CarePlus HEALTH PLANS, INC.

Quality Indicator Physician Medicare HEDIS®, HOS, CAHPS® and Part D Safety Measures Guide for 2016 (Measurement Year 2015)

NOTE: HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2015 specifications.

Healthcare Effectiveness Data and Information Set (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 those areas where a stronger focus could lead to improvements in member health. HEDIS reporting is mandated by the National Committee for Quality Assurance (NCQA) for compliance and accreditation.

Measure	Service needed	What to report *(sample of codes)*
Breast cancer screening (BCS) **Weight = 1** Percentage of women 50 to 74 years old who had a mammogram.	• Mammogram between Oct. 1, 2013, and Dec. 31, 2015.	**Radiology codes** • **CPT**: 77055 – 77057 • **HCPCS**: G0202, G0204, G0206 **Hospital codes** • **UB revenue**: 0401, 0403 • **ICD-9-CM procedure**: 87.36 – 87.37 **Medical record documentation** • Members are excluded if medical record documentation supports HX of bilateral mastectomy.
Colorectal cancer screening (COL) **Weight = 1** Percentage of members 50 to 75 years old who have evidence of one of the following three screenings: • Fecal occult blood test • Flexible sigmoidoscopy • Colonoscopy	• Fecal occult blood test (FOBT, gFOBT or iFOBT) in **2015** **and/or** • Flexible sigmoidoscopy in the **past five years** **and/or** • Colonoscopy in the **past 10 years.** **NOTE:** Clear documentation of previous colonoscopy or sigmoidoscopy, including year performed, is required.	**Pathology / laboratory codes** Fecal occult blood test between Jan. 1, 2015, and Dec. 31, 2015. • **CPT**: 82270, 82274 • **HCPCS**: G0328 • **LOINC**: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2 **Surgery/hospital codes** Flexible sigmoidoscopy between Jan. 1, 2010, and Dec. 31, 2015. • **CPT**: 45330 – 45335, 45337 – 45342, 45345 • **HCPCS**: G0104 • **ICD-9-CM Procedure**: 45.24 Colonoscopy between Jan. 1, 2005, and Dec. 31, 2015. • **CPT**: 44388 – 44394, 44397, 45355, 45378 – 45387, 45391, 45392 • **HCPCS**: G0105, G0121 • **ICD-9-CM procedure**: 45.22, 45.23, 45.25, 45.42, 45.43 **Medical record documentation** • Chart documentation as part of the medical history of colorectal screening performed within the required timeframe.

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Measure	**Service needed**	**What to report** *(sample of codes)*
Controlling high blood pressure (CBP) Weight = 3 Percentage of members 18 to 85 years old diagnosed with hypertension whose blood pressure was adequately controlled during the measurement year based on the following criteria: • Members 18 to 59 years old whose blood pressure was less than 140/90 mmHg. • Members 60 to 85 years old with a diagnosis of diabetes whose blood pressure was less than 140/90 mmHg. • Members 60 to 85 years old without a diagnosis of diabetes whose blood pressure was less than 150/90 mmHg.	**Documentation in the member's medical record of:** • Hypertension diagnosis **between Jan. 1, 2015, and June 30, 2015** **and** • The most recent adequately controlled blood pressure reading in 2015 based on age and diabetes diagnosis.	**Medical record documentation** • Hypertension diagnosis documented on or before June 30, 2015. • Document the actual blood pressure reading. In order to pass, the most recent adequately controlled blood pressure reading of the year must be documented. **Additional information** • Providers are able to submit the following CPT category II codes: o Systolic: 3074F, 3075F, 3077F o Diastolic: 3078F, 3079F, 3080F **Note**: CPT category II codes for systolic blood pressure greater than 140 currently do not exist. • ICD-9-CM diagnosis for hypertension 401, 401.0, 401.1 or 401.9 places the member in the measure.

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Diabetes – dilated or retinal eye exam (CDC2-EYE) **Weight = 1** Percentage of diabetic members 18 to 75 years old who have received a comprehensive eye exam.	• Encourage and/or refer member to see an eye care professional for a **comprehensive eye exam during 2015**.	**Physician codes** *Obtain the record of an eye exam performed in **2015** by an ophthalmologist or optometrist. Retain a copy of the exam in the member's medical record.* • **CPT category II:** 2022F, 2024F, 2026F **Medical record documentation** *Obtain the record of an eye exam performed in **2014** by an ophthalmologist or optometrist. **The eye exam must notate "no evidence of retinopathy."** Retain a copy of the exam in the member's medical record.* • **CPT category II**: 3072F **Eye professional codes** *The following codes must be submitted by an ophthalmologist or an optometrist for a date of service in **2015**.* • **CPT**: 67028, 67030, 67031, 67036, 67039 – 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92015, 92018, 92019, 92134, 92225 – 92228, 92230, 92235, 92240, 92250, 92260, 99203 – 99205, 99213 – 99215, 99242 – 99245 • **HCPCS**: S0620, S0621, S3000
Diabetes – HbA1c screening and control (CDC2-HBATEST and CDC2-HBAPOOR) **Test weight = N/A** **Poor control weight = 3** Percentage of diabetic members 18 to 75 years old who have evidence of: • HbA1c testing • HbA1c poor control (greater than 9 percent)	• At least one HbA1c test in 2015 for all eligible members. • The goal is for the **most recent** HbA1c level in **2015** to be less than **9 percent.**	**Physician codes** • **CPT category II**: 3044F, 3045F, 3046F ***Note**: These codes count for both the HbA1c test AND HbA1c poor control measures.* **Pathology/laboratory codes** • **CPT**: 83036, 83037 • **LOINC**: 4548-4, 4549-2, 17856-6 ***Note**: Pathology/laboratory codes count for the HbA1c test measure. It must include the result value to count for the HbA1c poor control measure.* A copy of all lab results should be kept in member's medical record.

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Healthcare Effectiveness Data and Information Set (HEDIS®)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Diabetes – nephropathy (CDC2-NPH) **Weight = 1** Percentage of diabetic members 18 to 75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy).	• Nephropathy screening **testing on all diabetic members in 2015 with**: - Timed, spot or 24-hour urine for microalbumin - 24-hour urine for total protein - Urine for microalbumin/ creatinine ratio - Random urine for protein/creatinine ratio **and/or** • Documented evidence of nephropathy with: - Any **positive** urine macroalbumin test - Medical attention for nephropathy **and/or** • Nephrology **consult in 2015** (include if primary care physician also is a nephrologist).	**Physician codes** *Nephropathy screening tests:* • **CPT category II**: 3060F, 3061F *Positive urine macroalbumin test:* • **CPT category II**: 3062F *Evidence of ACE/ARB therapy:* • **CPT category II**: 4010F *Treatment for nephropathy:* • **CPT category II**: 3066F • **ICD-9-CM diagnosis**: 250.4x, 403.x, 404.x, 405.01, 405.11, 405.91, 580.x – 588.x, 753.0, 753.1x, 791.0 *Evidence of nephropathy – CKD stage 4:* • **ICD-9-CM diagnosis**: 585.4 *Evidence of nephropathy – kidney transplant:* • **ICD-9-CM diagnosis**: V42.0 *Evidence of nephropathy – ESRD:* • **ICD-9-CM diagnosis**: 585.5, 585.6, V45.1, V45.11, V45.12 **Pathology/laboratory codes** *Nephropathy screening tests:* • **CPT**: 82042, 82043, 82044, 84156 • **LOINC**: 1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1 *The following codes are for urine macroalbumin tests. These tests must be submitted with a positive result.* • **CPT**: 81000 – 81003, 81005 • **LOINC**: 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

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Healthcare Effectiveness Data and Information Set (HEDIS®)		
Measure	**Service needed**	**What to report** ***(sample of codes)***
Diabetes – nephropathy (CDC2-NPH) **Continued**	**and/or** • A dispensed prescription for angiotensin converting enzyme (ACE) inhibitor / angiotensin receptor blockers (ARB) therapy in 2015.	**Surgery/hospital codes/specialist codes** *Evidence of nephropathy – kidney transplant:* • **CPT**: 50300, 50320, 50340, 50360, 50365, 50370, 50380 • **HCPCS**: S2065 • **UB revenue**: 0367 • **ICD-9-CM procedure**: 55.6, 55.61, 55.69 *Evidence of nephropathy – ESRD:* • **CPT**: 36147, 36800, 36810, 36815, 36818-36821, 36831 – 36833, 90935, 90937, 90940, 90945, 90947, 90957 – 90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512 • **HCPCS**: G0257, S9339 • **ICD-9-CM procedure**: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98 • **POS**: 65 • **UB revenue**: 0800 – 0804, 0809, 0820 – 0825, 0829 – 0835, 0839 – 0845, 0849 – 0855, 0859, 0880 – 0882, 0889 • **UB TOB**: 0720 – 0725, 0727, 0728, 072A – 072K, 072M, 072O, 072X – 072Z **NDC codes** There are several NDC codes for ACE/ARB therapy that indicate compliance (based upon pharmacy claims received by CarePlus). NCQA posts a comprehensive list of these NDC codes on its website each year. **Specialist visit** Any visit with a nephrologist would make a member compliant with the measure. CarePlus will identify these claims by the type of provider rendering the service (no specific codes are needed on the claim).

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Initiation and engagement of alcohol and other drug dependence treatment (IET-IETE and IET-IETI) **Weight = 1** Percentage of adolescent and adult members (13 years old and older) with a new episode of alcohol or other drug dependence (AOD).	• **Initiation of treatment:** Initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization **within 14 days of diagnosis** *See the patient for this diagnosis.* **and** • **Engagement of treatment**: Initiate treatment (as stated above) and have two or more additional services with a diagnosis of AOD **within 30 days of the initial visit.** *See the patient for this diagnosis.*	*One of the following diagnosis codes must be billed for the initiation and the engagement visits, in addition to the requirements listed in Option 1, Option 2 or Option 3.* • **ICD-9-CM diagnosis**: 291 – 292, 303.00 – 303.02, 303.90 – 303.92, 304.00 – 304.02, 304.10 – 304.12, 304.20 – 304.22, 304.30 – 304.32, 304.40 – 304.42, 304.50 – 304.52, 304.60 – 304.62, 304.70 – 304.72, 304.80 – 304.82, 304.90 – 304.92, 305.00 – 305.02, 305.20 – 305.22, 305.30 – 305.32, 305.40 – 305.42, 305.50 – 305.52, 305.60 – 305.62, 305.70 – 305.72, 305.80 – 305.82, 305.90 – 305.92, 535.3, 571.1 **Physician codes** **Option 1 –** *At least one code must be billed.* • **CPT**: 90804 – 90815, 98960 – 98962, 99078, 99201 – 99205, 99211 – 99215, 99217 – 99220, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99384 – 99387, 99394 – 99397, 99401 – 99404, 99408, 99409, 99411, 99412, 99510 • **HCPCS**: G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012 • **UB revenue**: 0510, 0513, 0515 – 0517, 0519, 0520 – 0523, 0526 – 0529, 0900, 0902-0907, 0911 – 0919, 0944, 0945, 0982, 0983 **Behavioral health codes** **Option 2 –** *At least one CPT code plus a POS code must be billed.* • **CPT**: 90791, 90792, 90801, 90802, 90832 – 90834, 90836 – 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876 **and** • **POS**: 03, 05, 07, 09, 11 – 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72 **Option 3** – *At least one CPT code plus a POS code must be billed.* • **CPT**: 90816 – 90819, 90821 – 90824, 90826 – 90829, 99221 – 99223, 99231 – 99233, 99238, 99239, 99251 – 99255 **and** • **POS**: 52, 53

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Measure	**Service needed**	**What to report** *(sample of codes)*
Osteoporosis screening and management after fracture (OMW) **Weight = 1** Percentage of females 67 to 85 years old who suffered a fracture and had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis within 24 months before or 180 days after the fracture.	• Perform **bone mineral density testing within six months of fracture date.** **and/or** • Prescribe a **medication to treat osteoporosis.**	**Physician codes** *Osteoporosis therapy – medication injections* • **HCPCS**: J0630, J0897, J1000, J1740, J3110, J3487, J3488 **Radiology codes** *Bone mineral density test* • **CPT**: 76977, 77078, 77080, 77081, 77082 • **HCPCS**: G0130 • **ICD-9-CM procedure**: 88.98 **NDC codes** There are several NDC codes for prescriptions to treat osteoporosis based upon pharmacy claims received by CarePlus. NCQA posts a comprehensive list of these NDC codes on its website each year. • **Description: Biphosphonates** ▪Alendronate ▪Ibandronate ▪Alendronate-cholecalciferol ▪Risedronate ▪Calcium carbonate-risedronate ▪Zoledronic acid • **Description: Other agents** ▪Calcitonin ▪Raloxifene ▪Denosumab ▪Teriparatide

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Measure	**Service needed**	**What to report** *(sample of codes)*
Osteoporosis screening and management after fracture (OMW) **Continued**		**Additional information** ***The following codes identify fractures (eligible members)*** • **CPT:** 21800, 21805, 21810, 21820, 21825, 22305, 22310, 22318, 22319, 22520, 22521, 22523, 22524, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 23665, 23670, 23675, 23680, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575-24577, 24579, 24582, 24620, 24635, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25600, 25605 – 25609, 25622, 25624, 25628, 25630, 25635, 25645, 25650, 25651, 25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27193, 27194, 27200, 27202, 27215 27218, 27220, 27222, 27226 – 27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27267 – 27269, 27500 – 27503, 27506-27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758 – 27760, 27762, 27766 – 27769, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822 – 27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485, 29850, 29851, 29855, 29856 • **HCPCS:** S2360 • **ICD-9-CM diagnosis:** 733.93 – 733.98, 805 – 806, 807.0 – 807.4, 808 – 815, 818 – 825, 827 – 828 • **ICD-9-CM procedure:** 79.01 – 79.03, 79.05 – 79.07, 79.11 – 79.13, 79.15 – 79.17, 79.21 – 79.23, 79.25 – 79.27, 79.31 – 79.33, 79.35 – 79.37, 79.61 – 79.63, 79.65 – 79.67, 81.65 – 81.66

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Disease-modifying antirheumatic drug (DMARD) therapy for rheumatoid arthritis (ART) **Weight = 1** Percentage of members who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription for a DMARD in 2015. *Codes that identify rheumatoid arthritis* ICD-9-CM diagnosis: 714.0, 714.1, 714.2, 714.81	• Assess all patients with diagnosis of rheumatoid arthritis for DMARD treatment in 2015. • All patients *not* currently treated with a DMARD should be referred for rheumatology consultation to confirm diagnosis and assess for DMARD therapy. Complete and return a rheumatoid arthritis verification form on any patient identified as not having rheumatoid arthritis *or* not currently treated with a DMARD.	**Physician codes** *DMARD therapy – medication Injections* • **HCPCS**: J0129, J0135, J0718, J1438, J1600, J1745, J3262, J7502, J7515, J7516, J7517, J7518, J9250, J9260, J9310 **Medical Record Review** • Rheumatoid arthritis verification via medical record and claim review. Identify any patient misdiagnosed with rheumatoid arthritis. • Identify reasons for not treating with a DMARD on all patients confirmed to have rheumatoid arthritis. Include findings and recommendations of rheumatology consultant. **NDC Codes** There are several NDC codes for prescriptions to treat rheumatoid arthritis based upon pharmacy claims received by CarePlus. NCQA posts a comprehensive list of these NDC codes on its website each year. DMARDs include the following: • **Description: 5-Aminosalicylates** ▪Sulfasalazine • **Description: Alkylating agents** ▪Cyclophosphamide • **Description: Aminoquinolines** ▪Hydroxychloroquine • **Description: Antirheumatics** ▪Auranofin ▪Methotrexate ▪Gold sodium thiomalate ▪Penicillamine ▪Leflunomide • **Description: Immunomodulators** ▪Abatacept ▪Etanercept ▪Adalimumab ▪Golimumab ▪Anakinra ▪Infliximab ▪Certolizumab ▪Rituximab

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Disease-modifying antirheumatic drug (DMARD) therapy for rheumatoid arthritis (ART) **Continued**		• **Description: Immunomodulators** ▪Certolizumab pegol ▪Tocilizumab • **Description: Immunosuppressive agents** ▪Azathioprine ▪Cyclosporine ▪Mycophenolate • **Description: Janus kinase (JAK) inhibitor** ▪Tofacitinib • **Description: Tetracyclines** ▪Minocycline
Adult body mass index (BMI) assessment (ABA) **Weight = 1** The percentage of members 18 to 74 years old who had an outpatient visit and who had a BMI documented during the measurement year or the year prior to the measurement year. *NOTE: The weight and BMI must be from the same data source.*	• Documented BMI for outpatient visits in **2014 or 2015.**	**<u>Physician codes</u>** **Codes to identify BMI assessment** • ICD-9-CM Diagnosis: V85.0, V85.1, V85.2, V85.21 – V85.25, V85.3, V85.30 – V85.39, V85.4, V85.41 – V85.45, V85.51 – V85.54 (Submit to the fifth digit specificity, i.e. V85.45)

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Care for older adults advanced care planning (COA–ACP) **Weight = N/A** *[Medicare special needs program (SNP) only]* The percentage of adults 66 years old and older who had advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical decision-maker or surrogate decision-maker) during the measurement year.	**Advance care planning** Documentation of advance care planning in **2015.** Evidence of advance care planning **must include**: • An advance care plan in the medical record. **or** • Advance care planning discussion with the provider documented and dated in the medical record. **or** • Notation that the member has previously executed an advance care plan that meets criteria.	**Physician codes** • **CPT category II**: 1157F, 1158F • **HCPCS**: S0257

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Care for older adults medication review (COA–MDR) **Weight = 1** *[Medicare Special Needs Program (SNP) only]* The percentage of adults 66 years old and older who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist **along** with a medication list or documentation of no medications.	**Medication review** • Documentation of at least one dated medication review conducted by a prescribing practitioner or clinical pharmacist in **2015.** **and** • A medication list present in the same medical record. If patient is not taking any medication, dated notation should be documented in the chart in **2015**. A review of side effects for a single medication at the time of prescription alone is not sufficient.	**Physician codes** *Both a medication review and medication list code must be billed for a member to be compliant.* **Medication review** • **CPT**: 90862, 90863, 99605, 99606 • **CPT category II**: 1160F **Medication List** • **CPT category II**: 1159F • **HCPCS**: G8427 *A transitional care management services code counts for both the medication review and medication list.* **Transitional Care Management Services** • **CPT:** 99495, 99496

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Care for older adults functional status (COA–FSA) **Weight = 1** *[Medicare special needs program (SNP) only]* The percentage of adults 66 years old and older who had documentation in the medical record of at least one complete functional status assessment in 2015.	**Functional status** • At least one complete functional status assessment in 2015. • The functional status assessment **must include the date it was performed**. • Reference "Additional Information" for detailed requirements.	**Physician codes** • **CPT category II**: 1170F **Additional information** Notations for a complete functional status assessment may include: • Assessment of instrumental activities of daily living (IADL), such as shopping for groceries, driving, using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications or handling finances. **or** • Assessment of activities of daily living (ADL), such as bathing, dressing, eating, transferring, using toilet, walking. **or** • Results using a standardized functional status assessment tool. **or** Documentation that **three of the four** following components were assessed: • Cognitive status • Ambulation status • Sensory ability (must include hearing, vision and speech) • Other functional independence (e.g., exercise, ability to perform job) A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.

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Measure	**Service needed**	**What to report** *(sample of codes)*
Care for older adults pain screening (COA–PNS) **Weight = 1** *[Medicare Special Needs Program (SNP) only]* The percentage of adults 66 years old and older who had documentation in the medical record of at least one pain screening assessment for more than one system in 2015.	**Pain assessment** Documentation in the medical record of at least one pain assessment or pain management plan in 2015, including the date it was performed. Notations can include: • A comprehensive pain assessment or results of a screening using a standardized tool. (May include positive or negative findings.) • Evidence of a pain management plan, such as notation of no pain intervention and the rationale, notation of plan for pain treatment (pain meds, psychological support and patient / family education) or notation of plan for reassessment of pain, including time interval. A pain assessment or management plan limited to an acute or single condition, event or body system does not meet criteria.	**Physician codes** • **CPT category II**: 1125F, 1126F

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Healthcare Effectiveness Data and Information Set (HEDIS®)		
Measure	**Service needed**	**What to report** ***(sample of codes)***
Plan all-cause readmissions (PCR) Weight = 3 Readmission to a hospital within 30 days of being discharged. Percent of members 18 years old and older discharged from a hospital stay and readmitted to a hospital within 30 days, either for the same condition or for a different reason. Patients 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.	• No specific services are needed, other than efforts from the plan and providers around coordination of care and prevention of all readmissions.	No reporting is needed from the providers as data for this measure are taken from health plan data.

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Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey, conducted by a contracted Centers for Medicare & Medicaid Services (CMS) vendor for Medicare Advantage plans. 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. Six of the survey areas are included in the CMS Star quality measures.

Measure	Services needed	Member survey questions
Physical activity assessment (Weight = 1) is part of the following **Star measures**: • Percentage of plan members 65 years old or older who 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.	Complete/document **functional assessment**. Encourage member to start, increase or maintain physical activity and document communication. Discuss member's: • Level of exercise or physical activity • Loss of independence/performance • Activities of daily living • Level of assistance needed • Social activities Advise member to: • Consult his/her health care provider to determine what level of physical activity is safe and appropriate. • Begin physical activity with short intervals of moderate activity (five to 10 minutes). • Perform flexibility training, such as stretching and yoga every day. • Perform strength training, such as carrying laundry or groceries, doing chair exercises or working in the yard two to three days per week. • Perform cardiorespiratory activities, such as walking, rolling a wheelchair or swimming three to five days a week for at least 30 minutes. Make efforts to ensure the member understands services rendered.	• In the past 12 months, did you talk with a doctor or other practitioner about your level of exercise or physical activity? • In the past 12 months, did a doctor or other practitioner advise you to start, increase or maintain your level of exercise or physical activity?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Physical health status assessment (Weight = 3) is part of the following **Star measure:** Percentage of plan members whose physical health status was better than expected or remained the same	Assess current issues and identify interventions to improve physical health status and document communication. Discuss member's: • Loss of independence and/or performance • Activities of daily living • Level of assistance needed • Social activities Make efforts to ensure the member understands services rendered.	• During the past four weeks, have you accomplished less than you would like with your work or other regular activities as a result of your physical health? • During the past four weeks, how much of the time has physical health interfered with your social activities?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Mental health status assessment (Weight = 3) is part of the following **Stars measure**: • Percentage of plan members whose mental health status was better than expected or remained the same.	Assess current issues and identify interventions to improve mental health status and document communication. Make efforts to confirm the member understands services rendered.	• During the past four weeks, have you accomplished less or were you limited with your work or other regular daily activities as a result of your emotional health? • During the past four weeks, have you felt peaceful and calm or had a lot of energy; or felt downhearted and blue? • During the past four weeks, how much of the time have emotional problems interfered with your social activities?
Fall risk and balance assessment (Weight = 1) is part of the following **Star measure**: • Percentage of members 65 years old or older who in the past 12 months had a fall or had problems with balance or walking, were seen by a practitioner and who received fall risk interventions from their current practitioner.	Discuss member balance/fall problem and document prevention interventions. Prevention/interventions: • Regular exercise and exercise programs (e.g., tai chi) may increase strength and improve balance among older adults. • Regular medication reviews by physicians or pharmacists can help reduce side effects and drug interactions. • Regular eye exams at least once a year can help maintain eye health. • Home assessment and modifications may reduce hazards in the home (e.g., improper lighting) that can lead to falls. • Fall prevention programs may be needed to provide and install safety devices to be effective in reducing environmental hazards. Make efforts to confirm the member understands services rendered.	• In the past 12 months, have you had a problem with balance or walking? • A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health care provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • Has your doctor or other health care provider done anything to help prevent falls or treat problems with balance or walking?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Urinary incontinence assessment and advice (Weight = 1) is part of the following **Star measure**: Percentage of plan members 65 years old or older who reported having a urine leakage problem in the past six months and who received treatment for their current leakage problem.	Assess all members to determine if they are having problems with urinary incontinence. Discuss urinary problem with member and document possible treatment options such as: • Behavioral therapies, such as bladder training and techniques for pelvic muscle rehabilitation. (Low-intensity behavioral therapies are ideal first-line interventions that are inexpensive, pose a low risk and can be initiated effectively by primary care providers.) • Pharmacologic therapies • Surgical therapies (if indicated) Make efforts to confirm the member understands services rendered.	• Many people experience problems with urinary incontinence, the leakage of urine. In the past six months, have you leaked urine? • How much of a problem, if any, was the urine leakage for you? • Have you talked with your current doctor or other health care provider about your urine leakage problem? • There are many ways to treat urinary incontinence, including bladder training exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problems?

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS is an annual member survey conducted by a contracted CMS vendor for Medicare Advantage plans. 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: http://www.medicare.gov. Eight areas of the member survey are included in the Star measures reporting.

Measure	Service needed	Survey questions
Member satisfaction with getting needed care quickly (Weight = 1.5) **Member satisfaction with getting needed care without delay (Weight = 1.5)**	Facilitate referral issuance and assist with the arrangement of specialist appointments, as appropriate. Ensure limited wait times and the availability of urgent appointments.	• In the last six months, how often was it easy to get appointments with specialists? • In the last six months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan? • In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
Member satisfaction with his/her current health care (Weight = 1.5)	Ask questions to gauge the member's current feeling about the care he/she is receiving. Discuss options to improve health care. Discuss options to improve the member's perception of health care delivery. • Make efforts to confirm the member understands services rendered.	• Using any number from zero to 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last six months?

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)		
Measure	**Service needed**	**Survey questions**
Influenza vaccination status (Weight = 1) • Percentage of plan members who reported having received an influenza vaccination between September and December of the previous year.	• Order influenza vaccine for your office in advance of flu season. • Identify options for purchasing additional vaccines and/or referring patients to alternative administration sites should demand exceed your supply of vaccines. • Make sure all eligible members are encouraged to receive an influenza vaccination between September and December each year. • Make efforts to confirm the member understands services rendered. NOTE: Make sure claim/encounter is submitted and that it includes the appropriate CPT code for the flu shot administration date of service.	• Did you get a flu shot last year?

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)		
Measure	**Service needed**	**Survey questions**
Care coordination (Weight = 1.5) • Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they need about members' care and how quickly members got their test results.)	• Whether doctor had medical records and other information about the enrollee's care, • Whether there was follow-up with the patient to provide test results, • How quickly the enrollee got the test results, • Whether the doctor spoke to the enrollee about prescription medicines, • Whether the enrollee received help managing care, and • Whether the personal doctor is informed and up to date about specialist care	• 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? (Responses: 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? (Responses: 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? (Responses: Never, Sometimes, Usually, Always) • In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking? (Responses: Never, Sometimes, Usually, Always) • In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists? (Responses: Never, Sometimes, Usually, Always, I do not have a personal doctor, I did not visit my personal doctor in the last six months) • 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? (Responses: Yes, definitely; Yes, somewhat; No)

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Centers for Medicare & Medicaid Services (CMS) Part D Safety Measures CMS includes several Part D measures in the Star measures reporting, including the following five safety measures.		
Measure	**Service needed**	**What to report**
Drug plan's members 65 and older who received prescriptions for certain drugs with a high risk of side effects, when there may be safer drug choices (Weight = 3) Percentage of Medicare Part D beneficiaries 65 years old or older who received two or more prescription fills for a drug with a high risk of serious side effects in the elderly.	• Follow the suggestions from NCQA's HEDIS measure on the cautionary use of high-risk medications in the elderly, and unless absolutely necessary, prescribe an alternative medication. This list can be found at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015/HEDIS2015NDCLicense/HEDIS2015FinalNDCLists.aspx. • Before making changes to your patient's therapy, please refer to http://www.care-plus-health-plans.com/medicare-plans.asp for current medication coverage. Choose "2015 CarePlus Prescription Drug Guides."	• No reporting required from a provider's perspective. The health plan evaluates prescription claims data for this measure.
Using the kind of blood pressure medication that is recommended for people with diabetes **(Weight = 3)** Percentage of Medicare Part D beneficiaries 18 years and older who were dispensed a medication for diabetes and a medication for hypertension and who were receiving an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) medication.	• Prescription of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for members with diagnoses of diabetes and hypertension.	• No reporting required from a provider's perspective. The health plan evaluates prescription claims data for this measure.

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Centers for Medicare & Medicaid Services (CMS) Part D Safety Measures CMS includes several Part D measures in the Star measures reporting, including those listed below.		
Measure	**Service needed**	**What to report**
Taking diabetes medication as directed (Weight = 3) Percentage of Medicare Part D beneficiaries 18 years old or older with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. Note: In this measure, "diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic or a meglitinide drug. Plan members who take insulin are not included.	• Proactively assess whether the patient is taking medication as prescribed. • If you identify barriers to adherence, resolve those barriers and find ways to help the member take his or her medication as directed.	• No reporting required from a provider's perspective. The health plan evaluates prescription claims data for this measure.

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Centers for Medicare & Medicaid Services (CMS) Part D Safety Measures CMS includes several Part D measures in the Star measures reporting, including those listed below.		
Measure	**Service needed**	**What to report**
Taking blood pressure medication as directed (Weight = 3) Medicare Part D beneficiaries 18 years old or older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. Note: In this measure, "blood pressure medication" means an ACE (angiotensin-converting enzyme) inhibitor or an ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug.	• Proactively assess whether patient is taking medication as prescribed. • If you identify barriers to adherence, resolve those barriers and find ways to help the member take his or her medication as directed.	• No reporting required from a provider's perspective. The health plan evaluates prescription claims data for this measure.
Taking cholesterol medication as directed (Weight = 3) Percent of Medicare Part D beneficiaries 18 years or older with a prescription for a cholesterol medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. Note: In this measure, "cholesterol medication" means a statin drug.	• Proactively assess whether patient is taking medication as prescribed. • If you identify barriers to adherence, resolve those barriers and find ways to help the member take his or her medication as directed.	• No reporting required from a provider's perspective. The health plan evaluates prescription claims data for this measure.

HEDIS® is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an "apples-to-apples" basis. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
HOS is an annual patient-reported outcome survey conducted on behalf of the Centers for Medicare & Medicaid Services (CMS).
CAHPS® is the Consumer Assessment of Healthcare Providers and Systems on behalf of CMS.
CPT® codes are the Current Procedural Terminology codes developed by the American Medical Association.
HCPCS is the Healthcare Common Procedure Coding System used by the Centers for Medicare & Medicaid Services.
LOINC® (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory and clinical test results.