Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Note: The information offered in this guide is based on measure specifications outlined by the Pharmacy Quality Alliance (PQA), as well as the current Healthcare Effectiveness Data and Information Set (HEDIS®) Volume 2 Technical Specifications for Health Plans and its corresponding Value Set Directory, as well as the current Centers for Medicare & Medicaid Services (CMS) Medicare Part C & D Star Ratings Technical Notes. This information can change from year to year and 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.

This guide contains links to additional Star measure resources and is intended to be used in this digital format—**please do not print**. To search the document for specific content, press "Ctrl + F" for Windows or "Command + F" for macOS and enter your search term.

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 the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is used by NCQA for compliance and accreditation. The HEDIS measures listed here are part of the Medicare Five-Star Quality Rating System governed by CMS.

Measure	Service needed	What to report (sample of codes)
Breast Cancer Screening (BCS-E) **Weight = 1** Percentage of women 52–74 years of age who had a mammogram (including digital breast tomosynthesis) **Note:** The patient must be at least 52 years of age in the measure year; however, since the measure has a "look-back" period of two years, the patient may have been 50 or 51 years of age at the time of the screening. **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients who died anytime during the measurement period • Patients who had a bilateral mastectomy or both right and left unilateral mastectomies anytime during the patient's history through the end of the measurement period (A single unilateral mastectomy does not	Mammogram(s) on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year (27-month period) Dated notation in the medical record of: • Most recent mammogram with date of service (minimum month and year) • Mastectomy status and date of service (minimum year performed) **Note:** Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments. There must be two indications of advanced illness on different dates of service during the measurement year or year prior or a dispensed dementia medication. Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be two indications of frailty on	**Radiology codes** • CPT®: 77061, 77062, 77063, 77065, 77066, 77067 **Medical record documentation** Patients are excluded if medical record documentation supports a history of bilateral mastectomy or a history of both a unilateral left and a unilateral right mastectomy. Unilateral mastectomy code and bilateral modifier must be from the same procedure. **Note:** Breast Cancer Screening (BCS-E) is reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically. Providers do not need to change their documentation or claim/encounter processes. For more information on BCS, see: Breast Cancer Screening flyer

count as a full exclusion.) • Patients 66 years of age 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 • Patients who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the patient's history through the end of the measurement period	different dates of service during the measurement year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.	

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)

Care for Older Adults (COA)

Eligible population

- Patients 66 years of age and older who are also enrolled in a Special Needs Plan (SNP)
  - SNPs are a type of Medicare Advantage (MA) 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 anytime during the measurement year

Measure	Service needed	What to report (sample of codes)
COA – Functional Status Assessment (COA–FSA) **Weight = Display (2024)** Percentage of COA-eligible patients who had documentation in the medical record of at least one completed functional status assessment in the current measurement year	**Functional status assessment** • At least one complete functional status assessment completed in an outpatient setting in the current measurement year • Document the type of assessment and the date it was performed in the medical record. **Note:** Functional status assessment limited to an acute or single condition, event or body system does not meet criteria. Assessments can occur via all telehealth methods, including audio-only telephone visit, e-visit and virtual check-in.	**Physician codes** • CPT: 99483 • CPT II: 1170F • HCPCS: G0438, G0439 **Additional information** Notations for a complete functional status assessment may include: • Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL) **or** • Results using a standardized functional status assessment tool For more information on COA, see: Care for Older Adults flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
COA – Medication Review (COA–MDR) **Weight = 1** 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 **Note:** A review of side effects for a single medication at the time of prescription alone is not sufficient.	**Both of these:** • Documentation of a dated and signed medication review conducted by a healthcare provider with prescribing authority or clinical pharmacist in the current measurement year **and** • A medication list present in the same medical record with a dated notation **or** • Transitional care management services during the measurement year • If the patient is not taking medication, dated notation of this should be documented in the chart in the current measurement year. **Note:** 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 patient's presence is not required.	**Physician codes** Both a medication review and medication list code must be billed with the same date of service for a patient to be compliant. Medication review • CPT: 90863, 99483, 99605, 99606 • CPT II: 1160F Medication list • CPT II: 1159F • HCPCS: G8427 Transitional care management services • CPT: 99495, 99496 A transitional care management services code counts for both the medication review and medication list. For more information on COA, see: Care for Older Adults flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
COA – Pain Screening (COA–PNS) **Weight = 1** Percentage of COA-eligible patients who had documentation in the medical record of at least one pain screening assessment for more than one system in the current measurement year Notation alone of the following activities does **not** meet criteria: • Pain management plan • Pain treatment plan • Screening for or presence of chest pain	**Pain assessment** Dated notation in the medical record of one pain assessment or screening performed in an outpatient setting in the current measurement year, which may include: • Documentation that the patient was assessed for pain (may include positive or negative findings) • Result of assessment using a standardized pain assessment tool **Note:** Pain screenings can be addressed via all telehealth methods, including audio-only telephone visit, e-visit and virtual check-in.	**Physician code** • CPT II: 1125F, 1126F For more information on COA, see: Care for Older Adults flyer

Quality Indicator Physician Guide for Medicare
HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Colorectal Cancer Screening (COL-E) **Weight = 1** Percentage of patients 50–75 years of age who had an appropriate screening for colorectal cancer **Exclusions** • Patients who have had a total colectomy or colorectal cancer anytime during the patient's history through Dec. 31 of the current measurement year **(Partial colectomy is not an exclusion)** • Patients in hospice, using hospice services or receiving palliative care • Patients who died anytime during the measurement year – Patients 66 years of and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) – Patients 66 years of age and older who have frailty and advanced illness	**Any one of the following:** • Fecal occult blood test (FOBT), guaiac FOBT or immunochemical FOBT (FIT) during the current measurement year • Stool DNA (sDNA) with FIT test during the current measurement year or the two years prior • Flexible sigmoidoscopy or computed tomography (CT) colonography during the current measurement year or four years prior • Colonoscopy during the current measurement year or the nine years prior **Note:** Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required. **Note:** Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments. 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 measurement year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom. For more information on COL-E, see: Colorectal Cancer Screening flyer	**Pathology/laboratory codes** Fecal occult blood test Jan. 1 through Dec. 31 of the current measurement year (one year) • CPT: 82270, 82274 • HCPCS: G0328 Stool DNA (sDNA) with FIT test Jan. 1 two years prior through Dec. 31 of the current measurement year (three years) • CPT: 81528 **Surgery/hospital codes** Flexible sigmoidoscopy Jan. 1 four years prior through Dec. 31 of the current year (five years) • CPT: 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350 • HCPCS: G0104 • ICD-9 Procedure: 45.24 CT colonography Jan. 1 four years prior through Dec. 31 of the current year (five years) • CPT: 74261, 74262, 74263 Colonoscopy Jan. 1 nine years prior through Dec. 31 of the current year (10 years) • CPT: 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398 • HCPCS: G0105, G0121 **Note:** The codes below within the HEDIS value set for this measure are considered obsolete and may be denied for payment processing, if received on claims/encounters submission. • CPT: 44393, 44397, 45383, 45387 • ICD-9 Procedure: 45.22, 45.23, 45.24, 45.25, 45.42, 45.43 **Note:** Colorectal Cancer Screening (COL-E) is reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically. Providers do not need to change their documentation or claim/encounter processes.

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Controlling High Blood Pressure (CBP) **Weight = 3** Percentage of hypertensive patients 18–85 years of age whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the current measurement year **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients who died anytime during the measurement year • Patients with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant • Patients with a diagnosis of pregnancy • Patients 66 years of age and older as of Dec. 31 of the measurement year living long-term in an institutional setting or enrolled in an Institutional Special Needs Plan (I-SNP) • Patients 66–80 years of age with frailty and advanced illness or 81 years of age and older with frailty only	• 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 < 140 mm Hg and a representative diastolic BP of < 90 mm Hg to be measure compliant. BP readings can be collected via any form of outpatient visits; any combination of visit types apply. Remote monitoring devices that transmit results to your office and patient-reported results are also acceptable. **Note:** Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments. 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 measurement year. Those indications can be a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.	**Note:** Document the actual blood pressure reading. To pass administratively, the most recent adequately controlled blood pressure reading of the year must be documented and reported. If there are multiple BPs on the same date of service, record the lowest systolic and diastolic BP on that date as the representative BP. **Physician codes** • CPT II codes: – Systolic: 3074F, 3075F, 3077F* – Diastolic: 3078F, 3079F, 3080F* * These results do not meet Star measure control levels and will not fully address care opportunities. However, these codes should be used to verify that the test was performed and for monitoring/reporting of results. For more information on CBP, see: Controlling High Blood Pressure flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)

Diabetes measures

New for 2024 – three important changes for HEDIS diabetes measures

1. Eligibility factors have changed for the HEDIS diabetes measures.
2. Hemoglobin A1c Control for Patients With Diabetes (HBD) has been renamed Glycemic Status Assessment for Patients With Diabetes (GSD) and adds the Glucose Management Indicator (GMI) as an option to measure blood sugar.
3. Kidney Health Evaluation for Patients With Diabetes (KED) is a 1x weighted measure.

Eligibility for HEDIS diabetes measures

There are two ways to identify patients with diabetes: by claims and encounters and by pharmacy data. Patients will be identified as "included" for the diabetes HEDIS measures based on claim/encounter data if there are two diagnoses of diabetes in the measure year or the year prior on different dates of service.

Pharmacy data coupled with a diabetes diagnosis can also be used to identify eligible patients. A patient is eligible if he or she has had one dispensed insulin or hypoglycemics/antihyperglycemic and has one diagnosis of diabetes in the measure year or year prior.

Changes to the blood sugar control measure

The HBD measure has been renamed Glycemic Status Assessment for Patients With Diabetes (GSD) and adds the Glucose Management Indicator as an additional option to measure blood sugar level and address the measure.

KED measure status change

KED moves from the display page and enters the Star Rating Program as a 1x weighted measure.

Diabetes measures eligible population

- **Patients 18–75 years of age with diabetes (types 1 and 2)** for Glycemic Status Assessment for Patients With Diabetes (GSD) and Eye Exam for Patients With Diabetes (EED)
- **Patients 18–85 years of age with diabetes (types 1 and 2)** for Kidney Health Evaluation for Patients With Diabetes (KED)
- To be included in the diabetes measures a patient would have had either of these:
  - Dispensed insulin, hypoglycemic or antihyperglycemic medication **and** at least one diagnosis of diabetes **or**
  - At least two diagnoses of diabetes on different dates of service

Diabetes measure exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measurement year
- Patients who died anytime during the measurement year
- Patients 66 years of age and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older (66–80 for KED) who have frailty and advanced illness
- For KED – patients 81 years of age and older with frailty only

Note: Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments.

There must be **two indications of frailty on different dates of service** during the measurement year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Glycemic Status Assessment for Patients With Diabetes (GSD) **Weight = 3** Percentage of eligible diabetic patients whose blood sugar is under control (9% or less) **Note:** Hemoglobin A1c Control for Patients With Diabetes (HBD) has been renamed Glycemic Status Assessment for Patients With Diabetes (GSD) and adds the Glucose Management Indicator (GMI) as an option to measure blood sugar.	• At least one HbA1c or GMI test in current measurement year with the resulting level reported • The most recent HbA1c or GMI result in the current measurement year must have a level of 9% or less to be measure compliant. • If there are multiple glycemic status assessments on the same date, use the lowest result.	**Physician codes** • CPT II: 3044F (< 7%), 3051F (≥ 7% and < 8%), 3052F (≥ 8% and ≤ 9%), 3046F (> 9%) **Pathology/laboratory codes** • CPT: 83036, 83037 • LOINC: Glucose Management Indicator A copy of all lab results should be kept in the patient's medical record. Only the most recent result is counted for the measure, and a patient's clinical opportunity may reopen if the test has a noncompliant or missing result. GMI results collected by the patient and documented in the patient's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist. For more information on GSD, see: Glycemic Status Assessment for Patients With Diabetes flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Eye Exam for Patients With Diabetes (EED) **Weight = 1** Percentage of eligible diabetic patients who had a retinal eye exam	• 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 or current measurement year • Bilateral eye enucleation anytime during the patient's history through the current measurement year • Two unilateral eye enucleations 14 days apart **or** • A left and right unilateral eye enucleation on the same or different dates of service **Note:** Obtain the record of an eye exam performed in the current year by an ophthalmologist or optometrist and retain in the patient's medical record.	**Physician codes** • CPT II – Without retinopathy: 2023F, 2025F, 2033F – With retinopathy: 2022F, 2024F, 2026F – Diabetic retinal screening negative in the prior year: 3072F **Eye professional codes** Must be submitted by an ophthalmologist or an optometrist: • CPT: 67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002†, 92004†, 92012†, 92014†, 92018, 92019, 92134†, 92201, 92202, 92227, 92228†, 92230†, 92235†, 92240†, 92250†, 92260†, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245 • HCPCS: S0620, S0621, S3000 **Unilateral eye enucleation** • ICD-10 Procedure: 08T0XZZ, 08T1XZZ • CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **Automated eye exam** • CPT: 92229 † Cost share will apply if not billed with diabetes diagnosis codes E08–E13. For more information on EED, see: Eye Exam for Patients With Diabetes flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Kidney Health Evaluation for Patients With Diabetes (KED) **Weight = 1** **Exclusions** • Patients in hospice, using hospice services or receiving palliative care anytime during the measurement year • Patients who died anytime during the measurement year • Patients 66 years of age and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) • Patients with evidence of end-stage renal disease or dialysis anytime during the patient's history on or prior to Dec. 31 of the measurement year • Patients who had dialysis anytime during the patient's history on or prior to Dec. 31 of the measurement year • Patients 66–80 years of age as of Dec. 31 of the measurement year with frailty and advanced illness	Patients should have a kidney health evaluation in the measurement year. A kidney health evaluation consists of both an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (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: • Both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart • A uACR **Exclusions continued** • Patients with advanced illness documented on at least two different dates of service • Patients 81 years of age and older as of Dec. 31 of the measurement year with at least two indications of frailty 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 measurement year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.	Estimated glomerular filtration rate lab test • 80047, 80048, 80050*, 80053, 80069, 82565 Quantitative urine albumin lab test • 82043 Urine creatinine lab test • 82570 * 80050 is a general health panel. Providers must share the components of the panel for Humana to pay. For more information on KED, see: Kidney Health Evaluation for Patients With Diabetes flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Osteoporosis Management in Women Who Had a Fracture (OMW) **Weight = 1** Percentage of women 67–85 years of age who suffered a fracture* and who had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis in the six months after the fracture * Fractures of face, skull, fingers or toes are excluded. **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients who died anytime during the measurement year • Patients 67 years of age and older living long-term in an institutional setting or enrolled in an Institutional Special Needs Plan (I-SNP) • Patients 67–80 years of age with frailty and advanced illness • Patients 81 years of age and older with frailty only with at least two indications of frailty	Within six months of fracture date or date of discharge (if hospitalized for a fracture): • A BMD test in any setting including tests administered during inpatient stay for fracture **or** • Dispensed osteoporosis medication therapy, including any long-acting treatment provided during inpatient stay for fracture **or** • Dispensed prescription to treat osteoporosis **Patients are removed from the eligible population if they have had any one of the following:** • BMD test within 24 months prior to the fracture • Patients who had a claim/encounter for osteoporosis medication therapy during the 365 days prior to the episode date • Patients who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the episode date	**Physician codes** Osteoporosis therapy – medication injections • HCPCS: J0897, J1740, J3110, J3111, J3489 **Radiology codes** Bone mineral density test • CPT: 76977, 77078, 77080, 77081, 77085, 77086 • ICD-10 Procedure: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 For more information on OMW, see: Osteoporosis Management in Women Who Had a Fracture flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Osteoporosis Management in Women Who Had a Fracture (OMW) **Osteoporosis medications**		
Bisphosphonates	**HCPCS**	**Formulary coverage**
Alendronate tablet		T1
Alendronate 70 mg tablet		T1
Alendronate-cholecalciferol		NF
Ibandronate tablet		T2
Ibandronate 3 mg/3mL syringe and vial	J1740	T4
Risedronate tablet		T3, DR 35 mg = T4
Zoledronic acid 5 mg/100 mL	J3489	T1 w/PA Reclast
Other agents		
Abaloparatide		NF
Denosumab	J0897	NF
Raloxifene		T3
Romosozumab	J3111	NF
Teriparatide 600 mcg/2.4 mL		NF
Teriparatide 620 mcg/2.48 mL	J3110	NF

Based on 2024 Super National 5 MAPD PA	**PA = Prior authorization**	**DR = Delayed release** **NF = Non-formulary**

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Statin Therapy for Patients With Cardiovascular Disease (SPC) **Weight = 1** Percentage of males 21–75 years of age and females 40–75 years of age 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 in the current measurement year **Exclusions** • Patients in hospice, using hospice or receiving palliative care • Patients who died anytime during the measurement year • Patients 66–75 years of age who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) • Patients 66–75 years of age who have frailty **and** advanced illness – Frailty must have **at least two indications on different dates of service** during the measurement year – Advanced illness must have **at least two different dates of service** in the measurement year or year prior or dispensed dementia medication • Patients with the following diagnoses or services in the current or prior measurement year:	At least one dispensing event for a high- or moderate-intensity statin medication in the measurement year 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** – during the current and prior measurement year: At least one acute inpatient or outpatient visit with a diagnosis of ischemic vascular disease (IVD) **Note:** Advanced illness can be diagnosed via telehealth visits, including audio-only and online assessments. Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.	**Statin medications** The statin medications listed below will address your patient's open SPC opportunities with a processed pharmacy claim. • **Moderate-intensity statin therapy** – Atorvastatin 10–20 mg* – Amlodipine-atorvastatin 10–20 mg – Ezetimibe-simvastatin 20–40 mg – Fluvastatin 40–80 mg – Lovastatin 40 mg – Pitavastatin 1–4 mg – Pravastatin 40–80 mg – Rosuvastatin 5–10 mg – Simvastatin 20–40 mg • **High-intensity statin therapy** – Atorvastatin 40–80 mg – Amlodipine-atorvastatin 40–80 mg – Ezetimibe-simvastatin 80 mg – Rosuvastatin 20–40 mg – Simvastatin 80 mg** * Evidence from one randomized controlled trial (RCT) only: down-titration if unable to tolerate atorvastatin 80 mg in Incremental Decrease in End Points 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. For more information on OMW, see: Statin Therapy for Patients With Cardiovascular Disease flyer

– Pregnancy or in vitro fertilization (IVF) – Cirrhosis – Dispensed clomiphene medication – End-stage renal disease or dialysis – Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year		

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)

Care Coordination measures

Measures in this section address a provider's awareness of a patient's hospital and emergency admissions and discharges.

- 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)
- Transitions of Care (TRC)
  - 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)

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

Measure	Service needed	What to report (sample of codes)
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) **Weight = 1** Medicare Advantage patients 18 years of age and older with multiple high-risk chronic conditions who had a follow-up visit within seven days of an emergency department (ED) visit on or between Jan. 1 and Dec. 24 of the measurement year. **Exclusions** • Patients in hospice or using hospice services • Patients who died anytime during the measurement year • Any ED visit resulting in an inpatient admission on the day of, or within seven days following, the ED visit regardless of the principal diagnosis for admission • ED visits occurring within the same eight-day period	FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed. Patients must have a follow-up visit or service within seven days of the ED visit (eight days total). This includes visits that occur on the day of the ED visit. **Example:** An ED visit on April 1 is in scope, but subsequent visits occurring April 2–8 are not. If the same patient visits an ED on April 9, this would be a new event requiring follow-up. • An outpatient, telephone or telehealth visit, including those for behavioral health services in a clinic, at home or at a community mental health center • An intensive outpatient encounter or partial hospitalization stay including observation visits Other settings are included. For more information, follow this link.	There is not a provider type requirement defined in the FMC measure specification itself. Any claim submitted with an appropriate clinical code would be considered toward the measure. • **Note:** If an ED visit results in an inpatient admission on the day of, or within seven days following, the ED visit is not considered for the FMC measure. • **Note:** If a patient has more than one ED visit in an eight-day period, only the first eligible ED visit is included. **Codes to address the measure:** **Outpatient visits** CPT/CPT II: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483 **Telephone visits** CPT/CPT II: 98966, 98967, 98968, 99441, 99442, 99443 **Transitional care management** CPT: 99495, 99496 For more information on FMC, see: Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Medication Reconciliation Post-Discharge (MRP)* **Weight = 1** Percentage of discharges from Jan. 1–Dec. 1 of the current measurement year for patients 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total). 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 Dec. 1. **Exclusions** • Patients in hospice or using hospice services • Patients who died anytime during the measurement year • Inpatient stays with a discharge date of Dec. 2–31 *** Medication Reconciliation Post-Discharge (MRP) remains a stand-alone measure, in addition to being a component of the Transitions of Care (TRC) measure.**	• Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the day the patient is discharged through 30 days after discharge (31 total days) • Licensed practical nurses and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider. • When patients are directly transferred to another facility, perform reconciliation for final discharge and document all medication reconciliations with a dated notation in outpatient medical records. **Additional considerations** • Medication name is required; while dose and frequency are not required, their inclusion is highly recommended. • The reconciled medication list should be communicated to the discharged patient by a clinician. • Medication reconciliation may be done via office visit, home visit or telehealth visit, including real-time, interactive audio/video visits and audio-only.	**Physician codes** • CPT: 99483, 99495, 99496, 99605, 99606 • CPT II: 1111F **Notations for a complete medication reconciliation may include:** • Current medications with a notation that a 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. 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 the discharge summary that discharge medications were reconciled with the current medications (There must be evidence that the discharge summary was filed in the outpatient chart within 30 days after discharge [31 days total].) • Notation that no medications were prescribed or ordered upon discharge For more information on MRP, see: Medication Reconciliation Post-Discharge flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Plan All-Cause Readmissions (PCR) **Weight = 3** Percentage of patients 18 years of age and older who have had an acute inpatient or observation stay through Dec. 1 of the measurement year 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 be admitted to the same hospital or a different one. * 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. **Exclusions** • Stays with discharge dates of Dec. 2–31 • Pregnancy-related admission • Patients in hospice or using hospice services • Patients who died during a stay • Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1 of the current measurement year • For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered.	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.	No reporting is needed from healthcare providers. For more information on PCR, see: Plan All-Cause Readmissions flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)

Care Coordination: Transitions of Care (TRC)

Weight = 1

The Transitions of Care 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. This 1.0 weighted measure consists of four component measures:

- 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)

Exclusions

- Patients in hospice or using hospice services
- Patients who died anytime during the measurement year
- Discharges occurring after Dec. 1 of the measurement year

Note: There is a Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure that is also referred to as Care Coordination (CC).

Measure	Service needed	What to report (sample of codes)
Transitions of Care – Notification of Inpatient Admission (TRC–NIA) **Weight = 1** Documentation of receipt of notification of inpatient admission on the day of admission or the two following days (three calendar days total) This is a component of Transitions of Care (TRC), a 1x weighted measure that is an average of four component measures (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP).	• 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	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 For more information on TRC–NIA, see: Transitions of Care flyer

	• Notification of admission by patient or patient's family to primary care physician 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 the information was filed in the EHR and is accessible to the primary care physician or ongoing care provider on the day of discharge through two days after discharge (three total days) meets criteria.	

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Transitions of Care – Receipt of Discharge Information (TRC–RDI) **Weight = 1** Documentation of receipt of discharge information on the day of discharge or the two following days (three calendar days total) This is a component of Transitions of Care (TRC), a 1x weighted measure that is an average of four component measures (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP).	• To address the measure, the patient's outpatient medical record must include documentation by his/her primary care physician 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.* * 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 primary care physician or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets 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.	Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structural fields in an EHR. At a minimum, the discharge information must include all of the following: • The practitioner responsible for the patient's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Testing results, or documentation of pending tests or no test pending • Instructions for patient care post-discharge For more information on TRC–RDI, see: Transitions of Care flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Transitions of Care – Patient Engagement After Inpatient Discharge (TRC–PED) **Weight = 1** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge (not the date of discharge) This is a component of Transitions of Care (TRC), a 1x weighted measure that is an average of four component measures (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP).	• 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 primary care physician 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 patient and provider) **Note:** If a patient is unable to communicate, his/her primary care physician can interact with a caregiver.	**Physician codes** • CPT: 98966, 98967, 98968, 99442, 99443, 99495, 99496, modifier 95 For more information on TRC–PED, see: Transitions of Care flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Transitions of Care – Medication Reconciliation Post-Discharge (TRC–MRP) **Weight = 1** Percentage of discharges from Jan. 1–Dec. 1 of the current measurement year for patients 18 years of age and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 days total). 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 Dec. 1. **Exclusions** • Patients in hospice or using hospice services • Patients who died anytime during the measurement year • Inpatient stays with a discharge date of Dec. 2–31 This is a component of Transitions of Care (TRC), a 1x weighted measure that is an average of four component measures (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP). 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.	• Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the day the patient is discharged from the hospital through 30 days after discharge (31 total days) • Licensed practical nurses and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider. • When patients are directly transferred to another facility, perform reconciliation for final discharge. • Document all medication reconciliations with a dated notation in outpatient medical records. **Additional considerations** • Medication name is required; dose and frequency are not but their inclusion is highly recommended. • The reconciled medication list should be communicated to the discharged patient by a clinician. • Medication reconciliation may be done via office, home or telehealth visit, including real-time, interactive audio/video visits and audio-only.	**Physician codes** • CPT: 99483, 99495, 99496, 99605, 99606 • CPT II: 1111F **Notations for a complete medication reconciliation may include:** • Current medications with a notation that a 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 filed in the outpatient chart within 30 days after discharge [31 days total].) • Notation that no medications were prescribed or ordered upon discharge For more information on TRC–MRP, see: Transitions of Care flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey conducted for Medicare Advantage (MA) plans by a vendor contracted by CMS. The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, MA 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 July and November.

Measure	Best practices	Survey questions
Improving Bladder Control – Management of Urinary Incontinence in Older Adults (MUI) **Weight = 1** Percentage of surveyed patients 65 years of age 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 **Exclusion** • Patients in hospice	• 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 with 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.	• Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? • During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep? • Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine? • 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?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Health Outcomes Survey (HOS)		
Measure	**Best practices**	**Survey questions**
Improving or Maintaining Mental Health (IMMH) **Weight = 1** Percentage of sampled Medicare enrollees 65 years of age and older whose mental health status was the same or better than expected after two years **No patient exclusions exist for this measure.**	• Administer PHQ-2 and PHQ-9 Mental Health Assessments. • Discuss mental/emotional health and explain to patients that this is a part of their well-being and is 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.	• 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 • 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? • During the past four weeks, how much of the time has your physical health or any emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Health Outcomes Survey (HOS)		
Measure	**Best practices**	**Survey questions**
Improving or Maintaining Physical Health (IMPH) **Weight = 1** Percentage of sampled Medicare enrollees 65 years of age and older whose physical health status was the same or better than expected after two years **No patient exclusions exist for this measure.**	• 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.	• 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? • 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? • During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
Monitoring Physical Activity – Physical Activity in Older Adults (PAO) **Weight = 1** Percentage of sampled Medicare patients 65 years of age and 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 **Exclusions** • Patients in hospice • Patients responding, "I had no visits in the past 12 months"	• Explain to patients that an exercise regimen could increase their quality of life and longevity. • Determine if it is appropriate for your patients to start, maintain or increase their 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.	• In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? 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? 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.

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Health Outcomes Survey (HOS)		
Measure	**Best practices**	**Survey questions**
Fall Risk Management (FRM) – Reducing the Risk of Falling **Weight = 1** Percentage of Medicare patients 65 years of age and older who had a fall or had problems with balance or walking 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 **Exclusion** • Patients in hospice and answering, "I had no visits in the past 12 months"	• Take advantage of and share the Centers for Disease Control and Prevention's Stopping Elderly Accidents, Deaths & Injuries (STEADI) online training and materials. • Provide questionnaires that address this topic that patients can complete prior to the appointment or while they wait in the waiting room. • Encourage your patients to talk about 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. • 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.	• 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 provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking? • Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? 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

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS is an annual patient survey conducted for Medicare Advantage (MA) plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in MA 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 his/her physicians and other healthcare providers; the remaining three correlate to patient experience with their MA plan. There are no patient exclusions for CAHPS measures.

Measure	Best practices	Survey questions
Annual Flu Vaccine (FLU) **Weight = 1** Percentage of sampled Medicare enrollees who received an influenza vaccination **No patient exclusions exist for this measure.**	• 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 of age and older – Patients with cardiovascular and/or respiratory disease – Cancer patients and survivors – Diabetic patients • Ensure any practice staff members scheduling appointments are 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.	• Have you had a flu shot since July 1 (prior year)?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Care Coordination (CC) **Weight = 2** 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). **No patient exclusions exist for this measure.**	• Within patients' medical records, 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 and document the names of the patients' interdisciplinary care team members, as well as the results of any services rendered by other healthcare providers. • 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 him/her the names and phone numbers of specialists. • Schedule follow-up with patients within one month of the specialist visit to discuss results. • Advise your patients to bring to their next appointment a list of all the prescription medicines they are taking 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, OTC 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.	• In the last six months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care? • 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? • 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? • In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • 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? • In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Getting Appointments and Care Quickly (GACQ) **Weight = 2** Assesses how quickly the patients were able to get appointments and care **No patient exclusions exist for this measure.**	• 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 complete 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.	• 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 get an appointment for a checkup or routine care as soon as 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?
Getting Needed Care (GNC) **Weight = 2** Assesses how easy it was for patients to get needed care and see specialists **No patient exclusions exist for this measure.**	• Schedule specialist follow-ups on behalf of your patients before they leave your office. • If specialist follow-up care cannot be scheduled when your patients are 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.	• In the last six months, how often did you get an appointment to see a specialist as soon as you needed? • In the last six months, how often was it easy to get the care, tests or treatment you needed?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Getting Needed Prescription Drugs (GNRx) **Weight = 2** Assesses how easy it is for patients to get the prescription drugs their doctor prescribed **No patient exclusions exist for this measure.**	• 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.	• In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Rating of Health Care Quality (RHCQ) **Weight = 2** Assesses patients' view of the quality of the healthcare they received **No patient exclusions exist for this measure.**	• Ask questions to gauge the patient's 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 patients understand: – Their care plan – Services performed or ordered – How to manage their chronic conditions – When and how to best take their medications	• Using any number from 0 to 10, with 0 being the worst healthcare possible and 10 being the best healthcare possible, what number would you use to rate all of your healthcare in the last six months?

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Patient Safety

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

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. Here is an example of how the PDC is calculated:

Patient 1: John had his first refill of diabetes medication in 2023 on Jan. 6. From Jan. 6, 2023, to Dec. 31, 2023, his days in the measurement period are 361. He is adherent and usually picks up refills on time for 90-day supplies. The only time he was late in 2023 was when he was out of town and picked up his medication 10 days late. Thus, his days covered are 351 (361 minus 10). John's PDC for the year is 97% (351 days out of 361).

Patient 2: Joan begins cholesterol medication on Aug. 13, 2023, and has her second fill on Oct. 2, 2023, which qualifies for the measure at that time. From Aug. 13, 2023, to Dec. 31, 2023, her days in the measurement period are 141. She fills a 30-day supply and is consistently late picking up her medication. She has four refills in 2023 and a total of 30 days late. Her days covered are 111 (141 minus 30). Her PDC rate for the year is 79% (111 days out of 141).

Best practices for medication adherence measures

- Ask patients if they are still taking medication and if they missed doses during the past week or month to identify and resolve patient-specific adherence barriers.
- Reinforce patients' understanding of the importance of taking their diabetes, cholesterol and hypertension medications exactly as prescribed, as well as the expected duration of the therapy.
- Inquire whether they forget to refill or have trouble getting medications from their pharmacy; retail or mail pharmacy 90-day fills may offer less-frequent trips to the pharmacy or eliminate them altogether
- If appropriate, prescribe 90-day supplies for maintenance medications and encourage patients to ask the pharmacy to auto-refill their medications.
- Offer tips for forgetfulness such as plastic pill box organizers, pairing medication placement with daily routine, setting alarms to take medications at the same time daily, and digital applications available on mobile devices (e.g., Medisafe or EveryDose).
- Giving patient materials—such as a medication instruction sheet covering common side effects, reasons why and how to take medication, and tips for remembering doses—might help reinforce discussions.
- Evaluate individual health-related social needs (HRSN)—conditions in which patients are born, work, live and age, which may impact adherence. If HRSN are a concern, you may refer patients to Humana Community Navigator® at **Humana.findhelp.com**, which is an online directory of over 500,000 community resources nationwide.
- 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.

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Patient Safety	
Medication adherence measure	**Exclusions**
Medication Adherence for Cholesterol (Statins) Proportion of Days Covered: Statins (PDC–STA/MAC) **Weight = 3** Percentage of patients 18 years of age 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	• Patients in hospice or using hospice services • Patients with end-stage renal disease or dialysis For more information on Medication Adherence measures, see: Medication Adherence flyer
Medication Adherence for Diabetes Medications Proportion of Days Covered: Diabetes All-Class Rate (PDC–DR/MAD) **Weight = 3** Percentage of patients 18 years of age 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	• Patients in hospice or using hospice services • Patients with end-stage renal disease or dialysis • Patients who had filled a prescription for insulin
Medication Adherence for Hypertension (RAS Antagonists) Proportion of Days Covered: Renin Angiotensin System Antagonists (PDC–RASA/MAH) **Weight = 3** Percentage of patients 18 years of age and older with Part D benefits with at least two high blood pressure medication prescription fills on unique dates 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	• Patients in hospice or using hospice services • Patients with end-stage renal disease or dialysis • Prescription(s) filled for Entresto® (sacubitril/valsartan)

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Patient Safety		
Measure	**Activity needed**	**Best practices**
Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) **Weight = 1** Percentage of Part D patients 18 years of age and older eligible for and enrolled in the MTM program for at least 60 days who received a comprehensive medication review (CMR) during the measurement year **MTM eligibility criteria** Have three of the following five chronic diseases: • Chronic heart failure • Osteoarthritis • Chronic obstructive pulmonary disease • Depression • Diabetes **and** • Be taking a minimum of eight chronic/maintenance Part D drugs; **and** • Anticipated Part D drug cost of more than $5,330 per year Eligibility is determined by looking back at the most recent three months' calculation. **Exclusion** • Patients in hospice or using hospice services	• An interactive, person-to-person or telehealth medication review and consultation of all medications must be completed by a pharmacist or qualified healthcare professional during the measurement year. • The review should include all of your patient's medications, including 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/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.	• 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 – Provide contact information for 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 CenterWell Pharmacy at **855-202-2510**, Monday – Friday, 9 a.m. – 5:30 p.m., Eastern time. For more information on CMR, see: Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Patient Safety		
Measure	**Activity needed**	**Best practices**
Statin Use in Persons with Diabetes (SUPD) **Weight = 1** Percentage of patients with Part D benefits who are 40–75 years of age 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 **Exclusions** • Patients in hospice or using hospice services • Patients with a diagnosis of end-stage renal disease or dialysis • Patients with rhabdomyolysis or myopathy • Patients who are pregnant, lactating or undergoing therapy for fertility • Patients with cirrhosis • Patients with prediabetes • Patients with polycystic ovary syndrome	• At least one fill for a statin medication of any intensity in the measurement year • Use lists of SUPD-eligible patients to review medications and evaluate addition of statin therapy to existing regimen in alignment with the 2018 American College of Cardiology and American Heart Association (ACC/AHA) guidelines.	• 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 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 patient's health factors and any drug-to-drug interactions with current medications. • Cross-reference patients qualifying for SUPD with patients qualifying for SPC. If the patient qualifies for both measures, consider a moderate- or high-intensity statin, as you deem medically appropriate. For more information on SUPD, see: Statin Use in Persons with Diabetes flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Polypharmacy measures

New CMS polypharmacy measures may be in effect starting in 2025. There is no standard definition for polypharmacy. However, the consensus is that the term "polypharmacy" means that a patient is taking **five or more** medications. Polypharmacy includes the use of medications that are not medically necessary. This includes medications that are not indicated, not effective and/or have therapeutic duplication.

The Use of High-Risk Medications in the Elderly (HRM) measure was a Star measure from MY2007–MY2015. HRM was replaced by two more targeted polypharmacy measures:

- Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)
- Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (POLY–CNS)

Measure	Activity needed	Best practices
Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH) **Weight = Display** Percentage of Part D beneficiaries 65 years of age and older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period. Only paid, irreversible prescription claims are included in the data set to calculate the measure. **Exclusion** • Patients enrolled in hospice during the measurement period	• CMS wants to ensure that patients are **not** taking **two or more** unique ACH medications that have overlapping days' supply for **30 or more cumulative days** during the measurement period. • "Unique" means that there are different active ingredients. • If the number of fills remains at less than two, there is no action at all. • If the number of fills is two or more and has an overlapping supply, the patient will be included in the numerator. • The more patients in the numerator, the worse the performance. A lower rate indicates a better performance.	**Anticholinergic medications** • Antihistamines • Antiparkinsonian agents • Skeletal muscle relaxants • Antidepressants: Tricyclic antidepressants (TCAs) and paroxetine • Antipsychotics **Antiarrhythmics (disopyramide)** • Antimuscarinics • Antispasmodics • Antiemetics **Recommended best practices** • Before prescribing a new medication, check to see if it falls on the POLY–ACH measure drug list. • If POLY–ACH medications cannot be avoided: – Use the lowest dose, frequency and duration necessary – Minimize overlap with other polypharmacy drugs (e.g., limit supply duration) – Document acknowledgment of risk in the patient's medical chart • Educate patients about the risk of falls, drug interactions and adverse drug events when taking multiple medications. • Review medications each visit for polypharmacy and consider removal or replacement with a clinical alternative. For more information on POLY–ACH, see: Polypharmacy flyer

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Polypharmacy measures		
Measure	**Activity needed**	**Best practices**
Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (POLY–CNS) **Weight = Display** Percentage of individuals 65 years of age and older with concurrent use of three or more unique central nervous system (CNS)-active medications Only paid, nonreversed prescription claims are included in the data set to calculate the measure. **Exclusions** • Patients with seizure disorder diagnosis during the measurement period • Patients in hospice care during the measurement period	CMS wants to ensure that patients are **not** taking three or more unique CNS medications that have overlapping days' supply for 30 or more cumulative days during the measurement period. "Unique" means that there are different active ingredients. If the number of fills for each unique CNS drug remains less than two, there is no action at all. If the number of fills for each unique CNS drug is two or more with unique dates of service, the patient will be included in the numerator. The more patients in the numerator, the worse the performance. A lower rate indicates a better performance.	**Medication classes included** • Antiepileptics • Antidepressants • Serotonin-norepinephrine reuptake inhibitors (SNRIs) • Selective serotonin reuptake inhibitors (SSRIs) • Tricyclic antidepressants (TCAs) • Antipsychotics • Opioid analgesics • Benzodiazepines • Nonbenzodiazepine sedative/ hypnotics **Recommended best practices** • Avoid unless safer drug alternatives and nonpharmacological strategies have been ineffective. • Consider reducing use of other CNS-active medications. • Consider tapering to avoid symptom recurrence and discontinuation syndromes. • Implement strategies to reduce fall risk (e.g., assistive devices, home safety evaluation, balance and strength training). For more information on POLY–CNS, see: Polypharmacy flyer

Additional Star Rating Program resources:
- CPT II Codes flyer
- Advanced Illness and Frailty guide
- HEDIS Eligibility and Exclusions flyer
- HEDIS Exclusions grid
- Cut Point Trends Chart

Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

Please ensure that all telehealth or telephone/virtual visits are billed in accordance with Humana's telehealth guidance. For more information, visit **Humana.com/provider/telehealth-faq**.

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