Medicare STARs Rating

Centers for Medicare & Medicaid Services (CMS) created a Five-Star Quality Rating System to help measure the quality in care for Medicare Advantage (MA) and Prescription Drug Plans (Part D Plans), and assist beneficiaries in finding the best plan for them. The ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Wt</th>
<th>4 Stars</th>
<th>Requirement and Documentation</th>
<th>Sample Codes</th>
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</thead>
<tbody>
<tr>
<td><strong>Adult Body Mass Index (BMI) Assessment</strong></td>
<td>1</td>
<td>&gt;87%</td>
<td>For members <strong>20 years and older</strong> document <strong>weight and BMI</strong> value every year.</td>
<td><strong>BMI ICD-10:</strong> Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 <strong>BMI PERCENTILE ICD-10:</strong> Z68.51, Z68.52, Z68.53, Z68.54</td>
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<tr>
<td><strong>Breast Cancer Screening</strong></td>
<td>1</td>
<td>&gt;69%</td>
<td>Mammogram screening every two years.</td>
<td><strong>ICD-10:</strong> Z12.31, Z12.39 <strong>CPT:</strong> 77055, 77056, 77057 <strong>HCPCS:</strong> G0202, G0204, G0206 <strong>Exclusion:</strong> Bilateral Mastectomy; absence of breast(s) <strong>ICD-10:</strong> Z90.11, Z90.12, Z90.13</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>1</td>
<td>&gt;71%</td>
<td>• Fecal occult blood (FOBT, gFOBT or iFOBT) test <strong>every year</strong> OR • Flexible sigmoidoscopy every <strong>5 years</strong> OR • Colonoscopy every <strong>10 years</strong> <strong>NOTE:</strong> Clear documentation of previous colonoscopy or sigmoidoscopy, including year performed, is required</td>
<td><strong>Colonoscopy CPT:</strong> G0105, G0121 <strong>Flexible Sigmoidoscopy CPT:</strong> 45330-45335, 45337-45342, 45345-45347, 45349, 45350 <strong>Sigmoidoscopy HCPCS:</strong> G0104 <strong>FOBT CPT:</strong> 82270, 82274 <strong>FOBT Reply Form ICD-10:</strong> Z12.11 <strong>HCPCS:</strong> G0328</td>
</tr>
<tr>
<td><strong>Care for Older Adults (COA)</strong></td>
<td>1</td>
<td>&gt;75%</td>
<td><strong>Medication Review</strong> – must include medication list in the medical record, and evidence of a medication review and the date when it was performed or notation that the member is not taking any medication and the date when it was noted.</td>
<td><strong>Medication Review:</strong> <strong>CPT:</strong> 90863, 99605, 99606 <strong>CPT II:</strong> 1160F <strong>Medication List:</strong> <strong>CPT II:</strong> 1159F <strong>Functional Status Assessment:</strong> <strong>CPT II:</strong> 1170F <strong>Pain Assessment:</strong> <strong>Pain Present CPT II:</strong> 1125F <strong>Pain not Present CPT II:</strong> 1126F</td>
</tr>
<tr>
<td><strong>Medicare Special Needs Plan (SNP) and MMP (Cal MediConnect)</strong></td>
<td>1</td>
<td>&gt;74%</td>
<td><strong>Functional Status Assessment</strong> – documentation must include evidence of functional status assessment <strong>and</strong> the date when it was performed.</td>
<td><strong>Pain Assessment:</strong> <strong>CPT II:</strong> 1125F <strong>Pain not Present CPT II:</strong> 1126F</td>
</tr>
<tr>
<td><strong>Medicare Special Needs Plan (SNP) and MMP (Cal MediConnect)</strong></td>
<td>1</td>
<td>&gt;75%</td>
<td><strong>Pain Assessment</strong> – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed.</td>
<td></td>
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</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Wt</th>
<th>4 Stars</th>
<th>WHAT SERVICE IS NEEDED</th>
<th>ACCEPTABLE CODES</th>
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<tbody>
<tr>
<td>Care for Older Adults (COA) (continued)</td>
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<tr>
<td>4. Advanced Care Planning</td>
<td></td>
<td>&gt;51%</td>
<td>Advanced Care Planning – evidence must include either the presence of advanced care plan in the medical record or documentation of advanced care planning discussion with the provider and the date when it was discussed.</td>
<td>Advanced Care Planning: CPT: 99497, 99498 Document Present CPT II: 1157F Discussion Documented CPT II: 1158F</td>
</tr>
<tr>
<td>Osteoporosis Therapies:</td>
<td></td>
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<td>AND/OR</td>
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<tr>
<td>Biphosphonates</td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis Medications: HCPSC: J0630, J0897, J1740, J3110, J3487, J3488, J3489, Q2051</td>
</tr>
<tr>
<td>Alendronate-cholecalciferol, Alendronate, Ibandronate, Risedronate, Zoledronic acid.</td>
<td></td>
<td></td>
<td></td>
<td>Long-Acting Osteoporosis Medications HCPSC: J0897, J1740, J3487 -J3489, Q2051</td>
</tr>
<tr>
<td>Other Agents</td>
<td></td>
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<tr>
<td>Calcitonin, Denosumab, Raloxifene, Teriparadite</td>
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<tr>
<td>MEASURE</td>
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</table>
| Diabetes Care – Dilated or Retinal Eye Exam (CDC / C13) | 1 | >73% | Diabetics who had one of the following with an eye care professional (optometrist or ophthalmologist) during the current measurement year:  
- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2017.  
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2016.  
**Note:** medical record documentation must include a note or letter from an ophthalmologist, optometrist, PCP that eye professional completed exam, date of service and result. | Diabetic Retinal Screening CPT: 67028-99245  
HCPCS: S0620, S0621, S3000  
Diabetic Retinal Screening Negative (for prior year) CPT II: 3072F  
Diabetic Retinal Screening with Eye Care Professional CPT II: 2022F, 2024F, 2026F  
**Exclusions:** Gestational diabetes (diabetes during pregnancy), steroid induced diabetes. |
| Diabetes Care – Kidney Disease Monitoring (Nephropathy) (CDC / C14) | 1 | >96% | A nephropathy screening or monitoring test or evidence of nephropathy during the measurement year.  
Including any one of the following:  
- urine protein test  
- nephropathy treatment  
- ACE/ARB therapy  
- evidence of stage 4 chronic kidney disease  
- evidence of ESRD  
- evidence of kidney transplant  
- a visit with a nephrologist  
- at least one ACE inhibitor or ARB dispensing event from medication list table (refer to NCQA for a comprehensive list) | Nephropathy Treatment CPT II: 3066F, 4010F  
Nephropathy Treatment ICD-10: E08.21-R80.9  
Urine Protein Tests CPT: 81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156  
Urine Protein Tests CPT II: 3060F-3062F  
HCPCS: G0257, S2065, S9339  
CKD Stage 4 ICD-10: N18.4  
Kidney Transplant CPT: 50300-50380  
Kidney Transplant ICD-10: Z94.0  
ESRD CPT: 36147-99512  
ESRD HCPCS: G0257, S9339  
ESRD ICD-10: N18.5-Z99.2  
**Exclusions:** Gestational diabetes, steroid induced diabetes. |
| Diabetes Care – Blood Sugar (HbA1c) (CDC / C15) | 3 | >76% | Documentation of a hemoglobin (HbA1c) blood test in current measurement year date and result.  
HbA1c testing  
- HbA1c control <8.0%  
- HbA1c poor control >9.0% | HbA1c Tests CPT: 83036, 83037  
HbA1c Level < 7.0 CPT II: 3044F  
HbA1c Level 7.0-9.0 CPT II: 3045F  
HbA1c Level > 9.0 CPT II: 3046F  
**Exclusions:** Gestational diabetes, steroid induced diabetes. |
<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Wt</th>
<th>4 Stars</th>
<th>WHAT SERVICE IS NEEDED</th>
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<tr>
<td><strong>Controlling Blood Pressure</strong> <em>(CBP / C16)</em></td>
<td>3</td>
<td>&gt;64%</td>
<td>Documentation of the most recent blood pressure in current year as long as it occurred after the diagnosis of hypertension;</td>
<td><strong>Essential Hypertension (primary)</strong> &lt;br&gt; ICD-10: I10 &lt;br&gt; CPT II: 3074F, 3075F, 3077F – 3080F</td>
</tr>
<tr>
<td>Members 18-85 years old diagnosed with hypertension who have a blood pressure reading below 140/90 mmHg.</td>
<td></td>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> Members with evident ESRD; kidney transplant; diagnosis of pregnancy during 2017; members who had an admission to a non-acute inpatient setting in 2017.</td>
</tr>
<tr>
<td><strong>Rheumatoid Arthritis Management</strong> <em>(C17)</em></td>
<td>1</td>
<td>&gt;76%</td>
<td>Confirm rheumatoid arthritis (RA) versus osteoarthritis (OA) or joint pain. (OA) is commonly misdiagnosed as (RA).</td>
<td><strong>Rheumatoid Arthritis ICD-10:</strong> M05.00 - M06.9 (189 codes available) &lt;br&gt; <strong>AND/OR</strong>&lt;br&gt; <strong>DMARD PRESCRIPTION:</strong> &lt;br&gt; HCPCS: J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310</td>
</tr>
<tr>
<td>Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid (ART)</td>
<td></td>
<td></td>
<td></td>
<td><strong>Exclusion:</strong> Diagnosis HIV or Pregnancy</td>
</tr>
<tr>
<td>Members 18 and older who were diagnosed with rheumatoid arthritis and were dispensed at least one DMARD prescription in 2017.</td>
<td></td>
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<td><strong>DMARDS include:</strong>&lt;br&gt; • Aminoquinolines: Hydroxychloroquine&lt;br&gt; • 5-Aminosalicylates: Sulfasalazine&lt;br&gt; • Alkylating agents: Cyclophosphamide&lt;br&gt; • Anti-rheumatics: Auranofin, gold sodium thiocolatate, leflunomide, methotrexate, penicillamine&lt;br&gt; • Immunomodulators: Abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, Tocilizumab&lt;br&gt; • Immunosuppressive agents: Azathioprine, cyclosporine, mycophenolate&lt;br&gt; Janus Kinase (JAK) inhibitor: Tofacitinib&lt;br&gt; • Tetracyclines: Minocycline</td>
</tr>
<tr>
<td><strong>Plan All-Cause Readmissions</strong> <em>(PCR / C19)</em></td>
<td>3</td>
<td>&lt;8%</td>
<td>No specific services are needed, other than efforts from the plan and providers around coordination of care and prevention of all readmissions.</td>
<td><strong>No reporting is needed from the providers as data for this measure is taken from health plan data.</strong></td>
</tr>
<tr>
<td>Readmissions to a hospital within 30 days of being discharged.</td>
<td></td>
<td></td>
<td></td>
<td>Patients may have been readmitted to the same hospital or a different one. Rates of readmission are risk-adjusted and account for how sick patients were on the first admission.</td>
</tr>
<tr>
<td>Percent of members 18 years old and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition or for a different reason.</td>
<td></td>
<td></td>
<td></td>
<td><strong>No specific services are needed, other than efforts from the plan and providers around coordination of care and prevention of all readmissions.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Patients may have been readmitted to the same hospital or a different one. Rates of readmission are risk-adjusted and account for how sick patients were on the first admission.</strong></td>
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### Centers for Medicare & Medicaid Services (CMS) Part D Safety Measures

CMS includes several Part D measures in the Star measures reporting, including the five drug safety measures listed below.

<table>
<thead>
<tr>
<th>MEASURE</th>
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<th>4 Stars</th>
<th>WHAT IS NEEDED</th>
<th>MEMBER SURVEY QUESTIONS</th>
</tr>
</thead>
</table>
| **TCM - Transitional Care Management with Medication Reconciliation Post-Discharge** | 3  | 72%     | The review of medication prescribed at the hospital must take place within 30 days of discharge. Medication reconciliation can help:  
• Address medication errors or duplicates  
• Educate patients on new medications and side effects  
• Lower the risk of adverse interaction | 99495 – Face-to-face visit within 14 days of discharge.  
99496 - Face-to-face visit within 7 days of discharge.  
1111F - medication reconciliation post-discharge |
| **High Risk Medication (D11)**                                        | 3  | <5%     | • Follow the suggestions from the Pharmacy Quality Alliance (PQA) on the cautionary use of high-risk medications in the elderly, and unless absolutely necessary, prescribe an alternative medication.  
This list can be found at: http://www.ncqa.org. | No reporting required from a provider’s perspective. The health plan evaluates prescription claims data for this measure. |
| **Medication Adherence for Diabetes Medications (D12)**                | 3  | >79%    | • Proactively assess whether the patient is taking medication as prescribed  
• If you identify barriers to adherence, resolve those barriers and find ways to help the member take his or her medication as directed. | No reporting required from a provider’s perspective. The health plan evaluates prescription claims data for this measure. |
| **Medication Adherence for Hypertensive (RAS antagonists) (D13)**      | 3  | >79%    | • Proactively assess whether the patient is taking medication as prescribed.  
• If you identify barriers to adherence, resolve those barriers and find ways to help the member take their medication as directed. | No reporting required from a provider’s perspective. The health plan evaluates prescription claims data for this measure. |
| **Medication Adherence for Cholesterol (Statins)**  
| ★毎日胆固醇药物按照处方服药。  
| (D14)  
| Taking cholesterol medication as directed.  
| Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.  
| | 3 | >77%  
| • Proactively assess whether patient is taking medication as prescribed.  
| • If you identify barriers to adherence, resolve those barriers and find ways to help the member take their medication as directed.  
| No reporting required from a provider’s perspective. The health plan evaluates prescription claims data for this measure.  

Please NOTE:

- The codes listed above are SAMPLE CODES. The codes listed are not inclusive and do not represent a complete list of codes.
- Please refer to NCQA’s HEDIS 2017 Value Set Directory and HEDIS 2017 Volume 2 Technical Specifications to ensure accurate documentation.
- This list contains MedPOINT Management focus measures only and does not include all STARs measures.
- CPT II codes must be submitted together with procedure codes; they cannot be submitted alone.

Definitions:

1. Wt = Measure weight • Star measures are weighted based on whether they are a procedure-based measure (counted at 1x) or an outcome-based measure (3x). A measure given a weight of 3 counts three times as much as a measure given a weight of 1.
2. **4 Stars** = Percentage of eligible members who must meet the measure in order to attain a 4 Star rating.

HEDIS® is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an “apples-to-apples” basis. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

CPT® codes are the Current Procedural Terminology codes. CPT® is a registered trademark of the American Medical Association.

HCPCS is the Healthcare Common Procedure Coding System used by the Centers for Medicare & Medicaid Services.

LOINC® (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory and clinical test results.

MedPOINT HEDIS/STARs Quality Department • QualityMeasures@medpointmanagement.com • 818.702.0100, ext. 353.

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