established patient, 40 minutes
99244	CPT	Office consultation for a new or established patient, 60 minutes
99245	CPT	Office consultation for a new or established patient, 80 minutes
2022F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2023F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	CPT II	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)

Code	Code type	Definition
2025F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy
2033F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
3072F	CPT II	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
S0620	HCPCS	Routine ophthalmological examination including refraction, new patient
S0621	HCPCS	Routine ophthalmological examination including refraction, established patient
S3000	HCPCS	Diabetic indicator, retinal eye exam, dilated, bilateral
08T0XZZ	ICD-10-PCS	Resection of Right Eye, External Approach
08T1XZZ	ICD-10-PCS	Resection of Left Eye, External Approach

Note: CPT code 99212 billed by an eye care professional does not meet the specification requirement of a retinal or dilated eye exam.

Exclusions

Unless otherwise indicated, these apply to Medicare, Medicaid and commercial patients.

- Patients in hospice or using hospice services or receiving palliative care
- Medicare-covered patients 66 years old and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year
- Medicare, Medicaid or commercial-covered patients 66 years old and older with frailty and advanced illness
- Patients without a diagnosis of diabetes during or prior to the measurement year and who have had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Kidney Health Evaluation for Patients with Diabetes (KED) | Weight = Display

Overview

Percentage of members 18–85 years old with diabetes (type 1 or 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

Service needed for compliance (any one of the following)

Patients should have a kidney health evaluation in the measurement year. A kidney health evaluation consists of both an eGFR and a uACR during the measurement year on the same or different dates of service.

Please note that the patient must have at least one uACR identified by either of the following:

- A urine albumin-creatinine ratio lab test
- Both a quantitative urine albumin test and a urine creatinine test with service dates four days or fewer apart

KED best practices

- Utilize appropriate coding to reflect care provided.
- Educate patients on how diabetes can affect the kidneys and recommend strategies to prevent kidney damage, including controlling blood pressure and blood sugar.
- Remind patients to take medication as prescribed; if member has chronic kidney disease (CKD), avoid non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and naproxen.
- Coordinate diabetic care as needed with specialists, such as endocrinologists, nephrologists, cardiologists and ophthalmologists.
- Provide diabetes education and support resources.

KED Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 80%	80% to less than93%	93% to less than 95%	95% to less than 97%	97% and above

Healthcare Effectiveness Data and Information Set (HEDIS)

KED Star measure codes

Code	Code type	Definition
80047	CPT	Estimated glomerular filtration rate lab test
80048	CPT	Estimated glomerular filtration rate lab test
80050*	CPT	Estimated glomerular filtration rate lab test
80053	CPT	Estimated glomerular filtration rate lab test
80069	CPT	Estimated glomerular filtration rate lab test
82565	CPT	Estimated glomerular filtration rate lab test
82043	CPT	Quantitative urine albumin lab test
82570	CPT	Urine creatinine lab test

*** 80050 is a general health panel. Providers must share the components of the panel for Humana to pay.**

Exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients without a diagnosis of diabetes during or prior to the measurement year and who have had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes
- Patients with evidence of end-stage renal disease (ESRD) or dialysis any time during the patient's history on or prior to December 31 of the measurement year
- Patients 66 years old and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old who have frailty and advanced illness
- Patients 81 years old and older with frailty only

CARE COORDINATION MEASURES

CARE COORDINATION: MEDICATION RECONCILIATION POST-DISCHARGE

Medication Reconciliation Post-Discharge (MRP) | Weight = 1

Overview

Percentage of discharges from January 1 to December 1 of the measurement year for patients 18 years old and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days). If a patient is readmitted or directly transferred to an inpatient care setting within 30 days of discharge, the final discharge date is included in the measure unless dated after December 1.

Note: Per the Final Rule announcement on April 5, 2023, Medication Reconciliation Post-Discharge (MRP) remains a stand-alone measure, in addition to being a component of the Transitions of Care (TRC) measure.

Service needed for compliance

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse (RN) on the day the patient is discharged from the hospital through 30 days after discharge.

- Licensed practical nurses (LPNs) and other non-licensed staff can perform the medication reconciliation, but it must be co-signed any time in the measurement year by an approved provider.
- When patients are directly transferred to another facility, perform reconciliation for final discharge.

MRP measure best practices

- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications. Medication names are needed. While dose, route and frequency are not required, their inclusion is highly recommended.
- See patients in the office as soon as possible after an acute discharge stay.
- If a patient is unable to visit the office, medication reviews can be completed via all telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or member presence is not required.
- Once medication reconciliation is complete, submit CPT II code 1111F on the patient's claim.

- Review all discharge summaries; document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record). Any of these medical record notations will ensure measure compliance:
- Current medications with a notation that clinician reconciled the current and discharge medications
- Current medications with a notation that references the discharge medications
- Patient's current medications with a notation that the discharge medications were reviewed
- Current medication list, a discharge medication list and a notation that both lists were reviewed on the same date of service
- Current medication list with documentation that patient was seen for post-discharge follow-up with medications reviewed or reconciled after hospitalization/discharge. Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient's hospitalization or discharge.
- Documentation in discharge summary that discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filled in outpatient record within 30 days after discharge (31 days total).
- Notation that no medications were prescribed or ordered upon discharge
- The final reconciled medication list should be communicated to the patient by the physician or clinical office staff during an office or home visit. It can also be communicated telephonically or virtually.

Exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year
- Inpatient stays with a discharge date of December 2–31

Healthcare Effectiveness Data and Information Set (HEDIS)

MRP Star measure cut points

Note: The same cut points, also referred to as thresholds, provided in the Medicare 2020 Part C & D Star Ratings Technical Notes were also applied to 2021 Star Ratings.

1 star	2 stars	3 stars	4 stars	5 stars
Less than 43%	43% to less than 57%	57% to less than 69%	69% to less than 82%	82% and above

MRP codes

Code	Code type	Definition
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision-making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social sports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan).
99495	CPT	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit, within 14 calendar days of discharge.
99496	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit, within 7 calendar days of discharge.
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record.

CARE COORDINATION: TRANSITIONS OF CARE

Transitions of Care (TRC) | Weight = 1

Overview

The Transitions of Care (TRC) measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided within 30 days after an acute or nonacute discharge on or between January 1 and December 1 of the measurement year for patients 18 years old and older. The measure is an average of four non-weighted components:

- Notification of Inpatient Admission (TRC–NIA)
- Receipt of Discharge Information (TRC–RDI)
- Patient Engagement after Inpatient Discharge (TRC–PED)
- Medication Reconciliation Post-Discharge (TRC–MRP)

Note: Because TRC is a new measure to the Star Rating Program and will be rated based on the average of its component measures, cut points are not available for the current measure year. CMS is not going to publish thresholds for the four separate TRC components; the published threshold will be for the Transitions of Care measure.

Exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year
- Discharges occurring after December 1 of the measurement year

Notification of Inpatient Admission (TRC–NIA)

Service needed for compliance

- Documentation in the patient's outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission or the two following days (three calendar days total).
- Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–NIA.
- If the discharge is preceded by an observation stay, use the admit date from the acute or nonacute inpatient stay.
- For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
- Must clearly apply to the admission event and include the time frame for the planned inpatient admission
- Is not limited to the admit date or the two following days
- Notification of admission by the patient or the patient's family to the PCP or ongoing care provider does not meet criteria. Any documentation of notification that does not include a time frame or date stamp does not meet criteria.
- When using a shared electronic health record (EHR) system, documentation of a "received date" in the EHR is not required to meet criteria. Evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets criteria.

Receipt of Discharge Information (TRC–RDI)

Service needed for compliance

- Documentation of receipt of notification of inpatient discharge on the day of discharge or the two following days.
- To address the measure, the patient's outpatient medical record must include documentation by his/her PCP practice that discharge information was received on the day of discharge or within the two following days. Evidence must include a date stamp when the documentation was received. Any documentation that does not include a time frame or date stamp does not meet criteria.*
- Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–RDI.

* When using a shared EHR system, documentation of a "received date" in the EHR is not required to meet criteria. Evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets criteria.

Patient Engagement after Inpatient Discharge (TRC–PED)

Service needed for compliance

- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days **after** discharge (not the date of discharge)
- To address the measure, the patient must be engaged within 30 days of discharge via:
  - Outpatient visits, including office or home visits
  - A telephone visit
  - A synchronous telehealth visit where real-time interaction occurred between the patient and his/her PCP with audio and video communication
  - An e-visit or virtual check-in (asynchronous where two-way interaction, which was not real-time, occurred between the member and provider)

Note: If a patient is unable to communicate, his/her PCP can interact with a caregiver.

TRC–PED codes

Code	Code type	Definition
95	CPT	Outpatient visit in the office or patient's home via a telehealth visit use modifier
98969–98972	CPT	Online evaluation and management services
98966–98968	CPT	Telehealth visit
99441–99444	CPT	Telehealth visit
99467	CPT	Pediatric Critical Care Patient Transport Services
99495	CPT	Transitional care management service
99496	CPT	Transitional care management service
HCPCS: G0071, G2010 and G2012		

Medication Reconciliation Post-Discharge (TRC–MRP)

Medication Reconciliation Post-Discharge (MRP) remains a stand-alone measure, in addition to being a component of the Transitions of Care (TRC) measure.

Service needed for compliance

- Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse (RN) on the day the patient is discharged from the hospital through 30 days after discharge (31 total days).
- Licensed practical nurses (LPNs) and other nonlicensed staff can perform the medication reconciliation, but it must be reviewed and approved by a physician, clinical pharmacist or RN.
- When patients are directly transferred to another facility, perform reconciliation for final discharge.

TRC–MRP measure best practices

- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications. Medication names are needed. While dose, route and frequency are not required, their inclusion is highly recommended.
- See patients in the office as soon as possible after an acute discharge stay.
- If a patient is unable to visit the office, medication reviews can be completed via all telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or member presence is not required.
- Once medication reconciliation is complete, submit CPT II code 1111F on the patient's claim.
- Review all discharge summaries; document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record). Any of these medical record notations will ensure measure compliance:
  - Current medications with a notation that the clinician reconciled the current and discharge medications
  - Current medications with a notation that references the discharge medications
  - Patient's current medications with a notation that the discharge medications were reviewed
  - Current medication list, a discharge medication list and a notation that both lists were reviewed on the same date of service
  - Current medication list with documentation that the patient was seen for post-discharge follow-up with medications reviewed or reconciled after hospitalization/discharge
  - Documentation in discharge summary that discharge medications were reconciled with the most recent medication list in the outpatient record. There must be evidence that the discharge summary was filled in the outpatient record within 30 days after discharge.
  - Notation that no medications were prescribed or ordered upon discharge
  - The final reconciled medication list should be communicated to the patient by the physician or clinical office staff during an office or home visit. It can also be communicated by telephone or virtually.

Exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year
- Inpatient stays with a discharge date of December 2–31

TRC–MRP Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 39%	39% to less than 56%	56% to less than 69%	69% to less than 82%	82% and above

TRC–MRP codes

Code	Code type	Definition
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision-making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social sports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan).
99495	CPT	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit, within 14 calendar days of discharge.
99496	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit, within 7 calendar days of discharge.
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record.

CARE COORDINATION: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) | Weight = 1

Overview

Medicare Advantage-covered patients 18 years old and older with multiple high-risk chronic conditions who visit an emergency department (ED) on or between January 1 and December 24 of the measurement year.

Actions needed for compliance

- Members must have a follow-up visit or service within seven days of the ED visit (eight days total) via:
  - An outpatient, telephone or telehealth visit, including those for behavioral health (BH) services in a clinic, at home or at a community mental health center
  - An intensive outpatient encounter or partial hospitalization stay, including observation visits
  - Transitional care management services
  - A case management visit
  - Complex care management services
  - Monitored electroconvulsive therapy in an outpatient, ambulatory surgical, community mental health or partial hospitalization setting
  - An e-visit or virtual check-in
  - A substance use disorder service
  - A domiciliary or rest home visit

Note: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed. There is not a provider type requirement defined in the FMC measure specification itself. Any claim that comes in with an appropriate clinical code would be considered toward the measure.

- Events are included for members diagnosed with at least two eligible chronic conditions on different dates of service. Visits must be for the same eligible chronic condition during the measurement year or the year prior to the measurement year, but prior to the ED visit. The following are eligible chronic condition diagnoses:
  - Chronic respiratory conditions like chronic obstructive pulmonary disease (COPD), asthma and emphysema
  - Alzheimer's disease and related disorders
  - Chronic kidney disease (CKD)
  - Depression
  - Heart failure
  - Acute myocardial infarction
  - Atrial fibrillation
  - Stroke and transient ischemic attack

FMC measure best practices

- Implement processes with hospitals to facilitate sharing of discharge information.
- Work with hospitals to obtain access to electronic health records.
- Obtain census information from EDs/facilities whenever possible.
- Allow scheduling flexibility to accommodate a follow-up visit within seven days of the ED visit.

Exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year
- Any ED visit that results in an inpatient admission on the day of, or within seven days following, the ED visit
- ED visits occurring within the same eight-day period. If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit

Example: An ED visit on April 1 is in scope, but subsequent visits occurring April 2–8 are not. If the same member visits an ED on April 9, this would be a new event requiring follow-up.

Note: Because FMC is a new measure to the Star Rating Program, cut points are not available for the current measure year.

CARE COORDINATION: PLAN ALL-CAUSE READMISSIONS

Plan All-Cause Readmissions (PCR) | Weight = 3

Overview

Percentage of patients 18 years old and older who have had an acute inpatient or observation stay and experience a subsequent unplanned* acute readmission or observation stay for any diagnosis to a hospital within 30 days, either for the same condition or for a different reason

This includes patients who may have been readmitted to the same hospital or a different one. Rates of readmission are risk-adjusted and account for how sick patients were on the first admission.

* Planned admissions for chemotherapy, rehabilitation, transplant, etc., are not included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.

Service needed for compliance

- No particular service is needed.
- Practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Outreaches to these patients to schedule follow-up care and medication reconciliation could reduce the risk of readmission.

PCR measure best practices

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Be aware of the daily discharge census.
- When possible, manage scheduling capacity to ensure discharged patients can be seen within seven days.
- Conduct medication reconciliation during first post-discharge visit with patient.
- Have a discussion with patients to determine if they have issues accessing the resources necessary to prevent a readmission (e.g., ability to get the medications prescribed at discharge, transportation for follow-up appointments, family or community support).
- Connect the patient to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.

Exclusions

- Stays with discharge dates of December 2–31
- Pregnancy-related admission
- Patients in hospice or using hospice services
- Patient died during stay
- Patients with four or more hospital stays (acute inpatient and observation) between January 1 and December 1
- For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered.

PCR Star measure cut points

Reminder: PCR was a display measure from MY2019 through the end of MY2021. Cut points for MY2022 will be released by CMS in October 2023.

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Osteoporosis Management in Women who had a Fracture (OMW) | Weight = 1

Overview

Percentage of women 67–85 years old who suffered a fracture* between July 1 of the prior year and June 30 of the current measurement year and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture

* Fractures of face, skull, fingers or toes are excluded.

- Patients will be removed from the eligible population if they have had a:
  - BMD test within 24 months prior to the fracture
  - Prescription to treat or prevent osteoporosis within 12 months before the fracture

Service needed for compliance (any one of the following)

- Within six months of fracture date or date of discharge (if hospitalized for fracture):
  - A BMD test in any setting, including tests administered during inpatient stay for fracture
  - Dispensed osteoporosis medication therapy, including any long-acting treatment provided during inpatient stay for fracture

OMW measure best practices

- Prescribe medication to treat osteoporosis. Use of calcium supplements will not meet criteria for the measure.
- Promote the use of remote/mobile dual-energy X-ray absorptiometry (DEXA) scans.
- Collaborate with our designated team of nurses to conduct outreach calls to your Humana-covered patients who have recently sustained a fracture. During the call, a nurse will inform patients about osteoporosis risks, encourage screenings and offer the scheduling of any needed bone density tests.
- Humana pays for a BMD test every two years for qualified patients—generally women older than 65 who are at risk of losing bone mass or are at risk for osteoporosis; and post-menopausal women older than 50 based on risk factors. Please encourage your at-risk patients to have a screening before a fracture occurs.
- Claims for BMD test should be submitted with an ICD-10 diagnosis code that indicates risk factors exist for osteoporosis. Claims submitted with screening diagnosis codes, such as Z13.820, may cause the claim to deny.
- For activity before the fracture, submit supplemental data (i.e., medical record) for BMD test performed within 24 months, or osteoporosis therapy medication prescribed within 12 months.
- For osteoporosis medication given to the patient in a clinical setting within the 12 months prior to the fracture, document in the medical record the medication name, the date that it was dispensed, its dosage/strength and administration route. This documentation can then be submitted as supplemental data.

Healthcare Effectiveness Data and Information Set (HEDIS)

Exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients 67 years old and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 67–80 years old with frailty and advanced illness or 81 years old and older with frailty only
  (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
  - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
  - Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.

OMW Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 32%	32% to less than 45%	45% to less than 55%	55% to less than 73%	73% and above

OMW Star measure codes

Code	Code type	Definition
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg
J3111	HCPCS	Injection, romosozumab-aqqg, 1 mg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
BP48ZZ1	ICD-10-PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10-PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10-PCS	Ultrasonography of right elbow, densitometry

OMW Star measure codes

Code	Code type	Definition
BP4HZZ1	ICD-10-PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD-10-PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD-10-PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD-10-PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD-10-PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD-10-PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD-10-PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD-10-PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD-10-PCS	Plain radiography of left femur, densitometry
BR00ZZ1	ICD-10-PCS	Plain radiography of cervical spine, densitometry
BR07ZZ1	ICD-10-PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD-10-PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD-10-PCS	Plain radiography of whole spine, densitometry

Note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing. CPT: 77082; ICD-9 Procedure: 88.98

Osteoporosis medications

Bisphosphonates	HCPCS	Formulary coverage
Alendronate tablet		T1
Alendronate 70 mg tablet		NF
Alendronate-cholecalciferol		NF
Ibandronate tablet		T2
ibandronate 1 mg/mL vial/syringe	J1740	T4
Risedronate tablet		T3, DR 35 mg = T4
Zoledronic acid 5 mg/100 mL	J3489	T1
Other agents		
Abaloparatide		T5
Denosumab	J0897	T4
Raloxifene		T3
Teriparatide 600 mcg/2.4 mL		T5
Teriparatide 620 mcg/2.48 mL	J3110	NF
Romosozumab	J3111	NF
Based on 2021 Super National 5 MAPD		

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE

Statin Therapy for Patients with Cardiovascular Disease (SPC) | Weight = 1

Overview

Percentage of men 21–75 years old and women who are 40–75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year

Note: The SPC measure component for statin adherence of 80% is not included in the Star Rating Program. Patients become eligible for this measure by event or by diagnosis.

Event: Any of the following during the prior measurement year:

- Inpatient discharges with a myocardial infarction (MI)
- Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure

Diagnosis: Claim(s) submitted during both the current and prior measurement years:

- With a diagnosis of ischemic vascular disease (IVD) diagnosis
- Via an acute inpatient, outpatient or telehealth visit

Service needed for compliance

At least one fill for a high- or moderate-intensity statin medication in the measurement year.

SPC measure best practices

- Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.
- Assess patients with cardiovascular disease for statin therapy in alignment with the 2018 American College of Cardiology/American Heart Association (ACC/AHA) guidelines.
- Be sure to share with patients that statin therapy can reduce their risk of heart attack and stroke.
- For patients beginning statin therapy: Discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing.
- To minimize potential side effects, select the appropriate dose based on patients' health factors and any drug-to-drug interactions with current medications.
- For medications given to the patient in a clinical setting, document in the medical record the statin name, the date that it was dispensed, its dosage/strength and administration route. This documentation can then be submitted as supplemental data.

Exclusions

- Patients in hospice, using hospice or receiving palliative care during the measurement year
- Patients who died any time during the measurement year
- Patients 66 years old who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
  - Have frailty and advanced illness
    (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
    - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
    - Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.
- Patients with the following diagnoses or services in the current or prior measurement year for:
  - Pregnancy or in vitro fertilization (IVF)
  - Dispensed clomiphene medication
  - End-stage renal disease (ESRD) or dialysis
  - Cirrhosis
  - Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year

SPC Star measure cut points

1 star	2 stars	3 stars	4 stars	5 stars
Less than 75%	75% to less than 81%	81% to less than 85%	85% to less than 89%	89% and above

Healthcare Effectiveness Data and Information Set (HEDIS)

SPC Star measure medications

Below are the medications that when prescribed and dispensed will ensure eligible patients are compliant with the SPC measure requirements.

High-intensity statin therapy	Moderate-intensity statin therapy
Daily dose lowers LDL-C on average by at least 50%	Daily dose lowers LDL-C on average between 30% and 50%
Atorvastatin (40) 80 mg†	Atorvastatin 10 (20) mg
Rosuvastatin 20 (40) mg	Rosuvastatin (5) 10 mg
Simvastatin 80 mg ‡	Simvastatin 20–40 mg
Amlodipine-atorvastatin 40–80 mg	Pravastatin 40 (80) mg
Ezetimibe-simvastatin 80 mg	Lovastatin 40 mg
	Fluvastatin 40–80 mg
	Pitavastatin 1–4 mg
	Amlodipine-atorvastatin 10–20 mg
	Ezetimibe-simvastatin 20–40 mg

† Evidence from one randomized controlled trial (RCT) only: down-titration if unable to tolerate atorvastatin 80 mg in incremental decrease in events through aggressive lipid lowering (IDEAL).

‡ Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the Food and Drug Administration due to the increased risk of myopathy, including rhabdomyolysis.

HEDIS DISPLAY MEASURES

Measures on display are those that are not included in the Star Ratings calculation for the current measure year. However, they may become Star measures in future years or may have previously been Star measures.

The performance of these measures is released by CMS at the end of each year; but as they are not rated, they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Access to Primary Care Doctor Visits (AAP)

Percentage of patients 20 years old and older who had an ambulatory or preventive care visit during the measurement year

Exclusion

Patients in hospice or using hospice services during the measurement year

Antidepressant Medication Management (AMM)

Percentage of patients 18 years old and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 180 days

Exclusion

Patients in hospice or using hospice services during the measurement year

Continuous Beta-Blocker Treatment (PBH)

Percentage of patients 18 years old and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year. The diagnosis would reflect acute myocardial infarction (AMI) and the patient will have received persistent beta-blocker treatment for six months after discharge.

Exclusions

- Patients with any of the following identified at any time during their medical history:
  - Asthma
  - Chronic obstructive pulmonary disease (COPD)
  - Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes and vapors
  - Hypotension, heart block >1 degree or sinus bradycardia
  - A medication dispensing event indicative of a history of asthma
  - Intolerance or allergy to beta-blocker therapy
  - Patients in hospice or using hospice services
- Patients 66 years old and older living long-term in an institutional setting or enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients in hospice or using hospice services during the measurement year

- Patients 66–80 years old with frailty and advanced illness or 81 years and older with frailty (Find more information here: https://apps.humana.com/marketing/documents.asp?file=3551470)
- Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.

Follow-Up Visit after Hospital Stay for Mental Illness (FUH)

Percentage of discharges for patients 6 years old and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge

Exclusion

Patients in hospice or using hospice services during the measurement year

Hospitalization for Potentially Preventable Complications (HPC)

For patients 67 years old and older, the rate of acute inpatient and observation discharges with a diagnosis considered a chronic or acute ambulatory care sensitive condition (ACSC) per 1,000 members and the risk- adjusted ratio of observed-to-expected discharges for ACSC.

The rate is risk-adjusted based on comorbidity, age and gender.

Patients may be identified as a chronic or acute ACSC outlier once they have three or more hospital stays (acute inpatient and observation) for related ACSCs.

Chronic ACSCs considered for this measure are:

- Diabetes – short- and long-term complications
- Uncontrolled diabetes
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Hypertension
- Heart failure
- Lower extremity amputation among patients with diabetes

Acute ACSCs considered for this measure are:

- Bacterial pneumonia
- Urinary tract infection
- Cellulitis
- Pressure ulcer

HPC measure best practices

- Ensure early identification of patients and appropriate outpatient management for ACSCs, with an emphasis on:
- Increasing patient engagement through disease management and lifestyle change programs
- Developing condition-specific action plans for exacerbations
- Promote health coaching and case management services. Coordinate efforts with specialists and other healthcare providers to prevent complications and subsequent admissions.
- Provide prompt follow-up care post-discharge to prevent complications and subsequent readmissions.
- Inform patients of access to after-hours care by providing a list of options (PCP after-hours clinic, access to urgent care, telemedicine, etc.).

- Use in-home programs as warranted for evaluation and treatment to prevent unnecessary emergency room and inpatient care.

Exclusions

- Patients with three or more inpatient or observation stays with a diagnosis for chronic ACSCs during the measurement year
- Patients with three or more inpatient or observation stays with a diagnosis for acute ACSCs during the measurement year
- Patients in hospice or using hospice services during the measurement year
- Patients enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institutional setting

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (IET)

Percentage of patients who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis—and who had two or more additional services with a diagnosis of SUD within 30 days of the initiation visit

Kidney Health Evaluation for Patients with Diabetes (KED)

Percentage of patients 18–85 years old who receive an annual evaluation of kidney health function, which includes a urine albumin-creatine ration test (uACR) and the estimated glomerular filtration rate (eGFR). The NCQA retired HEDIS measure Comprehensive Diabetes Care – Nephropathy (CDC–NEPH) effective MY2022. As of January 6, 2022, CMS has not clarified the potential retirement of this measure from the Star Rating Program.

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator

Percentage of chronic obstructive pulmonary disease (COPD) exacerbations for patients 40 years old and older who had an acute inpatient discharge or emergency department (ED) encounter on or between January 1 and November 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event

Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid

Percentage of chronic obstructive pulmonary disease (COPD) exacerbations for patients 40 years old and older who had an acute inpatient discharge or emergency department (ED) encounter on or between January 1 and November 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event

Please note that the patient must have at least one uACR identified by either of the following:

- A urine albumin-creatinine ratio lab test
- Both a quantitative urine albumin test and a urine creatinine test with service dates four days or fewer apart

Testing to Confirm Chronic Obstructive Pulmonary Disease (SPR)

Healthcare Effectiveness Data and Information Set (HEDIS)

Percentage of patients 40 years old and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) during the measurement year who received appropriate spirometry testing to confirm the diagnosis

Best practices for management of COPD and the PCE and SPR measures

- Ensure a COPD diagnosis with use of a spirometry test.
- Educate patients on the importance of a spirometry test and subsequent reading.
- Schedule the patient's appointment with a pulmonologist and schedule a follow-up appointment in the PCP's office and ensure the patient's understanding of risks associated with COPD.
- Coordinate with pulmonologist to administer test, read and report results and dispense proper medications and equipment:
- A systemic corticosteroid within 14 days of the event
- A bronchodilator within 30 days of the event
- During the follow-up appointment after specialist appointment:
  - Ensure prescriptions for corticosteroid and/or bronchodilator are filled
  - Have patient demonstrate proper use of the bronchodilator

HEALTH OUTCOMES SURVEY (HOS)

HOS is an annual patient-reported outcome survey conducted for Medicare Advantage plans by a vendor contracted by the Centers for Medicare & Medicaid Services (CMS). The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, Medicare Advantage Organization accountability and improving health outcomes. The survey contains questions regarding physical and mental health, chronic medical conditions, functional status (e.g., activities of daily living), clinical measures and other health status indicators. The survey is distributed annually between August and November.

HOS (measured August–November)	ABBR	Weight
Improving Bladder Control	MUI	1x
Improving or Maintaining Mental Health	IMMH	**
Improving or Maintaining Physical Health	IMPH	**
Monitoring Physical Activity	MPA	1x
Reducing the Risk of Falling	FRM	1x

** Measure on display for MY2023

Changes to HOS measures

Note: Changes apply to measure year 2023 (MY2023).

- **Improving or Maintaining Physical Health** moved to display
- **Improving or Maintaining Mental Health** moved to display

IMPROVING BLADDER CONTROL

Management of Urinary Incontinence in Older Adults (MUI) | Weight = 1

Overview

Percentage of surveyed patients 65 years old and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider

Best practices for MUI

- Provide questionnaires that address this topic that patients can complete prior the appointment or while they wait in the waiting room.
- Discuss bladder control issues and symptoms with your older patients, including during telehealth visits.
- Ask patients to keep a daily diary tracking when they urinate and when they experience urine leakage.
- Assist patients in determining the right bladder control product for their size, lifestyle and severity of condition.
- Determine if exercise or other treatment options, such as medications or surgery, may help.
- If surgery is needed, refer patient to a specialist to follow through on the care plan.

Patient survey questions

- Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? (Yes/No)
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep? (A lot, Somewhat, Not at all)
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine? (Yes/No)
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other healthcare provider about any of these approaches? (Yes/No)

Exclusion

Patients in hospice

IMPROVING OR MAINTAINING MENTAL HEALTH

Improving or Maintaining Mental Health (IMMH) | Weight = N/A – Display

Overview

Percentage of sampled Medicare patients 65 years old and older whose mental health status was the same or better than expected after two years

Note: IMMH moved to the display due to validity concerns related to the COVID-19 public health emergency.

Best practices for IMMH

- Administer PHQ-2 and PHQ-9 mental health assessments.
- Discuss mental/emotional health and explain to patients that it is a part of their well-being and is just as important as their physical health. Try to have these discussions during all visits, including telehealth.
- Provide written materials regarding mental well-being and identify local resources.
- Listen to patients' stories and suggest activities or recommend medication, when necessary.

Patient survey questions

- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
- Accomplished less than you would like as a result of any emotional problems?
- Didn't do work or other activities as carefully as usual as a result of any emotional problems?
  - **Answer choices:** No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; or Yes, all of the time
- These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.
- How much of the time during the past four weeks:
- Have you felt calm and peaceful?
- Did you have a lot of energy?
- Have you felt downhearted and blue?
  - **Answer choices:** All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; or None of the time
- During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
  - **Answer choices:** All of the time; Most of the time; Some of the time; A little of the time; or None of the time

IMPROVING OR MAINTAINING PHYSICAL HEALTH

Improving or Maintaining Physical Health (IMPH) | Weight = N/A – Display

Overview

Percentage of sampled Medicare patients 65 years old and older whose physical health status was the same or better than expected after two years

Note: IMPH moved to the display page due to validity concerns related to the COVID-19 public health emergency.

Best practices for IMPH

- Assess the overall physical health of your patients annually.
- Ensure patients understand the personalized health advice you provide based on their risk factors.
- Develop a plan for preventive screenings and services that will help patients manage their chronic conditions.
- Determine an exercise or physical therapy program that is appropriate for patients' needs and abilities.
- Perform a pain assessment to determine if a pain management or treatment plan is needed.

Patient survey questions

- In general, would you say your health is:
  - **Answer choices:** Excellent; Very good; Good; Fair; or Poor
- The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
- Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
- Climbing several flights of stairs?
  - **Answer choices:** Yes, limited a lot; Yes, limited a little; No, not limited at all
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
- Accomplished less than you would like as a result of your physical health?
- Were limited in the kind of work or other activities as a result of your physical health?
  - **Answer choices:** No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; or Yes, all of the time
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
  - **Answer choices:** Not at all; A little bit; Moderately; Quite a bit; or Extremely

MONITORING PHYSICAL ACTIVITY IN OLDER ADULTS

Monitoring Physical Activity in Older Adults (PAO) | Weight = 1

Overview

Percentage of sampled Medicare members 65 years old and older who have had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity

Best practices for PAO

- Explain to patients that an exercise regimen could increase quality of life and longevity.
- Determine if is appropriate for your patients to start, maintain or increase the level of physical activity, based on their overall health.
- Include any recommended activity with frequency and duration in the patient after-visit summary.
- Use physical activity prescription pads to "prescribe" the exercise regimen.

Patient survey questions

- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise of physical activity? (Yes/No)
  - For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? (Yes/No)
  - For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Exclusions

- Patients in hospice
- Patients responding, "I had no visits in the past 12 months"

FALL RISK MANAGEMENT

Fall Risk Management (FRM) – Reducing the Risk of Falling | Weight = 1

Overview

Percentage of Medicare members 65 years old and older who have had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner

Best practices for FRM

- Take advantage of, and share, the CDC's "Stopping Elderly Accidents, Deaths and Injuries" (STEADI) online training and materials.
- Educate your patients to discuss fear of falling or feelings of imbalance and have discussions with them about any existing fears or feelings of unsteadiness. Discuss during all visits, including telehealth.
- Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives such as recommending shoes that provide extra security.
- Advise your Humana-covered patients to use their over-the-counter (OTC) benefits and the CenterWell Pharmacy™ OTC product catalog to purchase items that may help, such as canes or night lights.

Patient survey questions

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking? (Yes/No)
- Did you fall in the past 12 months? (Yes/No)
- In the past 12 months, have you had a problem with balance or walking? (Yes/No)
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (Yes/No)
  - Some things they might do include:
    - Suggest that you use a cane or walker
    - Suggest that you do an exercise or physical therapy program
    - Suggest a vision or hearing test

Exclusions

- Patients in hospice
- Patients answering, "I had no visits in the past 12 months"

HOS DISPLAY MEASURES

Measures on display are those that are not included in the Star Ratings calculation for the current measure year. However, they may become Star measures in future years or may have previously been Star measures.

The performance of these measures is released by CMS at the end of each year. However, since they are not rated, they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Physical Functioning Activities of Daily Living Patient survey questions

- Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person? Bathing, Dressing, Eating, Getting in or out of chairs, Walking, Using the toilet
- Because of a health or physical problem, do you have any difficulty doing the following activities? Preparing meals, Managing money, Taking medication as prescribed.

Improving or Maintaining Physical Health

Improving or Maintaining Mental Health

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

CAHPS is an annual patient survey conducted for Medicare Advantage plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in Medicare Advantage plans. The results of the survey are published in the "Medicare & You" handbook and on the Medicare website: www.medicare.gov. Nine areas of the patient survey are included in the star measures reporting. The six areas below directly correlate to patient experience with their physicians and other healthcare providers, the remaining three correlate to patient experience with their MA plan. There are no member/patient exclusions for CAHPS measures.

CAHPS (measured February–June of following year)	ABBR	Weight
Annual Flu Vaccine	FLU	1x
Care Coordination	CC	4x
Getting Needed Care	GNC	4x
Getting Appointments and Care Quickly	GACQ	4x
Customer Service	CS	4x
Overall Rating of Health Care Quality	RHCQ	4x
Overall Rating of Health Plan	RHP	4x
Overall Rating of Drug Plan	RDP	4x
Getting Needed Prescription Drugs	GNRx	4x

ANNUAL FLU VACCINE

Annual Flu Vaccine (FLU) | Weight = 1

Overview

Percentage of sampled Medicare enrollees who received an influenza vaccination

Best practices for FLU

- Stress the importance of flu vaccination for all patients in your practice, as it can increase the herd immunity effect.
- Talk to patients about getting vaccinated during regularly scheduled visits during flu season.
- Reach out to your patients who are at a higher risk of experiencing flu complications with a reminder to be vaccinated. High-risk patients include:
- Individuals who are 65 years old and older
- Patients with cardiovascular and/or respiratory disease
- Cancer patients and survivors
- Diabetic patients
- Ensure any practice staff scheduling appointments is aware of community resources for flu vaccines.
- Encourage patients to take advantage of vaccination opportunities at convenient locations, such as their local pharmacies.
- During their next office visit, confirm patients were vaccinated.

Patient survey question

Have you had a flu shot since July 1 (prior year)?

CARE COORDINATION

Care Coordination (CC) | Weight = 4

Overview

Assesses how well patient care is coordinated, including whether or not doctors had the records and information they needed about patients' care and how quickly patients got their test results.

Note: There are four HEDIS Star measures that are also referred to as Care Coordination measures. See Follow-Up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC), Medication Reconciliation Post-Discharge (MRP), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC).

Best practices for CC

- Within patient's medical record, document services rendered with date of service and results.
- During visits, use family history, medical record information and any reporting available to you to provide personalized health advice based on each patient's risk factors.
- Contact patients with the results of any screenings as soon as they are available and schedule any necessary follow-up care.
- Talk to patients about the specialists providing care to them. Document the names of members of patients' interdisciplinary care team, as well as the results of any services rendered by other healthcare providers.
- Schedule specialist follow-ups on behalf of patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patient is in your office, give them the names and phone numbers to call specialists.
- Schedule follow-up with patient within one month of the specialist visit to discuss the results.
- Advise your patients to bring in all prescription medicines they are taking to their next appointment so you can evaluate whether changes are needed. Have your Humana-covered patients use their over-the-counter (OTC) benefits and CenterWell Pharmacy's OTC product catalog to purchase items that may help them organize medication, such as medication pill boxes.
- Review all of your patient's medications, including prescription medicines, over-the-counter medications and herbal or supplemental therapies. This review can occur during telehealth visits.
- Complete and provide a medication action plan and/or personal medication list to educate and help patients organize medication-related information.

Patient survey questions

- In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
  - **Answer choices:** Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
  - **Answer choices:** Never; Sometimes; Usually; Always

- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
  - **Answer choices:** Never; Sometimes; Usually; Always

Patient survey questions

- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
  - **Answer choices:** Never; Sometimes; Usually; Always
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
  - **Answer choices:** Yes, definitely; Yes, somewhat; No
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?
  - **Answer choices:** Never; Sometimes; Usually; Always; I do not have a personal doctor; I did not visit my personal doctor in the last six months; My personal doctor is a specialist

GETTING APPOINTMENTS AND CARE QUICKLY

Getting Appointments and Care Quickly (GACQ) | Weight = 4

Overview

Assesses how quickly the patients were able to get appointments and care.

Best practices for GACQ

- If possible, schedule patients' follow-up visits and provide discharge summary in the exam room before patients leave their appointment.
- Reach out periodically to patients who have not been in for their annual visits to make sure they do not wait until the end of the year to schedule them.
- Advise patients to schedule appointments outside of your practice's busiest hours. Suggest they arrive a few minutes early to address any required intake forms.
- Try to take patients back to the exam room within 15 minutes of their scheduled appointment time even if they aren't seeing the physician right away.
- If possible, avoid overscheduling patients to prevent appointments from backing up.

Patient survey questions

- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
  - **Answer choices:** Never; Sometimes; Usually; Always
- In the last six months, how often did you get an appointment for a checkup or routine care as soon as you needed?
  - **Answer choices:** Never; Sometimes; Usually; Always
- Wait time includes time spent in the waiting room and exam room. In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
  - **Answer choices:** Never; Sometimes; Usually; Always

GETTING NEEDED CARE

Getting Needed Care (GNC) | Weight = 4

Overview

Assesses how easy it was for patients to get needed care and see specialists.

Best practices for GNC

- Schedule specialist follow-ups on behalf of your patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patient is in your office, give them the names and phone numbers to call for an appointment.
- Use specialist appointment reminder cards so patients remember that your office assisted in scheduling the follow-up appointment.
- Check the current preauthorization and notification list(s) at Humana.com/PAL to determine if the service requires preauthorization before being administered. If a service requires preauthorization, obtain approval from Humana before performing or ordering it.

Patient survey questions

- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
  - **Answer choices:** Never; Sometimes; Usually; Always
- In the last six months, how often was it easy to get the care, tests or treatment you needed?
  - **Answer choices:** Never; Sometimes; Usually; Always

GETTING NEEDED PRESCRIPTION DRUGS

Getting Needed Prescription Drugs (GNRx) | Weight = 4

Overview

Assesses how easy it is for patients to get the medicines prescribed by their doctor.

Best practices for GNRx

- Consult the Humana formulary at **Humana.com/MedicareDrugList** prior to prescribing a new medication.
- Check the current preauthorization and notification list(s) at **Humana.com/PAL** to determine if a medication requires preauthorization before it can be dispensed or administered.
- If available and clinically appropriate, consider a generic or lower-cost brand alternative drug or therapeutic equivalent.
- Recommend switching to 90-day supplies from their community pharmacy or via a mail-order pharmacy.

Patient survey questions

- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
  - **Answer choices:** Never; Sometimes; Usually; Always; I did not use my prescription drug plan to get any medicines in the last six months
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
  - **Answer choices:** Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription at my local pharmacy in the last six months
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
  - **Answer choices:** Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription by mail in the last six months; I am not sure if my drug plan offers prescriptions by mail

RATING OF HEALTHCARE QUALITY

Rating of Healthcare Quality (RHCQ) | Weight = 4

Overview

Assesses patients' view of the quality of the healthcare they received.

Best practices for RHCQ

- Ask questions to gauge patients' current experience and perception of the care they are receiving from your practice, specialists and other healthcare providers.
- Based on feedback, discuss options to improve the perception of their healthcare.
- Make efforts to confirm that patients understand:
- Their care plan
- Services performed or ordered
- How to manage their chronic conditions
- When and how to best take their medications

Patient survey question

Using any number from 0 to 10, in which 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?

CAHPS DISPLAY MEASURES

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The performance of these measures is released by CMS at the end of each year. They are not rated so they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Doctors who Communicate Well

Assesses how well doctors communicate.

Patient survey questions

- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often did your personal doctor listen carefully to you?
- In the last six months, how often did your personal doctor show respect for what you had to say?
- In the last six months, how often did your personal doctor spend enough time with you?

Pneumonia Vaccine

Percentage of surveyed Medicare patients who reported if they have ever received a pneumococcal vaccine

Patient survey question

Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime, and these are different from a flu shot. It is also called the pneumococcal vaccine.

Reminders to Fill Prescriptions

Percentage of surveyed Medicare patients who reported that they were reminded about filling or refilling a prescription

Patient survey question

In the last six months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?

Reminders to Take Medications

Percentage of surveyed Medicare patients who reported that they were reminded about taking medications as directed

Patient survey question

In the last six months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you were taking medicine as directed?

PATIENT SAFETY

Patient Safety includes measures to assess prescription drug plan (Part D) quality and performance in the Star Rating Program. The Patient Safety measures monitor Part D services to ensure the safety of Medicare Advantage enrollees. These measures are developed and endorsed by the Pharmacy Quality Alliance (PQA). They apply to both Medicare Advantage plans with prescription drug coverage (MAPD) and prescription drug-only plans (PDP). When a prescription is filled under a Medicare Part D plan, a prescription drug event (PDE) is submitted to CMS by Medicare Advantage Organizations, such as Humana. Only PDE information is used by CMS to evaluate these measures; therefore, no quality reporting is required by physicians.

Patient Safety (measured January–December)	ABBR	Weight
Medication Adherence: Cholesterol (statins)	MAC	3x
Medication Adherence: Diabetes Medication	MAD	3x
Medication Adherence: Hypertension (ACE/ARB)	MAH	3x
Statin Use in Persons with Diabetes	SUPD	1x

MEDICATION ADHERENCE

CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. PDC is determined by dividing the days of medication coverage—which is determined based on the claims billed to the insurance plan—by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication.

If a patient's PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.

Best practices for Medication Adherence measures

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers.
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy.
- Ask if transportation to the pharmacy is an issue. Retail 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery.
- Encourage adherence by providing a 90-day prescription for maintenance drugs.
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription.
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools.

MEDICATION ADHERENCE FOR CHOLESTEROL (STATINS)

Medication Adherence for Cholesterol (Statins) | Weight = 3

Overview

Proportion of days covered: Statins (PDC–STA/MAC)

Percentage of patients 18 years old and older with Part D benefits with at least two cholesterol medication (a statin drug) prescription fills on unique service dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Exclusions

- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis

PDC–STA Star measure cut points

Plan type	1 star	2 stars	3 stars	4 stars	5 stars
MAPD	Less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	92% and above
PDP	Less than 84%	84% to less than 87%	87% to less than 88%	88% to less than 90%	90% and above

MEDICATION ADHERENCE FOR DIABETES MEDICATIONS

Medication Adherence for Diabetes Medications | Weight = 3

Overview

Proportion of days covered: Diabetes all-class rate (PDC–DR/MAD)

- Percentage of patients 18 years old and older with Part D benefits with at least two diabetes medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
- Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Exclusions

- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Prescription(s) filled for insulin

PDC–DR Star measure cut points

Plan type	1 star	2 stars	3 stars	4 stars	5 stars
MAPD	Less than 79%	79% to less than 85%	85% to less than 88%	88% to less than 92%	92% and above
PDP	Less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	90% and above

MEDICATION ADHERENCE FOR HYPERTENSION

Medication Adherence for Hypertension (RAS antagonists) | Weight = 3

Overview

Proportion of days covered: renin angiotensin system antagonists (PDC–RASA/MAH)

- Percentage of patients 18 years old and older with Part D benefits with at least two high blood pressure medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
- Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

Exclusions

- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Prescription(s) filled for Entresto® (sacubitril/valsartan)

PDC–RASA Star measure cut points

Plan type	1 star	2 stars	3 stars	4 stars	5 stars
MAPD	Less than 78%	78% to less than 86%	86% to less than 89%	89% to less than 91%	91% and above
PDP	Less than 86%	86% to less than 89%	89% to less than 91%	91% to less than 96%	96% and above

COMPREHENSIVE MEDICATION REVIEW

Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) | Weight = 1

Overview

Percentage of Part D patients eligible for and enrolled in the MTM program for at least 60 days who received a comprehensive medication review (CMR) during the measurement year

To be eligible for MTM, patients must:

- Have three of five chronic diseases: hypertension, chronic heart failure, osteoarthritis, asthma or schizophrenia; **and**
- Be taking a minimum of eight Part D drugs; **and**
- Have anticipated drug costs totaling more than $4,935 per year

CMR measure best practices

- Reference health plan reports for MTM-eligible patients.
- Conduct discussions with MTM-eligible patients, explaining the importance and benefits of completing a CMR.
- Complete and provide a written summary of the CMR discussion to patients. The summary should:
- Remind patient of what occurred during the CMR
- Describe how to contact the MTM program
- Include a plan to assist in resolving current drug therapy issues
- Help achieve treatment goals with specific action items
- Have a reconciled list of all medications in use at the time of the CMR
- Inform patients with Humana coverage that they can schedule a CMR by calling Humana at **855-202-2510**, Monday – Friday, 9 a.m. – 7 p.m., Eastern time.

Activity needed for compliance

- An interactive, person-to-person or telehealth medication review and consultation of all medications completed by a pharmacist or qualified healthcare professional during the measurement year.
- The review should include all of your patient's medication, such as prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies.
- Following the CMR, the patient should receive a written summary of the discussion, including an action plan that recommends what the patient can do to better understand and use his or her medications.
- Medication reviews can be completed via all telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals.

Exclusion

Patients in hospice or using hospice services

CMR Star measure cut points

Plan type	1 star	2 stars	3 stars	4 stars	5 stars
MAPD	Less than 47%	47% to less than 67%	67% to less than 82%	82% to less than 89%	89% and above
PDP	Less than 34%	34% to less than 49%	49% to less than 62%	62% to less than 78%	78% and above

STATIN USE IN PERSONS WITH DIABETES

Statin Use in Persons with Diabetes (SUPD) | Weight = 1

Overview

Percentage of patients with Part D benefits who are 40–75 years old who received at least two diabetic medication fills, on unique dates, during the measurement year and were dispensed a statin medication fill during the measurement year

SUPD measure best practices

- Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.
- Assess patients with cardiovascular disease for statin therapy in alignment with the 2018 American College of Cardiology/American Heart Association (ACC/AHA) guidelines.
- Be sure to share with patients that statin therapy can reduce their risk of heart attack and stroke.
- For patients beginning statin therapy, discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing.
- To minimize potential side effects, select the appropriate dose based on the patient's health factors and any drug-to-drug interactions with current medications.
- Cross-reference patients qualifying for SUPD with members qualifying for SPC. If the member qualifies for both measures, consider a moderate- or high-intensity statin as you deem medically appropriate.

Activity needed for compliance

At least one fill for a statin medication of any intensity in the measurement year

Exclusions

- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Patients with rhabdomyolysis or myopathy
- Patients who are pregnant, lactating or undergoing therapy for fertility
- Patients with liver disease
- Patients with prediabetes
- Patients with polycystic ovary syndrome (PCOS)

Note: 2023 change – T46.6X5A Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter removed as an exclusion.

SUPD Star measure cut points

Plan type	1 star	2 stars	3 stars	4 stars	5 stars
MAPD	Less than 80%	80% to less than 84%	84% to less than 86%	86% to less than 90%	90% and above
PDP	Less than 80%	80% to less than 82%	82% to less than 84%	84% to less than 86%	86% and above

PATIENT SAFETY DISPLAY MEASURES

Measures on display are those that are not included in the Star Ratings calculation for the current measure year, but they may become Star measures in future years or may have previously been Star measures.

The performance of these measures is released by CMS at the end of each year, but as they are not rated they are also not weighted. The measures listed here are directly impactable by physicians and other healthcare providers.

Antipsychotic Use in Persons with Dementia

Percentage of patients with Part D benefits who are 65 years old and older with a diagnosis of or prescriptions for dementia who received at least one prescription and greater than a 30-day supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette syndrome

Antipsychotic Use in Persons with Dementia – for long-term nursing home residents

Percentage of patients with Part D benefits who are 65 years old and older with a diagnosis of or prescriptions for dementia who received at least one prescription and greater than a 30-day supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette syndrome AND were long-term nursing home (LTNH) residents

Concurrent Use of Opioids and Benzodiazepines (COB)

The measure is defined by the percentage of Part D beneficiaries 18 years old and older with concurrent use of prescription opioids and benzodiazepines during the measurement period.

Use of Opioids at High Dosage in Persons without Cancer (OHD)

This measure is defined by the percentage of Part D beneficiaries 18 years old and older without cancer who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.

Use of Opioids from Multiple Providers in Persons without Cancer (OMP)

This measure is defined by the percentage of Part D beneficiaries 18 years old and older without cancer who received prescriptions from four or more prescribers AND four or more pharmacies within 180 days or less.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)

This measure is defined by the percentage of Part D beneficiaries 65 years old and older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period.

Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (POLY–CNS)

This measure is defined by the percentage of individuals 65 years old and older with concurrent use of three or more unique central nervous system (CNS)-active medications.

APPENDIX

GLOSSARY

Baseline survey
For the Health Outcomes Survey (HOS), the baseline survey is the first of two surveys performed to assess the member's perception of their own health. The same population, or cohort, of members will receive a follow-up survey two years later.

Bonus year (BY)
Bonus year is the year in which CMS pays bonuses for currently enrolled members based on the prior calendar year's rating.

CAHPS
CAHPS® is the Consumer Assessment of Healthcare Providers and Systems. It is conducted on behalf of CMS. CAHPS is a survey that assesses consumers' experiences with the quality of healthcare and plan services and is focused on Medicare Advantage and prescription drug plans.

CMS
CMS is the Centers for Medicare & Medicaid Services.

Composite measures
Composite measures are only applicable to the CAHPS survey. The pass rate for these measures is determined by the responses to multiple questions. The rate for each question is calculated and those rates are averaged into a combined, or composite, score for the measure.

CPT
Current Procedural Terminology (CPT®) codes are developed by the American Medical Association. CPT Category I codes are used to communicate a procedure or service administered to a patient. CPT Category II codes are supplemental codes used for quality performance measurement.

Denominator
Denominator includes the eligible population or events being assessed via a measure.

Discussion measures
Discussion measures apply to the HOS survey and assess how well physicians are doing in initiating discussion of certain health topics and addressing them with their patients.

Display measures
Display measures do not currently impact a Medicare Advantage plan's Star rating. In some cases, these are former Star measures that have been transitioned to display. However, most of them are new measures being tested before they are designated as a Star measure, or they are on display for informational purposes only. If they become a Star measure, they would then be assigned one of the Star measures type (outcome or intermediate outcome).

Exclusions
Exclusions are the CMS determined criteria that exempts a Medicare Advantage member or an event from being included when determining pass rate of a measure.

APPENDIX

Follow-up survey

For the Health Outcomes Survey (HOS), the follow-up survey is the second of two surveys performed to assess the member's perception of their own health. The same population, or cohort, of members would have received a baseline survey two years earlier.

In order to be included in the follow-up cohort, the member must still be enrolled in the plan.

HCPCS

HCPCS is the Healthcare Common Procedure Coding System used by CMS and maintained by the American Medical Association (AMA).

HEDIS

HEDIS® stands for the Healthcare Effectiveness Data Information Set. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). It is a set of standardized performance measures designed to help compare the performance of health plans on an "apples-to-apples" basis. The details of its measures can change annually. It is governed by NCQA. HEDIS measure performance is used to determine clinical quality performance.

HOS

HOS is the Health Outcomes Survey, an annually reported outcome survey conducted on behalf of CMS. It assesses the ability of a Medicare Advantage Organization (MAO) to maintain or improve its patients' physical and mental health, as well as ascertain if physicians are having meaningful discussions with patients on certain health topics.

ICD-10-CM

ICD-10-CM is the International Classification of Diseases, 10th Revision, Clinical Modification developed by the World Health Organization and provided by CMS and the National Center for Health Statistics (NCHS).

Improvement measures

Improvement measures, unlike other Star measures, are not based on a data set of their own, but rather are determined by comparing the current year performance of eligible Star measures against the prior year. Eligible measures will be rated only if there is enough data to determine significant improvement or decline of ≥ 50%. There are two measures—one for Part C and one for Part D. These measures have a weight of 5.

Improvement survey measures

Improvement survey measures apply to the HOS survey and are used to assess whether a patient's self- reported physical and/or mental health has improved or declined between the two survey periods: baseline and follow-up.

APPENDIX

Intermediate outcome measures

Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status and are triple-weighted. Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with diabetes.

Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes, Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS antagonists), Medication Adherence for Cholesterol (Statins), and Statin Use in Persons with Diabetes (SUPD) are all intermediate outcome measures.

IRE

IRE is an Independent Review Entity. Currently CMS' IRE is Maximus.

MAO

Medicare Advantage Organization

MAPD

Medicare Advantage prescription drug plan

Measure year (MY)

Measure year or measurement year is the period of time when patients are receiving their screenings, filling prescriptions and responding to surveys. Information regarding this activity is being exchanged with CMS or the IRE.

Measures capturing access

Measures capturing access are designed to ensure beneficiaries have access to health plan services and needed care. These measures changed from two to four weighted beginning in measurement year 2021.

Metric

Metric is the methodology used to assess a particular measure as it pertains to Medicare Advantage members.

Numerator

Numerator includes the patients or events for a specific test, screening or survey that are used to determine measure compliance or pass rates.

Operational categories

Operational categories are tied to specific information that is used by CMS to measure quality or performance. For example, prescription claims data is used to determine drug safety.

Outcome measures

Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care. These measures are all triple-weighted. Improving or Maintaining Physical Health and Improving or Maintaining Mental Health are all outcome measures.

APPENDIX

Overall rating

The overall rating of a plan is calculated using the weighted average Star Ratings of the included measures. It is not an aggregate of the summary rating. This is the rating that will be visible on Medicare Plan Finder when members are choosing their plan.

Part C

Part C measures evaluate the health or medical portion of an MAPD plan and make up the Part C summary rating.

Part D

Part D relates to prescription drug plan services. Part D measures are used when assessing both prescription drug plan (PDP) and Medicare Advantage with Prescription Drug (MAPD) plans. These measures make up the Part D summary rating for these plans. In the case of a PDP, these measures make up both the Part D summary rating and the overall rating of the plan.

Pass rate

Pass rate is the resulting percentage of a measure when assessed and is also referred to as a compliance rate. For most measures, a higher rate indicates better performance. However, there are inverse measures, such as Plan All-Cause Readmissions, for which a lower rate indicates better performance.

Patient Safety

Patient Safety is the operational category used to assess quality and performance of drug plan services. The Pharmacy Quality Alliance (PQA) oversees the Patient Safety category.

Patients' experience and complaints measures

These measures assess a member's perspectives about the service they are receiving within their personal healthcare experience—both from their plan and healthcare providers. Like measures capturing access, these measures moved from two to four weighted beginning with measurement year 2021.

PDP

Prescription drug plan

Process measures

Most Star measures are process measures. These measures must have a process in place to gather information—primarily from healthcare providers—that will be reported to CMS to demonstrate services are being provided to improve, maintain or monitor the health of Medicare Advantage members. Process measures are single-weighted.

Quality bonus

Quality bonuses are earned on plans rated four stars or higher and are invested back into Medicare Advantage plans to provide more benefits and services to members.

Rating year

Rating year is the plan year (January 1 to December 31) for which a Star rating is in effect. MAOs learn their plans' Star ratings in October of the prior year, just before AEP, which is the Annual Election Period for Medicare Advantage members.

Reporting year

Reporting year is when data from all plan administrators is being submitted to and collected by CMS.

APPENDIX

Special Needs Plan (SNP)

Special Needs Plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions who have both Medicare and Medicaid or who live in an institution such as a nursing home.

Star measures

Star measures are Medicare population-specific metrics that are the building blocks of a Star rating.

Star Ratings

Star Ratings use more than 40 measures to determine quality of Medicare Advantage plans and assesses both Part C and Part D plan services. Medicare Advantage plans can earn one to five Star ratings. The ratings allow members to compare quality of care between Medicare Advantage plans. MAOs receive additional incentives for producing plans with ratings of four stars and above.

Summary ratings

Summary ratings communicate the performance of a plan's drug or health plan services. The Part C summary rating group, the Part C or medical measures and Part D measures are grouped to calculate the Part D summary rating. They are calculated using the weighted average Star ratings of the included measures.

Thresholds

Thresholds are percentage ranges, referred to as cut points by CMS, used to determine the star level of a measure based on its pass rate. For example, pass rates of 75%–86% could qualify a measure for four stars. Thresholds are unique to each measure and set by CMS after analyzing industry pass rate performance at the measure level.

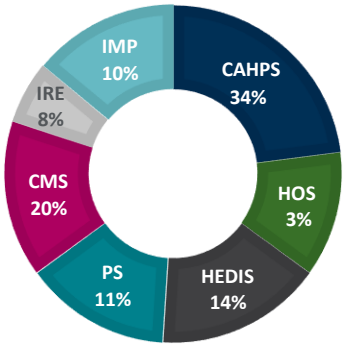
Weights

Weights are the values assigned to measure types to indicate their impact on the overall or summary Star rating of a plan.

APPENDIX

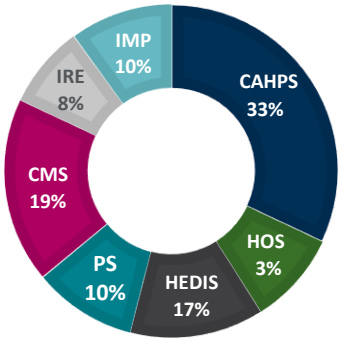
Breakdown of operational categories
Measurement Year 2021 – Bonus Year 2024

CAHPS: Consumer Assessment of Healthcare Providers and Systems	34%
HOS: Health Outcomes Survey	3%
HEDIS: Healthcare Effectiveness Data and Information Set	14%
PS: Patient Safety	11%
CMS: Centers for Medicare & Medicaid Services	20%
IRE: Independent Review Entity	8%
IMP: Improvement	10%



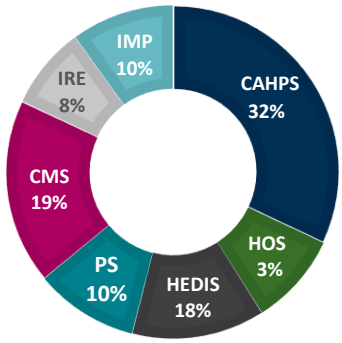
Measurement Year 2022 – Bonus Year 2025

CAHPS: Consumer Assessment of Healthcare Providers and Systems	33%
HOS: Health Outcomes Survey	3%
HEDIS: Healthcare Effectiveness Data and Information Set	17%
PS: Patient Safety	10%
CMS: Centers for Medicare & Medicaid Services	19%
IRE: Independent Review Entity	8%
IMP: Improvement	10%



Measurement Year 2023 – Bonus Year 2026

CAHPS: Consumer Assessment of Healthcare Providers and Systems	32%
HOS: Health Outcomes Survey	3%
HEDIS: Healthcare Effectiveness Data and Information Set	18%
PS: Patient Safety	10%
CMS: Centers for Medicare & Medicaid Services	19%
IRE: Independent Review Entity	8%
IMP: Improvement	10%



APPENDIX

Star “years”

Measure or measurement year	The period of time designated for collection of claims and other data, as well as patient feedback
Reporting year	Data is being collected and sent to CMS for them to compile and determine measure and plan performance
Rating year	The plan year for which the Star rating applies effective January 1 to December 31
Bonus year	Once the ratings have been determined by CMS, bonuses are included in monthly premiums paid to the plan—based on the measure year that occurred three years prior

APPENDIX

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
Breast Cancer Screening	Part C	HEDIS	Process measure	1	BCS	
Controlling High Blood Pressure	Part C	HEDIS	Outcome measure	3	CBP	
Care for Older Adults – Functional Status Assessment[2, 4]	Part C	HEDIS	Process measure	0	COA	COA–FSA, COA–F
Care for Older Adults – Medication Review[2]	Part C	HEDIS	Process measure	1	COA	COA–MDR, COA–M
Care for Older Adults – Pain Assessment[2]	Part C	HEDIS	Process measure	1	COA	COA–PNS, COA–P
Colorectal Cancer Screening	Part C	HEDIS	Process measure	1	COL	
Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes	Part C	HEDIS	Intermediate outcome measure	3	HBD	
Diabetes Care – Eye Exam for Patients with Diabetes	Part C	HEDIS	Process measure	1	EED	
Osteoporosis Management in Women who had a Fracture	Part C	HEDIS	Process measure	1	OMW	BMD
Statin Therapy for Patients with Cardiovascular Disease	Part C	HEDIS	Process measure	1	SPC	
Plan All-Cause Readmissions	Part C	HEDIS	Outcome measure	3	PCR	

APPENDIX

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Part C	HEDIS	Outcome measure	1	FMC	FMC
Transitions of Care[5]	Part C	HEDIS	Outcome measure	1	TRC	TRC
TRC – Medication Reconciliation Post-Discharge[5]	Part C	HEDIS	Process measure	-	MRP	TRC–MRP
TRC – Notification of Inpatient Admission[5]	Part C	HEDIS	Process measure	-	NIA	TRC–NIA
TRC – Patient Engagement after Inpatient Discharge[5]	Part C	HEDIS	Process measure	-	PED	TRC–PED
TRC – Receipt of Discharge Information[5]	Part C	HEDIS	Process measure	-	RDI	TRC–RDI
Medication Reconciliation Post-Discharge	Part C	HEDIS	Process measure	1	MRP	
Annual Flu Vaccine	Part C	CAHPS	Process measure	1	FVO	Flu, AFV
Care Coordination	Part C	CAHPS	Patients' experience and complaints measure	4		CC
Customer Service	Part C	CAHPS	Patients' experience and complaints measure	4		CS
Getting Appointments and Care Quickly	Part C	CAHPS	Patients' experience and complaints measure	4		GACQ

APPENDIX

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
Getting Needed Care	Part C	CAHPS	Patients' experience and complaints measure	4		GNC
Getting Needed Prescription Drugs	Part D	CAHPS	Patients' experience and complaints measure	4		GNRx
Rating of Drug Plan	Part D	CAHPS	Patients' experience and complaints measure	4		RDP
Rating of Healthcare Quality	Part C	CAHPS	Patients' experience and complaints measure	4		RHCQ
Rating of Health Plan	Part C	CAHPS	Patients' experience and complaints measure	4		RHP
Improving Bladder Control	Part C	HOS	Process measure	1	MUI	Bladder, IBC
Improving or Maintaining Mental Health	Part C	HOS	Outcome measure	0	MCS	Mental Health, IMMH
Improving or Maintaining Physical Health	Part C	HOS	Outcome measure	0	PCS	Physical Health, IMPH
Monitoring Physical Activity	Part C	HOS	Process measure	1	PAO	Physical Activity, MPA
Reducing the Risk of Falling	Part C	HOS	Process measure	1	FRM	ROF
Medication Adherence for Cholesterol (Statins)	Part D	Patient Safety	Intermediate outcome measure	3	PDC–STA	MAC

APPENDIX

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
Medication Adherence for Diabetes Medications	Part D	Patient Safety	Intermediate outcome measure	3	PDC–DR	MAD
Medication Adherence for Hypertension (RAS Antagonists)	Part D	Patient Safety	Intermediate outcome measure	3	PDC–RASA	MAH
Statin Use in Persons with Diabetes	Part D	Patient Safety	Intermediate outcome measure	1	SUPD	
Drug Plan Quality Improvement[3]	Part D	Improvement	Improvement measure	5		DPQI
Health Plan Quality Improvement[3]	Part C	Improvement	Improvement measure	5		HPQI
Call Center – Foreign Language Interpreter and TTY Availability	Part C	CMS	Measures capturing access	4		TTY, TTY/FL, FLIC
Call Center – Foreign Language Interpreter and TTY Availability	Part D	CMS	Measures capturing access	4		TTY, TTY/FL, FLID
Complaints About the Drug Plan	Part D	CMS	Patients' experience and complaints measure	4		CTM, Complaints, CHDP
Complaints About the Health Plan	Part C	CMS	Patients' experience and complaints measure	4		CTM, Complaints, CHPC
Members Choosing to Leave the Plan	Part C	CMS	Patients' experience and complaints measure	4		Voluntary Disenrollment, MLPC
Members Choosing to Leave the Plan	Part D	CMS	Patients' experience and complaints measure	4		Voluntary Disenrollment, MLPD

APPENDIX

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
MPF Price Accuracy	Part D	CMS	Process measure	1	MPF	
MTM Program Completion Rate for CMR	Part D	CMS	Process measure	1	CMR	MTM
Special Needs Plan (SNP) Care Management[2]	Part C	CMS	Process measure	1		SNP
Plan makes Timely Decisions About Appeals	Part C	IRE	Measures capturing access	4		Part C Timeliness, PTD
Reviewing Appeals Decisions[5]	Part C	IRE	Measures capturing access	4		Part C Fairness, RAD

[1] Measures and weights reflect latest CMS guidance.
[2] Measures apply only to Special Needs Plans (SNPs).
[3] Measures that are NOT part of the Improvement calculation.
[4] COA–FSA on display; is anticipated to return with a weight of 1 for BY2026.
[5] TRC measure average is new to Star measures as of MY2022. It is an average of its four nonweighted components.

Note: All information is subject to change as additional details are defined by CMS.

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