Quality Indicator Reference for Physicians

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

Provided by CarePlus

238005CP0623

H1019_SMPrvdQualityMeasuresGuide2023

Quality Indicator Reference Guide Overview

The Centers for Medicare & Medicaid Services (CMS) created the Star Rating Program to raise the quality of care for Medicare enrollees electing Medicare Advantage (MA) coverage from health plans versus Original Medicare. The program is aligned with CMS' quality strategy goals to optimize health outcomes, improve members' experience and access to care, and maximize efficiency and cost savings.

Star Ratings are released annually by CMS and help Medicare beneficiaries select the best Medicare Advantage plan for their healthcare needs. The ratings enable health plan performance comparison on an apples-to-apples basis and hold plans accountable for the care of their members by physicians, hospitals and other healthcare providers.

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

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

In the guide for each measure, we've provided the:

- Measure name and abbreviation
- Weight assigned by CMS that is used when calculating summary or overall Star ratings
- Definition of the measure, including its eligible population and expected quality activity and/or outcome
- Best practices for addressing the measure with patients
- Applicable exclusions that will remove a patient from the eligible population for a measure
- For HEDIS measures: the service(s) needed and coding guidance to ensure measure compliance
- For Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures: applicable question(s) from the respective survey administered to Medicare Advantage patients
- For Patient Safety measures: the prescription drug activity needed for compliance

You will also find information for display measures within this guide. These measures are not currently part of the Star Rating Program, but, in some cases, they may be recent Star measures that underwent substantive changes and have been temporarily moved to display. In many cases, these are new measures being performance tested before they are designated as a Star measure. They could also be former Star measures that may be retired in the future. As we do not have access to the same details that are available for Star measures, we have provided any information available from CMS' Medicare current Part C & D Display Measure Technical Notes and HEDIS current Vol. 2 technical specifications. For MY 2023, some display measures are averaged to obtain a score for a Star measure (see Transitions of Care).

The information in this guide is subject to change based on CMS regulatory guidance and technical specification changes from NCQA and/or PQA. Measure details can change annually (i.e., service needed for compliance, applicable codes).

Table of contents

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 required by the NCQA for compliance and accreditation. HEDIS measures are created for all types of health plans – commercial, Medicaid and Medicare. Listed here are those chosen by CMS to include in the Medicare Star Rating Program as they align with their domains of care for Medicare beneficiaries.

CarePlus weights are aligned with CarePlus' Star reports. Measure weights may differ from CMS weights and are subject to change.

Measurement year (MY) 2023 priority HEDIS measures

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

Changes to HEDIS measures

Note: Changes apply to measurement year 2023 (MY2023) and subsequent measure years unless otherwise specified.

Breast Cancer Screening (BCS)

- Bilateral mastectomy is a required exclusion.
- Patients who died during the measurement year is a required exclusion.
- Measure to be reported via Electronic Clinical Data Systems.

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Conditions (FMC)

- Added domiciliary/rest home visit to the follow-up services list.
- Required exclusion added for patients who died during the measurement year.

Care for Older Adults (COA) and its submeasures

- Functional Status Assessment (COA–FSA) remains a display measure.

Colorectal Cancer Screening (COL)

- Colorectal cancer, total colectomy and patients who died are now required exclusions.

Controlling High Blood Pressure (CBP)

- Pregnancy, end-stage renal disease/dialysis/nephrectomy/kidney transplant and nonacute inpatient admissions are now required.

Plan All-Cause Readmissions (PCR)

- Plan All-Cause Readmissions returns to the Star Rating Program as an active measure at 3x weight.

HEDIS | BREAST CANCER SCREENING

Breast Cancer Screening (BCS) | CMS Weight = 1 CarePlus Weight = 1

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

Service needed for compliance

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

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

BCS measure best practices

- Due to the unique 27-month measurement period, physician practices may want to consider ordering a mammogram every two years for their patients beginning at 50 years old, or sooner when risk factors such as family history exist.
- Provide female patients with a list of facilities that provide mammograms, schedule appointments and follow up to confirm completion and obtain reports.
- Document date of service (at minimum month and year) of most recent mammogram in the medical record.
- Document mastectomy status and date of service (minimum year performed) in the medical record.
- If patient meets exclusion criteria, ensure proper code(s) and modifier(s) are submitted to ensure he/she is excluded from the measure.

Required exclusions

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

Breast Cancer Screening (BCS)

Code	Code type	Definition
77061	CPT	Breast, mammography
77062	CPT	Breast, mammography
77063	CPT	Breast, mammography
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed

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

Current Procedural Terminology (CPT): 77055, 77056 and 77057; Healthcare Common Procedure Coding System (HCPCS): G0202, G0204 and G0206; International Classification of Diseases (ICD)-9 Procedure: 87.36 and 87.37

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

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

The eligible population for this measure includes Medicare Advantage patients 18 years old and older with multiple high-risk chronic conditions who visit an emergency department (ED) on or between Jan. 1 and Dec. 24 of the measurement year. Not included in the denominator are:

- Any ED visits that result in an inpatient stay
- ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within seven days after the ED visit
- Any additional ED visits occurring within the same eight-day period of the initial ED visit

Service needed for compliance

Members must have a follow-up visit or service within seven days of the ED visit via:

- An outpatient, telephone or telehealth visit, including those for behavioral health (BH) services in a clinic, at home or at a community mental health center
- An outpatient or partial hospitalization stay including observation visits
- Transitional care management services
- A case management visit
- Complex care management services
- Monitored electroconvulsive therapy in an outpatient, ambulatory surgical or partial hospitalization setting
- An e-visit or virtual check-in
- A domiciliary or rest home visit
- A substance use disorder service

Note: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed.

Events are included for members diagnosed with two or more of these chronic conditions on different dates of service. Visits must be for the same eligible chronic condition during the current measurement year or the year prior:

- Chronic respiratory conditions such as chronic obstructive pulmonary disease (COPD), asthma and emphysema
- Alzheimer's disease and other dementia-related disorders
- Chronic kidney disease (CKD)
- Depression

- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

FMC measure best practices

- Work with hospitals and/or the Florida Health Information Exchange (HIE) system to receive notifications of ED visits.
- Obtain census information from EDs/facilities whenever possible.
- Implement nurse-led clinical outreaches post ED visit.

Required exclusions

- Patients in hospice or using hospice services
- Patients who died any time during the measurement year
- Any ED visit that results in an inpatient admission on the day of, or within seven days following, the ED visit
- ED visits occurring within the same eight-day period

FMC follow-up service codes

Code	Code type	Definition
98960	CPT	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	CPT	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	CPT	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
98966	CPT	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	CPT	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

98968	CPT	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99078	CPT	Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
99201	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making
99202	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	CPT	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
99212	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

99215	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99217	CPT	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])
99218	CPT	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
99219	CPT	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99220	CPT	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99241	CPT	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	CPT	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or

		coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	CPT	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	CPT	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	CPT	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99341	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99342	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99343	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

		family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99344	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99345	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
99347	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99348	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99349	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99350	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other

		qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99366	CPT	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99385	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99395	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided

		to individuals in a group setting (separate procedure); approximately 30 minutes
99412	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99429	CPT	Unlisted preventive medicine service
99439	CPT	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99441	CPT	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	CPT	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	CPT	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99455	CPT	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

99456	CPT	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
99487	CPT	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99489	CPT	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care

		plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	CPT	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month.) (Use G2058 in conjunction with 99490.) (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.)
99491	CPT	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
99492	CPT	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	CPT	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing

		collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
99494	CPT	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
99495	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
99510	CPT	Home visit for individual, family, or marriage counseling
G0155	HCPCS	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0176	HCPCS	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	HCPCS	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0402	HCPCS	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0409	HCPCS	Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-

		face; individual (services provided by a CORF qualified social worker or psychologist in a CORF)
G0410	HCPCS	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	HCPCS	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0463	HCPCS	Hospital outpatient clinic visit for assessment and management of a patient
G0506	HCPCS	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
G0512	HCPCS	Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month
H0002	HCPCS	Behavioral health screening to determine eligibility for admission to treatment program
H0004	HCPCS	Behavioral health counseling and therapy, per 15 minutes
H0031	HCPCS	Mental health assessment, by nonphysician
H0034	HCPCS	Medication training and support, per 15 minutes
H0035	HCPCS	Mental health partial hospitalization, treatment, less than 24 hours
H0036	HCPCS	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	HCPCS	Community psychiatric supportive treatment program, per diem

H0039	HCPCS	Assertive community treatment, face-to-face, per 15 minutes
H0040	HCPCS	Assertive community treatment program, per diem
H2000	HCPCS	Comprehensive multidisciplinary evaluation
H2001	HCPCS	Rehabilitation program, per 1/2 day
H2010	HCPCS	Comprehensive medication services, per 15 minutes
H2011	HCPCS	Crisis intervention service, per 15 minutes
H2012	HCPCS	Behavioral health day treatment, per hour
H2013	HCPCS	Psychiatric health facility service, per diem
H2014	HCPCS	Skills training and development, per 15 minutes
H2015	HCPCS	Comprehensive community support services, per 15 minutes
H2016	HCPCS	Comprehensive community support services, per diem
H2017	HCPCS	Psychosocial rehabilitation services, per 15 minutes
H2018	HCPCS	Psychosocial rehabilitation services, per diem
H2019	HCPCS	Therapeutic behavioral services, per 15 minutes
H2020	HCPCS	Therapeutic behavioral services, per diem
S0201	HCPCS	Partial hospitalization services, less than 24 hours, per diem

S9480	HCPCS	Intensive outpatient psychiatric services, per diem
S9484	HCPCS	Crisis intervention mental health services, per hour
S9485	HCPCS	Crisis intervention mental health services, per diem
T1015	HCPCS	Clinic visit/encounter, all-inclusive
T1016	HCPCS	Case management, each 15 minutes
T1017	HCPCS	Targeted case management, each 15 minutes
T2022	HCPCS	Case management, per month
T2023	HCPCS	Targeted case management; per month

HEDIS | CARE COORDINATION: PLAN ALL-CAUSE READMISSIONS

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

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

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

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

Service needed for compliance

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

PCR measure best practices

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Monitor admission and discharge reports.
    - Ensure discharged patients are seen within seven days.
    - Conduct medication reconciliation during first post-discharge visit with patients.
    - Have a discussion with patients to determine if they understand the discharge instructions, or if they have issues requiring immediate attention.
    - Remove access to care barriers to prevent a readmission (e.g., ability to get the medications prescribed at discharge, transportation for follow-up appointments and/or home health).
    - Connect patients to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.

Required exclusions

- Pregnancy-related admission
- Patients in hospice or using hospice services
- Patients who died during their inpatient stay
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1
- For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered.

HEDIS | CARE COORDINATION: TRANSITIONS OF CARE

Transitions of Care (TRC) | CMS Weight = 1

The Transitions of Care (TRC) measures evaluate patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year for patients 18 years old and older. The measure is an average of four submeasures: MRP*, NIA, PED, RDI. **Note:** There is a CAHPS measure that is also referred to as Care Coordination (CC).

Note: Per CMS' Final Rule from 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.

The four composite measures include:

- 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)

Required exclusions

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

Medication Reconciliation Post-Discharge (TRC–MRP) | CMS Weight = 1 CarePlus Weight = 1

Percentage of discharges from Jan. 1–Dec. 1 of the measurement year for patients 18 years old and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

Please note: Inpatient stays with a discharge date of Dec. 2–31 are excluded from this measure.

Service needed for compliance

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

- Licensed practical nurses (LPNs) and other nonlicensed staff can perform the medication reconciliation, but it must be reviewed and co-signed by a physician, clinical pharmacist, physician assistant or RN any time during the measure year (MY).
- When patients are directly transferred to another facility, perform reconciliation for final discharge.

TRC–MRP measure best practices

- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications. Medication names are needed. While dose, route and frequency are not required, their inclusion is highly recommended.
- See patients in the office as soon as possible after an acute discharge stay.

- If a patient is unable to visit the office, medication reviews can be completed via all telehealth methods including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or member presence are not required.
- Review all discharge summaries and document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record). Any of these medical record notations will ensure measure compliance:
    - Document a statement of medication reconciliation in the progress notes and submit via supplemental data
    - 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
    - Documentation in the discharge summary that discharge medications were reconciled with most recent medication list in the outpatient record. There must be evidence that the discharge summary was filed in outpatient record within 30 days after discharge.
    - Notation that no medications were prescribed or ordered upon discharge
    - The final reconciled medication list should be communicated to the patient by the physician or clinical office staff during an office or home visit. It can also be communicated by telephone or virtually.

TRC – Medication Reconciliation Post-Discharge

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

99495	CPT	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, face-to-face visit, within 14 calendar days of discharge.
99496	CPT	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, face-to-face visit, within 7 calendar days of discharge.
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record.

Notification of Inpatient Admission (TRC–NIA) | CMS Weight = N/A CarePlus Weight = N/A

Service needed for compliance

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

Patient Engagement after Inpatient Discharge (TRC–PED) | CMS Weight = N/A CarePlus Weight = 1

Service needed for compliance

- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge (not the date of discharge)
- To address the measure, the patient must be engaged within 30 days of discharge via:
    - Outpatient visits, including office or home visits

- A telephone visit
- A synchronous telehealth visit where real-time interaction occurred between the patient and his/her PCP with audio and video communication
- An e-visit or virtual check-in (asynchronous where two-way interaction, which was not real-time, occurred between the member and provider)

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

TRC – Patient Engagement after Inpatient Discharge (PED) codes

Code	Code type	Definition
95	CPT	Outpatient visit in the office or patient's home via a telehealth visit use modifier
98966	CPT	Telehealth visit
98967	CPT	Telehealth visit
98968	CPT	Telehealth visit
98969	CPT	Online evaluation and management services
98970	CPT	Online evaluation and management services
98971	CPT	Online evaluation and management services
98972	CPT	Online evaluation and management services
99441	CPT	Telehealth visit
99442	CPT	Telehealth visit
99443	CPT	Telehealth visit
99444	CPT	Telehealth visit
99467	CPT	Pediatric Critical Care Patient Transport Services
99495	CPT	Transitional care management service
99496	CPT	Transitional care management service
G0071	HCPCS	Interactive outpatient encounter
G2010	HCPCS	Interactive outpatient encounter
G2012	HCPCS	Interactive outpatient encounter

Receipt of Discharge Information (TRC–RDI) | CMS Weight = N/A CarePlus Weight = N/A

Service needed for compliance

- Documentation of receipt of notification of inpatient admission on the day of admission or the two following days

- To address the measure, the patient's outpatient medical record must include documentation by his/her PCP practice that discharge information was received on the day of discharge or within the two following days. Evidence must include a date stamp when the documentation was received. Any documentation that does not include a time frame or date stamp does not meet criteria.*
- Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–RDI.
- Discharge information may be included in:
    - A discharge summary
    - A summary of care record
    - Structured fields in an electronic health record (EHR)

    At a minimum, the discharge information must include all 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

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

Eligible population:

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

Required exclusions

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

Care for Older Adults – Functional Status Assessment (COA–FSA) | CMS Weight = N/A – Display CarePlus Weight = 1

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

Service needed for compliance

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

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

Please note: Functional status assessment limited to an acute or single condition, event or body system does not meet criteria.

COA–FSA measure best practices

- Perform a comprehensive functional status assessment with older patients as a part of an Annual Wellness Visit or physical exam. These can be conducted via all telehealth methods including audio-only telephone visit*, e-visit and virtual check-in.
- Schedule Annual Wellness Visits early in the year.
- Complete the COA assessment form annually with eligible patients and submit as supplemental data.
- Document functional assessment was reviewed and submit as supplemental data.

COA – Functional Status Assessment (FSA)

Code	Code type	Definition

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

COA – Medication Review (COA–MDR) | CMS Weight = 1 CarePlus 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.

Service needed for compliance

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

COA–MDR measure best practices

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

COA – Medication Review (MDR)

Code	Code type	Definition
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy.

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

COA – Medication Review (MDR)

Code	Code type	Definition
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge.
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge.
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face to face with patient, with assessment and intervention if provided, initial 15 minutes, new patient.
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face to face with patient, with assessment and intervention if provided, initial 15 minutes, established patient.
1159F	CPT II	Medication list documented in medical record.
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record.
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route.

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

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

Service needed for compliance

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

COA–PNS measure best practices

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

COA – Pain Screening (PNS)

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

HEDIS | COLORECTAL CANCER SCREENING

Colorectal Cancer Screening | CMS Weight = 1 CarePlus Weight = 3

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

Note: Per CMS' Final Rule from April 5, 2023, COL age range for the Star Rating Program remains 50–75 years old.

Service needed for compliance (any one of the following)

- Fecal occult blood test (FOBT) during the current measurement year
- Stool DNA (sDNA) with FIT test during the current measurement year or the two years prior
- Flexible sigmoidoscopy or CT colonography during the current measurement year or the four years prior
- Colonoscopy during the current measurement year or the nine years prior

COL measure best practices

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

Required exclusions

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

Colorectal Cancer Screening

Fecal occult blood test (FOBT)

Code	Code type	Definition
82270	CPT	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, one determination
82274	CPT	Blood, occult, by fecal hemoglobin, qualitative, one to three simultaneous determinations
G0328	HCPCS	Colorectal cancer screening, fecal occult blood test, immunoassay, one to three simultaneous determinations

Flexible sigmoidoscopy

Code	Code type	Definition
45330	CPT	Sigmoidoscopy, flexible, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	CPT	Sigmoidoscopy, flexible, with biopsy, single or multiple
45332	CPT	Sigmoidoscopy, flexible, with removal of foreign body
45333	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	CPT	Sigmoidoscopy, flexible, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	CPT	Sigmoidoscopy, flexible, with directed submucosal injection(s), any substance
45337	CPT	Sigmoidoscopy, flexible, with decompression (for pathological distention) (e.g., volvulus, megacolon) including placement of decompression tube, when performed
45338	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45340	CPT	Sigmoidoscopy, flexible, with transendoscopic balloon dilation, one or more strictures
45341	CPT	Sigmoidoscopy, flexible, with endoscopic ultrasound examination
45342	CPT	Sigmoidoscopy, flexible, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45346	CPT	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)

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

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

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

Colonoscopy

44388	CPT	Colonoscopy through stoma, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	CPT	Colonoscopy through stoma, with biopsy, single or multiple
44390	CPT	Colonoscopy through stoma, with removal of foreign body
44391	CPT	Colonoscopy through stoma, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	CPT	Colonoscopy through stoma, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps
44394	CPT	Colonoscopy through stoma, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
44401	CPT	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)
44402	CPT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guidewire passage, when performed)
44403	CPT	Colonoscopy through stoma; with endoscopic mucosal resection
44404	CPT	Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	CPT	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	CPT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures

Colonoscopy

Code	Code type	Definition
44407	CPT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408	CPT	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45378	CPT	Colonoscopy, flexible diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of foreign body
45380	CPT	Colonoscopy, flexible, proximal to splenic flexure, with biopsy, single or multiple
45381	CPT	Colonoscopy, flexible, proximal to splenic flexure, with directed submucosal injection(s), any substance
45382	CPT	Colonoscopy, flexible, proximal to splenic flexure, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45384	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	CPT	Colonoscopy, flexible, proximal to splenic flexure, with transendoscopic balloon
45388	CPT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)
45389	CPT	Colonoscopy, flexible, with endoscopic stent placement (includes pre- and post-dilation and guidewire passage, when performed)
45390	CPT	Colonoscopy, flexible, with endoscopic mucosal resection
45391	CPT	Colonoscopy, flexible, proximal to splenic flexure, with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	CPT	Colonoscopy, flexible, proximal to splenic flexure, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

45393	CPT	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398	CPT	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0105	HCPCS	Colorectal cancer screening, colonoscopy on individual at high risk
G0121	HCPCS	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk

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

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

CT colonography

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

Stool DNA (sDNA) with FIT test

Code	Code type	Definition
81528	CPT	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
G0464	HCPCS	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

HEDIS | CONTROLLING HIGH BLOOD PRESSURE

Controlling High Blood Pressure (CBP) | CMS Weight = 3 CarePlus Weight = 3

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

Patients become eligible for this measure once they have had two visits with a diagnosis of hypertension. The visits:

- Can occur during the prior year or first six months of the current measurement year
- Must have two different dates of service
- Can be any type of outpatient visit, telephone visit, virtual or e-visit and any combination of visit type applies

Service needed for compliance

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

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

CBP measure best practices

- BP readings can be collected in a number of ways – via outpatient and telehealth visits including real-time, interactive audio/video visits, audio-only and online assessments, as well as remote monitoring devices that transmit results to your office. Your patients can also report their results to you.
- Advise patients not to smoke, drink caffeinated beverages or exercise within 30 minutes of their reading, and to have at least five minutes of quiet rest before BP measurement.
- Patients should sit with their back straight and supported with feet flat on the floor. Their lower arm should be supported on a flat surface and upper arm should be at heart level.
- Document blood pressure readings at each visit. If the blood pressure (BP) is high (140/90 or greater), repeat the measurement before checkout. HEDIS allows the lowest systolic and lowest diastolic readings in the same day. Often, the second reading is lower. Do not round BP values. If using an automated machine, record exact values.
- Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed.
- Ensure submitted claims or encounters include the appropriate CPT Category II codes for BP readings.

Required exclusions

- Patients with a diagnosis of pregnancy in the measurement year
- Patients in hospice, using hospice services or receiving palliative care

- Patients who died any time during the measurement year
- Patients with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant
- Patients 66 years old and older living long-term in an institutional setting or enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66-80 years old with frailty and advanced illness
    - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
    - Advanced illness can be diagnosed via any telehealth visits including audio-only and online assessments.

Controlling High Blood Pressure

Code	Code type	Definition
I10	ICD-10	Essential (primary) hypertension
3074F	CPT II	Most recent systolic blood pressure less than 130 mmHg (Diabetes Mellitus [DM]) (Hypertension (HTN), chronic kidney disease (CKD), (coronary artery disease [CAD])
3075F	CPT II	Most recent systolic blood pressure 130–139 mmHg (DM)
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mmHg (HTN, CKD, CAD) (DM)
3078F	CPT II	Most recent diastolic blood pressure less than 80 mmHg (HTN, CKD, CAD) (DM)
3079F	CPT II	Most recent diastolic blood pressure 80–89 mmHg (HTN, CKD, CAD) (DM)
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mmHg (HTN, CKD, CAD) (DM)
93784	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
93788	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report

99091	CPT	Collection and interpretation of physiologic data (e.g., electrocardiogram (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, and training
99453	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial setup and patient education on use of equipment
99454	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	CPT	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
99473	CPT	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	CPT	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

HEDIS | DIABETES CARE

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

The Diabetes Care measures include patients with type 1 or type 2 diabetes in the following age ranges:

- HBD and EED: 18–75 years old
- KED: 18–85 years old

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

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

Required exclusions

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

Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes (HBD) | CMS Weight = 3 CarePlus Weight = 3

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

Service needed for compliance

- At least one HbA1c test in current measurement year for all eligible patients with the resulting level reported
- The most recent HbA1c test in the current measurement year must have a level of 8% or less to be measure compliant.

HBD measure best practices

- Encourage patients to perform and return in-home blood glucose test kits. Discuss results they receive.
- When point-of-care HbA1c tests are completed in-office, bill for service with results. Ensure submitted claims or encounters include the appropriate CPT Category II codes for the most recent HbA1c level.
- Ensure documentation in the medical record includes the date when the HbA1c test was performed along with the result or finding.
- Finding must be in the format of a value (e.g., 7%). Missing values or results recorded in a format other than this example will result in noncompliance for the measure.

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

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

Diabetes Care – Eye Exam for Patients with Diabetes (EED) | CMS Weight = 1 CarePlus Weight = 3

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

Service needed for compliance (any one of the following)

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

EED measure best practices

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

EED

Code	Code type	Definition
65091	CPT	Evisceration of ocular contents; without implant
65093	CPT	Evisceration of ocular contents; with implant

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

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

92004*	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits
92012*	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient
92014*	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, comprehensive, established patient, one or more visits
92018	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, complete
92019	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, limited
92134*	CPT	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92225*	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, initial
92226*	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, subsequent
92227*	CPT	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228*	CPT	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92230*	CPT	Fluorescein angioscopy with interpretation and report
92235	CPT	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	CPT	Indocyanine green angiography with interpretation and report
92250*	CPT	Fundus photography with interpretation and report
92260*	CPT	Ophthalmodynamometry

99203	CPT	Office or other outpatient visit for evaluation and management of a new patient, 30 minutes
99204	CPT	Office or other outpatient visit for evaluation and management of a new patient, 45 minutes
99205	CPT	Office or other outpatient visit for evaluation and management of a new patient, 60 minutes
99213	CPT	Office or other outpatient visit for evaluation and management of an established patient, 15 minutes
99214	CPT	Office or other outpatient visit for evaluation and management of an established patient, 25 minutes
99215	CPT	Office or other outpatient visit for evaluation and management of an established patient, 40 minutes
99242	CPT	Office consultation for a new or established patient, 30 minutes
99243	CPT	Office consultation for a new or established patient, 40 minutes
99244	CPT	Office consultation for a new or established patient, 60 minutes
99245	CPT	Office consultation for a new or established patient, 80 minutes
2022F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2023F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	CPT II	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2025F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy
2033F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy

3072F	CPT II	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
S0620	HCPCS	Routine ophthalmological examination including refraction, new patient
S0621	HCPCS	Routine ophthalmological examination including refraction, established patient
S3000	HCPCS	Diabetic indicator, retinal eye exam, dilated, bilateral
08T0XZZ	ICD-10-PCS	Resection of Right Eye, External Approach
08T1XZZ	ICD-10-PCS	Resection of Left Eye, External Approach

HEDIS | DIABETES CARE – KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Diabetes Care – Kidney Health Evaluation for Patients with Diabetes (KED) | CMS Weight = N/A – Display CarePlus Weight = 1

Percentage of patients 18–85 years old with type 1 or type 2 diabetes who had a kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatine ratio (uACR).

Service needed for compliance

Patients should have a kidney health evaluation in the measurement year. Both an eGFR and a uACR test are required on same or different dates of service.

- At least one estimated glomerular filtration rate (eGFR); **and**
- At least one urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test **and** a urine creatinine test four or fewer days apart; **or**
  - A uACR

KED measure best practices

- Review diabetes services needed at each office visit and order labs prior to patient appointments.
- Ensure appropriate CPT codes are selected on the lab order.
- Remind patients to take medication as prescribed; if member has chronic kidney disease (CKD), avoid nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen.
- Provide diabetes education and support resources.

Required exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients who did not have a diagnosis of diabetes during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year
- Patients 66 years old and older who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old who have frailty and advanced illness or 81 years old and older with frailty only
  - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
  - Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.

Kidney Health Evaluation for Patients with Diabetes (KED)

Estimated glomerular filtration rate (eGFR)

Code	Code type	Definition
80047	CPT	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)
80048	CPT	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80050	CPT	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
80053	CPT	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
80069	CPT	Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
82565	CPT	Creatinine; blood

Quantitative urine albumin lab test and urine creatinine lab test

Code	Code type	Definition
82043	CPT	Albumin; urine (e.g., microalbumin), quantitative
82570	CPT	Creatinine; other source

HEDIS | OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Osteoporosis Management in Women who had a Fracture (OMW) | CMS Weight = 1 CarePlus Weight = 3

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

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

Patients will be removed from the eligible population if they have had a:

- BMD test within 24 months prior to the fracture
- Dispensed osteoporosis medication therapy to treat or prevent osteoporosis within 12 months before the fracture

Service needed for compliance (any one of the following)

Within six months of fracture date or date of discharge (if hospitalized for fracture):

- A BMD test in any setting including tests administered during inpatient stay for fracture
- Dispensed osteoporosis medication therapy including any long-acting treatment provided during inpatient stay for fracture

OMW measure best practices

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

Required exclusions

- Patients in hospice, using hospice services or receiving palliative care
- Patients who died any time during the measurement year
- Patients 67 years old and older who live long-term in an institutional setting or are enrolled in an Institutional

Special Needs Plan (I-SNP)

- Patients 67–80 years old who have frailty and advanced illness or 81 years old and older with frailty only
  - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
  - Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.

Osteoporosis Management in Women who had a Fracture (OMW)

Code	Code type	Definition
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg
J3111	HCPCS	Injection, romosozumab-aqqg, 1 mg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
BP48ZZ1	ICD-10-PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10-PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10-PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD-10-PCS	Ultrasonography of left elbow, densitometry

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

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

ICD-9 Procedure: 88.98

Osteoporosis medications

Drug type	Drug name	HCPCS codes
Biphosphonates	Alendronate	N/A
	Alendronate-cholecalciferol	N/A
	Ibandronate	J1740
	Risedronate	N/A
	Zoledronic acid	J3489
	Abaloparatide	N/A
	Denosumab*	J0897

Other agents	Raloxifene	N/A
	Romosozumab	J3111
	Teriparatide	J3110

* **Note:** CarePlus added step therapy requirements for some drugs. This step therapy requirement will not apply to patients who already are actively receiving treatment with a nonpreferred drug and have a paid drug claim within the past 365 days.

Statin Therapy for Patients with Cardiovascular Disease (SPC) |

CMS Weight = 1 CarePlus Weight = 1

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

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

- Event: Any of the following during the prior measurement year:
  - Inpatient discharges with a myocardial infarction (MI)
  - Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure
- Diagnosis: Claim(s) submitted during both the current and prior measurement years:
  - With a diagnosis of ischemic vascular disease (IVD) diagnosis
  - Via an acute inpatient, outpatient or telehealth visit

Service needed for compliance

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

SPC measure best practices

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

Required exclusions

- Patients in hospice, using hospice or receiving palliative care
- Patients who died any time during the measurement year
- Patients 66 years old and older who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) and/or

- Have frailty and advanced illness
  - Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
  - Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.

- Patients with the following diagnoses or services in the current or prior measurement year for:
  - Pregnancy or in vitro fertilization (IVF)
  - Dispensed clomiphene medication
  - End-stage renal disease (ESRD) or dialysis
  - Cirrhosis
  - Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year

---

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

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

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

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

HEDIS DISPLAY MEASURES

Display measures

Measures on display are those that are not included in the Star Ratings calculation for the current measure year. However, they may become Star measures in future years or may have previously been Star measures. The performance of these measures are released by CMS at the end of each year, but as they are not rated, they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Access to Primary Care Doctor Visits (AAP)

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

Required exclusions

Patients in hospice or using hospice services during the measurement year

Antidepressant Medication Management (AMM)

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

Required exclusions

Patients in hospice or using hospice services during the measurement year.

Continuous Beta-Blocker Treatment (PBH)

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

Required exclusions

Patients with any of the following identified at any time during their medical history:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes and vapors
- Hypotension, heart block >1 degree or sinus bradycardia
- A medication dispensing event indicative of a history of asthma
- Intolerance or allergy to beta-blocker therapy
- Patients in hospice or using hospice services during the measurement year
- Patients 66 years old and older living long-term in an institutional setting or enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old with frailty and advanced illness or 81 years old and older with frailty

- Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. There must be **two indications of frailty on different dates of service** during the measure year. Those indications can include a frailty device, frailty diagnosis, frailty encounter and/or frailty symptom.
- Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.

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

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

Required exclusions

Patients in hospice or using hospice services during the measurement year.

Hospitalization for Potentially Preventable Complications (HPC)

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

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

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

Chronic ACSCs considered for this measure are:

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

Acute ACSCs considered for this measure include:

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

HPC measure best practices

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

Required exclusions

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

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

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

Kidney Health Evaluation for Patients with Diabetes (KED)

Percentage of patients 18–85 years old with type 1 or type 2 diabetes who had a kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatine ratio (uACR).

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator

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

Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid

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

the event.

Testing to Confirm Chronic Obstructive Pulmonary Disease (SPR)

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

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

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

Health Outcomes Survey (HOS)

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

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

**Measure on Display for MY2023, but actively pursuing improvement in anticipation of return to the Star Rating Program.

HOS | IMPROVING BLADDER CONTROL

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

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

Best practices for MUI

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

Patient survey questions

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

Required exclusions

Patients in hospice

Improving or Maintaining Mental Health (IMMH)| CMS Weight = N/A Display (MY2023)

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

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

Best practices for IMMH

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

Patient survey questions

- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
  - Accomplished less than you would like as a result of any emotional problems
  - Didn't do work or other activities as carefully as usual as a result of any emotional problems

  Answer choices:

  No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

- How much of the time during the past four weeks:
  - Have you felt calm and peaceful?
  - Did you have a lot of energy?
  - Have you felt downhearted and blue?

  Answer choices:

  All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; None of the time
- During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

  Answer choices:

  All of the time; Most of the time; Some of the time; A little of the time; None of the time

Improving or Maintaining Physical Health (IMPH) | CMS Weight = N/A Display (MY2023)

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

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

Best practices for IMPH

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

Patient survey questions

- In general, would you say your health is:

  Answer choices: Excellent; Very good; Good; Fair; Poor
- The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
  - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
  - Climbing several flights of stairs

  Answer choices: Yes, limited a lot; Yes, limited a little; No, not limited at all
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
  - Accomplished less than you would like as a result of your physical health
  - Were limited in the kind of work or other activities as a result of your physical health

  Answer choices: No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

  Answer choices: Not at all; A little bit; Moderately; Quite a bit; Extremely

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

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

Best practices for physical activity in older adults (PAO)

- Explain to patients that an exercise regimen could increase 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 activities with frequency and duration in the patient after-visit summary.
- Use physical activity prescription pads to "prescribe" the exercise regimen.

Patient survey questions

- In the past 12 months, did you talk with a doctor or other healthcare provider about your level of exercise or physical activity? (Yes/No)

  For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? (Yes/No)

  For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Required exclusions

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

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

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

Best practices for FRM

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

Patient survey questions

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other healthcare provider talk with you about falling or problems with balance or walking? (Yes/No)
- Did you fall in the past 12 months? (Yes/No)
- In the past 12 months, have you had a problem with balance or walking? (Yes/No)
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (Yes/No)

  Some things they might do include:

  - Suggest that you use a cane or walker
  - Suggest that you do an exercise or physical therapy program
  - Suggest a vision or hearing test

Required exclusions

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

HOS DISPLAY MEASURES

Display measures

Measures on display are those that are not included in the Star Ratings calculation for the current measure year. However, they may become Star measures in future years or may have previously been Star measures. The performance of these measures is released by CMS at the end of each year. However, since they are not rated, they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Physical Functioning Activities of Daily Living Patient survey questions

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

Improving or Maintaining Physical Health

Improving or Maintaining Mental Health

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is an annual patient survey conducted for Medicare Advantage plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in Medicare Advantage plans. The results of the survey are published in the "Medicare & You" handbook and on the Medicare website: **www.medicare.gov**. Nine areas of the patient survey are included in the Star measures reporting.

The six areas below directly correlate to patient experience with their physicians and other healthcare providers. The remaining three correlate to patient experience with their MA plan. There are no member/patient exclusions for CAHPS measures.

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

CAHPS | Annual Flu Vaccine

Annual Flu Vaccine (FLU) | CMS Weight = 1

Percentage of surveyed patients who received an influenza vaccination.

Best practices for FLU

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

Patient survey question

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

CAHPS | Care Coordination

Care Coordination (CC) | CMS Weight = 4

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.

Please note: There are three 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), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC).

Best practices for CC

- 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. Document the names of members of the patients' interdisciplinary care team, as well as the results of any services rendered by other healthcare providers.
- Schedule specialist follow-up visits on behalf of patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patient is in your office, give them the names and phone numbers to call specialists.
- Schedule follow-up with patient within one month of the specialist visit to discuss the results. Advise your patients to bring in all prescription medicines they are taking to their next appointment so you can evaluate whether changes are needed. Have your CarePlus-covered patients use their over-the-counter (OTC) benefits and CenterWell Pharmacy™ OTC product catalog to purchase items that may help, such as canes or night lights. The catalog is available at CarePlusHealthPlans.com/members/otc-products.
- Review all of your patient's medications, including prescription medicines, OTC medications and herbal or supplemental therapies. This review can occur during telehealth visits.
- Complete and provide a medication action plan and/or personal medication list to educate patients and help them organize medication-related information.

Patient survey questions

- In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?

  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?

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

  Answer choices: Never; Sometimes; Usually; Always

- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?

  Answer choices: Yes, definitely; Yes, somewhat; No
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

  Answer choices: Never; Sometimes; Usually; Always; I do not have a personal doctor; I did not visit my personal doctor in the last six months; My personal doctor is a specialist

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

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

Best practices for GACQ

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

Patient survey questions

- In the last six months, when you needed care right away, how often did you get care as soon as you needed?

  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often did you get an appointment for a checkup or routine care as soon as you needed?

  Answer choices: Never; Sometimes; Usually; Always
- Wait time includes time spent in the waiting room and exam room. In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?

  Answer choices: Never; Sometimes; Usually; Always

Getting Needed Care (GNC) | CMS Weight = 4

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

Best practices for GNC

- Schedule specialist follow-up visits on behalf of your patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patient is in your office, give them the names and phone numbers to call for an appointment.
- Use specialist appointment reminder cards so patients remember that your office assisted in scheduling the follow-up appointment.
- If a service requires preauthorization, obtain approval from CarePlus before performing or ordering it. Ensure expedited requests meet criteria.

Patient survey questions

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

Getting Needed Prescription Drugs (GNRx) | CMS Weight = 4

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

Best practices for GNRx

- Consult the CarePlus formularies at CarePlusHealthPlans.com/medicare-plans/2023-prescription-drug-guides prior to prescribing a new medication.
- If available and clinically appropriate, consider a generic or lower-cost brand alternative drug or therapeutic equivalent.
- Recommend switching to 90-day supplies from their community pharmacy or via a mail-order pharmacy.

Patient survey questions

- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

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

  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription at my local pharmacy in the last six months
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription by mail in the last six months/I am not sure if my drug plan offers prescriptions by mail

Rating of Health Care Quality (RHCQ) | CMS Weight = 4

Assesses patients' view of the quality of the health care they received.

Best practices for RHCQ

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

Patient survey question

Using any number from 0 to 10, where 0 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?

CAHPS DISPLAY MEASURES

Display measures

Measures on display are those that are not included in the Star Ratings calculation for the current measure year. However, they may become Star measures in future years or may have previously been Star measures. The performance of these measures is released by CMS at the end of each year. They are not rated so they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Doctors who Communicate Well

Assesses how well doctors communicate

Patient survey questions

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

Pneumonia Vaccine

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

Patient survey question

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

Reminders to Fill Prescriptions

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

Patient survey question

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

Reminders to Take Medications

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

Patient survey question

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

Patient Safety

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

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

PATIENT SAFETY | MEDICATION ADHERENCE

CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. PDC is determined by dividing the days of medication coverage – which is determined based on the claims billed to the insurance plan – by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication. If a patient's PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.

Best practices for Medication Adherence measures

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

PATIENT SAFETY | MEDICATION ADHERENCE FOR CHOLESTEROL (Statins)

Medication Adherence for Cholesterol (Statins) | CMS Weight = 3 CarePlus Weight = 3

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

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

Required exclusions

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

PATIENT SAFETY | MEDICATION ADHERENCE FOR DIABETES MEDICATIONS

Medication Adherence for Diabetes Medications | CMS Weight = 3 CarePlus Weight = 3

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

Percentage of patients 18 years old and older with Part D benefits with at least **two** diabetes medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Required exclusions

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

PATIENT SAFETY | MEDICATION ADHERENCE FOR HYPERTENSION (RAS Antagonists)

Medication Adherence for Hypertension (RAS Antagonists) | CMS Weight = 3 CarePlus Weight = 3

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

Percentage of patients 18 years old and older with Part D benefits with at least **two** high blood pressure medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

Required exclusions

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

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

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

To be eligible for MTM, patients must:

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

Best practices for CMR

- Reference health plan reports for MTM-eligible patients.
- Conduct discussions with MTM-eligible patients, explaining the importance and benefits of completing a CMR
- Complete and provide a written summary of the CMR discussion to patients. The summary should:
  - Remind patient of what occurred during the CMR.
  - Describe how to contact the MTM program.
  - Include a plan to assist in resolving current drug therapy issues.
  - Help achieve treatment goals with specific action items.
  - Have a reconciled list of all medications in use at the time of the CMR.

Refer patients with CarePlus coverage to the CarePlus Member Services department at 1-800-794-5907 (TTY: 711). From Oct. 1–March 31, we are open seven days a week, 8 a.m. – 8 p.m. From April 1–Sept. 30, we are open Monday – Friday, 8 a.m. – 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays, and we will return your call within one business day.

Activity needed for compliance

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

Required exclusions

Patients in hospice or using hospice services

PATIENT SAFETY | STATIN USE IN PERSONS WITH DIABETES

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

Percentage of patients with Part D benefits who are 40–75 years old, 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.

Best practices for SUPD

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

Activity needed for compliance

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

Required exclusions

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

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

PATIENT SAFETY DISPLAY MEASURES

Display measures

Measures on display are those that are not included in the Star Ratings calculation for the current measure year, but they may become Star measures in future years or may have previously been Star measures. The performance of these measures is released by CMS at the end of each year, but as they are not rated, they are also not weighted. The measures listed here are directly impacted by physicians and other healthcare providers.

Antipsychotic Use in Persons with Dementia

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

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

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

Concurrent Use of Opioids and Benzodiazepines (COB)

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

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

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

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

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

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

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

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

CNS)

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

APPENDIX

Glossary

Baseline survey

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

Bonus year (BY)

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

CAHPS

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

CMS

CMS is the Centers for Medicare & Medicaid Services.

Composite measures

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

CPT

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

Denominator

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

Discussion measures

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

Display measures

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

Glossary

Exclusions

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

Follow-up survey

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

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

HCPCS

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

HEDIS

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

HOS

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

ICD-10-CM

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

Improvement measures

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

Improvement survey measures

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

Glossary

Intermediate outcome measures

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

Diabetes Care – Blood Sugar Controlled, Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS antagonists) and Medication Adherence for Cholesterol (Statins).

IRE

IRE is an Independent Review Entity.

MAO

Medicare Advantage Organization

MAPD

Medicare Advantage prescription drug plan

Measurement year (MY)

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

Measures capturing access

Measures capturing access are designed to ensure beneficiaries have access to health plan services and needed care. These measures moved from 2 to 4 weighted beginning in measurement year 2021.

Metric

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

Numerator

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

Operational categories

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

Outcome measures

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

Glossary

Overall rating

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

Part C

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

Part D

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

Pass rate

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

Patient Safety

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

Patients' experience & complaints measure

These measures assess a member's perspectives about the service they are receiving within their personal healthcare experience – both from their plan and healthcare providers. Like measures capturing access, these measures moved from 2 to 4 weighted beginning with measurement year 2021.

PDP

Prescription drug plan

Process measures

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

Quality bonus

Quality bonuses are earned on plans rated 4 stars or higher and are invested back into MA plans to provide more benefits and services to members.

Glossary

Rating year

Rating year is the plan year (Jan. 1–Dec. 31) for which a Star Rating is in effect. Medicare Advantage Organizations (MAOs) learn their plans' Star Ratings in October of the prior year, just before the Annual Enrollment Period (AEP) for Medicare Advantage members.

Reporting year

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

Special Needs Plan (SNP)

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

Star measures

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

Star Ratings

Star Ratings use more than 40 measures to determine quality of Medicare Advantage plans and assesses both Part C and Part D plan services. Medicare Advantage plans can earn 1 to 5 star ratings. The ratings allow members to compare quality of care between Medicare Advantage plans. Medicare Advantage Organizations (MAOs) receive additional incentives for producing plans with ratings of 4 stars and above.

Summary ratings

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

Thresholds

Thresholds are percentage ranges, referred to as cut points by CMS, used to determine the Star level of a measure based on its pass rate. For example, pass rates of 75%–86% could qualify a measure for 4 stars. Thresholds are unique to each measure and set by CMS after analyzing industry pass rate performance at the measure level.

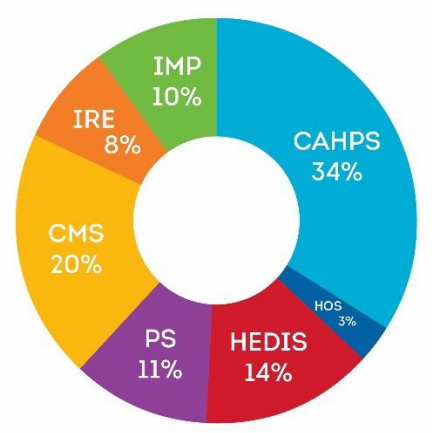
Weights

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

Breakdown of operational categories

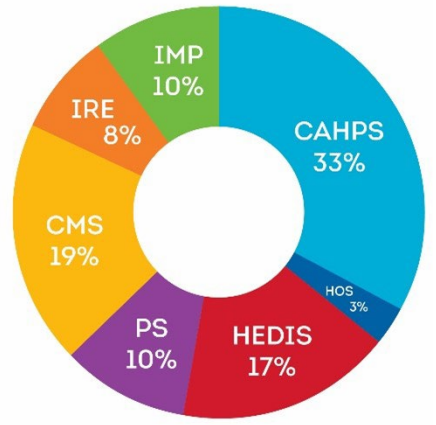
Measurement Year 2021 – Bonus Year 2024

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



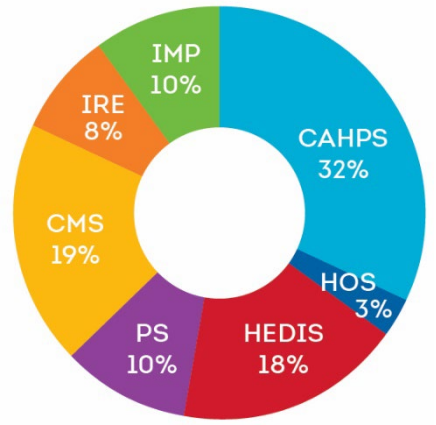
Measurement Year 2022 – Bonus Year 2025

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



Measurement Year 2023 – Bonus Year 2026

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



Star “years”

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

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2023 weight	NCQA or PQA abbreviation	Also referred to as
Breast Cancer Screening	Part C	HEDIS	Process measure	1	BCS	
Care for Older Adults – Functional Status Assessment[2,4]	Part C	HEDIS	Process measure	0	COA	COA–FSA, COA–F
Care for Older Adults – Medication Review[2]	Part C	HEDIS	Process measure	1	COA	COA–MDR, COA–M
Care for Older Adults – Pain Assessment[2]	Part C	HEDIS	Process measure	1	COA	COA–PNS, COA–P
Colorectal Cancer Screening	Part C	HEDIS	Process measure	1	COL	
Controlling High Blood Pressure	Part C	HEDIS	Intermediate outcome measure	3	CBP	
Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes	Part C	HEDIS	Intermediate outcome measure	3	HBD	
Diabetes Care – Eye Exam for Patients with Diabetes	Part C	HEDIS	Process measure	1	EED	
Diabetes Care – Kidney Health Evaluation for Patients with Diabetes	Part C	HEDIS	Process measure	0	KED	
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Part C	HEDIS	Outcome measure	1	FMC	
Osteoporosis Management in Women who had a Fracture	Part C	HEDIS	Process measure	1	OMW	BMD
Plan All-Cause Readmissions	Part C	HEDIS	Outcome measure	3	PCR	
Statin Therapy for Cardiovascular Disease	Part C	HEDIS	Process measure	1	SPC	
Transitions of Care[5]	Part C	HEDIS	Outcome measure	1	TRC	TRC

TRC – Medication Reconciliation Post-Discharge[5]	Part C	HEDIS	Process measure	0	MRP	
TRC – Notification of Inpatient Admission[5]	Part C	HEDIS	Process measure	0	NIA	
TRC – Patient Engagement after Inpatient Discharge[5]	Part C	HEDIS	Process measure	0	PED	
TRC – Receipt of Discharge Information[5]	Part C	HEDIS	Process measure	0	RDI	
Annual Flu Vaccine	Part C	CAHPS	Process measure	1	FVO	FLU, AFV
Care Coordination	Part C	CAHPS	Patients' experience and complaints measure	4		CC
Customer Service	Part C	CAHPS	Patients' experience and complaints measure	4		CS
Getting Appointments and Care Quickly	Part C	CAHPS	Patients' experience and complaints measure	4		GACQ
Getting Needed Care	Part C	CAHPS	Patients' experience and complaints measure	4		GNC
Getting Needed Prescription Drugs	Part D	CAHPS	Patients' experience and complaints measure	4		GNRx
Rating of Drug Plan	Part D	CAHPS	Patients' experience and complaints measure	4		RDP
Rating of Health Care Quality	Part C	CAHPS	Patients' experience and complaints measure	4		RHCQ
Rating of Health Plan	Part C	CAHPS	Patients' experience and complaints	4		RHP

			measure			
Improving Bladder Control	Part C	HOS	Process measure	1	MUI	Bladder, IBC
Improving or Maintaining Mental Health[6]	Part C	HOS	Outcome measure	0	MCS	Mental Health, IMMH
Improving or Maintaining Physical Health[6]	Part C	HOS	Outcome measure	0	PCS	Physical Health, IMPH

CMS Star measures[1]

CMS Star measure name	Part C or Part D	Operational category	Measure type	MY2022 weight	NCQA or PQA abbreviation	Also referred to as
Monitoring Physical Activity	Part C	HOS	Process measure	1	PAO	Physical Activity, MPA
Reducing the Risk of Falling	Part C	HOS	Process measure	1	FRM	ROF
Medication Adherence for Cholesterol (Statins)	Part D	Patient Safety	Intermediate outcome measure	3	PDC-STA	MAC
Medication Adherence for Diabetes Medications	Part D	Patient Safety	Intermediate outcome measure	3	PDC-DR	MAD
Medication Adherence for Hypertension (RAS Antagonists)	Part D	Patient Safety	Intermediate outcome measure	3	PDC-RASA	MAH
Statin Use in Persons with Diabetes	Part D	Patient Safety	Process measure	1	SUPD	
Drug Plan Quality Improvement[3]	Part D	Improvement	Improvement measure	5		DPQI
Health Plan Quality Improvement[3]	Part C	Improvement	Improvement measure	5		HPQI
Call Center – Foreign Language Interpreter and TTY Availability	Part C	CMS	Measures capturing access	4		TTY, TTY/FL, FLIC
Call Center – Foreign Language Interpreter and TTY Availability	Part D	CMS	Measures capturing access	4		TTY, TTY/FL, FLID
Complaints About the Drug Plan	Part D	CMS	Patients' experience and complaints measure	4		CTM, Complaints, CDP
Complaints About the Health Plan	Part C	CMS	Patients' experience and complaints measure	4		CTM, Complaints, CHP
Members Choosing to Leave the Plan	Part C	CMS	Patients' experience and complaints measure	4		Voluntary Disenrollment, MLPC
Members Choosing to Leave the Plan	Part D	CMS	Patients' experience and complaints measure	4		Voluntary Disenrollment, MLPD
MPF Price Accuracy	Part D	CMS	Process measure	1	MPF	
MTM Program Completion Rate for CMR	Part D	CMS	Process measure	1	CMR	MTM

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

[1] Measures and weights reflect latest CMS guidance
[2] Measures apply only to Special Needs Plans (SNP)
[3] Measures that are **not** part of the Improvement calculation
[4] COA–FSA remains on display
[5] TRC measure average is an average of its four display measures
[6] Measure on display for MY2023, but actively pursuing improvement in anticipation of return to the Star Rating Program

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

NCQA copyright notice and disclaimer

The HEDIS measure specifications were developed by and are owned by NCQA. The HEDIS measure specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measure specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Use of the Rules for Allowable Adjustments of HEDIS to make permitted adjustments of the materials does not constitute a modification. Any commercial use and/or internal or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. Any use of the materials to identify records or calculate measure results, for example, requires a custom license and may necessitate certification pursuant to NCQA's Measure Certification Program. Reprinted with permission by NCQA.

Limited proprietary coding is contained in the measure specifications for convenience. NCQA disclaims all liability for use or accuracy of any third-party code values contained in the specifications.

The full text of this notice and disclaimer is available at CarePlusHealthPlans.com/HEDISdisclaimer.

PQA is a registered trademark of Pharmacy Quality Alliance, Inc. and is used with permission in this article.
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).