MASSACHUSETTS

2024 MEDICARE ADVANTAGE 5-STAR PLAYBOOK

A resource for providers and office staff

INTRODUCTION

This Playbook gives Blue Cross Blue Shield of Massachusetts providers and office staff a comprehensive overview of the Centers for Medicare & Medicaid Services (CMS) 5-Star Quality Rating Program.

It details the program's 42 measures and provides actionable, evidence-based information to impact the quality of your patients' care. It is designed to help providers and office staff coordinate and close gaps in care for your patients.

For each 5-Star measure, we define the measure, describe who the measure affects, suggest CPT codes to use as applicable, and recommend best practices to close gaps in care.

We also provide an overview of the two member surveys that CMS conducts annually with Medicare beneficiaries: the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and the Health Outcomes Survey (HOS). Included are recommend best practices to improve performance in these member-facing surveys.

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WHAT IS THE CMS STAR RATING PROGRAM?

- CMS uses the 5-Star Quality Rating Program to evaluate the quality of health care and drug services that Medicare Advantage and Part D prescription drug plan members receive.
- The rating system uses a scale of 1-5 stars, where 5 is excellent and 1 is poor. The rating is based on feedback from members, health care providers, and CMS staff who examine performance measures.
- CMS publishes Star ratings annually to help members compare the quality of Medicare health and drug plan options to make the best health care decisions.

HOW ARE STAR RATINGS DETERMINED?

Star ratings are determined using different data sets, including:

- **Health Effectiveness Data and Information Set (HEDIS®)**
  - This data set collects all information related to physical and mental health services.
- **Prescription Drug Event (PDE)**
  - Health plans collect this data about prescription drug cost and payment information to provide insight for prescription drug-related measures.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
  - CMS sends this survey to a random sample of members every spring to measure their experience with care delivery, the health plan, and access to quality care.
- **Health Outcomes Survey (HOS)**
  - CMS sends this survey to a random sample of members every spring to measure their self-reported health status and quality of their health care. The same members receive a follow-up survey two years later to measure changes in health perception.
- **Operations data**
  - This data from health plans assesses the quality of customer service and other member services.

STAR TIMELINE

	2024												2025	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2
HEDIS	Medical record audit for hybrid measures													
HEDIS	Service dates for gap closure												Medical record audit	
CAHPS			Official survey fielding period											
CAHPS													Official survey fielding	
HOS								Official survey fielding period						
Star Rating Publication										Final Star Ratings Published				

Key
Measurement Year 2023/Star Rating 2025
Measurement year 2024/Star Rating 2026

STAR MEASURE DOMAINS

- Health plans receive an overall Star rating based on performance across 42 measures.
- The measures are divided into Part C and Part D and grouped in domains.
- Star ratings are also given for Part C and Part D performance, as well as the overall performance for each domain.
- CMS publishes each health plan's overall Star rating, as well as their Part C and Part D scores, on Medicare.gov for Medicare beneficiaries to review.

OVERALL STAR RATINGS	
Part C Domains	**Part D Domains**
1. Staying healthy: screenings, tests, and vaccines 2. Managing chronic (long-term) conditions 3. Member experience with health plan 4. Member complaints and changes in the health plan's performance 5. Health plan customer service	1. Drug plan customer service 2. Member complaints and changes in the drug plan's performance 3. Member experience with the drug plan 4. Drug safety and accuracy of drug pricing

STAR MEASURE DOMAINS, CONTINUED

Domain	Part C Measures
1. Staying Healthy: Screenings, Tests and Vaccines	Breast Cancer Screening
	Colorectal Cancer Screening
	Annual Flu Vaccine
	Monitoring Physical Activity
2. Managing Chronic (Long-Term) Conditions	Special Needs Plan (SNP) Care Management
	Care for Older Adults – Medication Review
	Care for Older Adults – Pain Assessment
	Osteoporosis Management in Women Who Had a Fracture
	Eye Exam for Patients with Diabetes
	Hemoglobin A1C Control for Patients with Diabetes
	Controlling Blood Pressure
	Reducing the Risk of Falling
	Improving Bladder Control
	Medication Reconciliation Post-discharge
	Plan All-cause Readmissions
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care
	Follow-up after Emergency Department Visit for People with Multiple High-risk Chronic Conditions
	New Measure: Kidney Health Evaluation for Patients with Diabetes
3. Member Experience with Health Plan	Getting Needed Care
	Getting Appointments and Care Quickly
	Customer Service
	Rating of Health Care Quality
	Rating of Health Plan
	Care Coordination
4. Member Complaints and Changes in the Health Plan's Performance	Complaints About the Health Plan
	Members Choosing to Leave the Plan
	Health Plan Quality Improvement
5. Health Plan Customer Service	Plan Makes Timely Decisions About Appeals
	Reviewing Appeals Decisions
	Call Center – Foreign Language Interpreter and TTY Availability
	Part D Measures
1. Drug Plan Customer Service	Call Center Foreign Language Interpreter and TTY Availability
2. Member Complaints and Changes in the Drug Plan's Performance	Complaints About the Drug Plan
	Members Choosing to Leave the Plan
	Drug Plan Quality Improvement
3. Member Experience with the Drug Plan	Rating of Drug Plan
	Getting Needed Prescription Drugs
4. Drug Safety and Accuracy of Drug Pricing	MPF Price Accuracy
	Medication Adherence for Diabetes Medications
	Medication Adherence for Hypertension (RAS Antagonists)
	Medication Adherence for Cholesterol (Statins)
	MTM Program Completion Rate for CMR
	Statin Use in Persons with Diabetes (SUPD)

STAR RATING CHANGES

CMS reviews and updates Star measures each year to reflect the changes in health care trends. They also evaluate Star cut points annually, based on national performance. Proposed changes include technology improvements, prioritizing health equity, and improving the member experience. Below are changes to the 2026 and 2027 measures.

2026 STAR RATINGS (MEASUREMENT YEAR 2024)

- **Colorectal Cancer Screening** measure moved to electronic clinical data system (ECDS) and now assesses ages 45-49.
- **Kidney Health Evaluation for Patients with Diabetes** (KED) measure became an active Star measure.
- **Breast Cancer Screening** measure revised eligible age from 50 to 40 and adjusted measure for gender neutrality.

2027 STAR RATINGS (MEASUREMENT YEAR 2025)

- **Eye Exam for Patients with Diabetes:** CMS is reviewing codes and considering moving the measure to electronic clinical data system.
- **Blood Pressure Control for Patients with Hypertension:** NCQA is exploring a new electronic clinical data system quality measure. The new approach will expand the denominator by including members with at least one claims-based diagnosis and at least one dispensed anti-hypertensive medication.

HEDIS MEASURES

Healthcare Effectiveness Data and Information Set (HEDIS) standardized performance measures are designed to ensure that consumers have the information they need for reliable comparison of health plan performance. The National Committee for Quality Assurance (NCQA) updates HEDIS measures every year.

Providers and health plans use HEDIS scores to identify gaps in care or other opportunities for improvement and ensure positive patient health outcomes. Blue Cross also uses these scores to direct our quality initiatives, including incentive programs and education for clinicians and members.

Sources of data that contribute to HEDIS calculations

Administrative

- Claims records and pharmacy data collected on a calendar-year basis

Hybrid

- Combined claims data and member medical information
- Medical records (either reviewed throughout the year or during the audit period)

Supplemental data

- Additional information supporting gap in care closure or lab results
- Supplemental data file (must comply with NCQA technical requirements)

BREAST CANCER SCREENING

Administrative measure

MEASURE DEFINITION

Percent of women, age 50-74, who had a mammogram during the past two years.
For example: If the measurement year is 2024, patients must have had at least one mammogram between October 1, 2022 and December 31, 2024.

✓ Recommended CPT codes for mammograms (new codes indicated by **bold text**)

Code	Definition
77061	Diagnostic digital breast tomosynthesis; unilateral
77062	Diagnostic digital breast tomosynthesis; bilateral
77063	Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Exclude these patients from the measure

Certain conditions prevent the patient from completing their mammogram. These conditions should be **documented in the patient's medical record using the codes below as appropriate.**

Code	Definition
ICD-10: 85.42, 85.46, 85.44, 85.48, 0HTV0ZZ	Bilateral mastectomy any time during the patient's history
CPT: 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307 **ICD-10:** 85.41, 85.43, 85.45, 85.47 **Modifier:** 50	Unilateral mastectomy with a bilateral modifier
CPT: 19180, 19200, 19240, 19303, 19304, 19305, 19306, 19307 **ICD-10**: 85.41, 85.43, 85.45, 85.47	Two unilateral mastectomies with service dates 14 or more days apart
ICD-10: Z90.13	History of bilateral mastectomy

BREAST CANCER SCREENING, CONTINUED

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. Use a health equity lens to **identify patient populations behind on screening and develop a targeted outreach**.
2. **Increase access hours** and number of locations. **Offer walk-in** or same day appointments.
3. Establish procedures to **directly schedule screening with radiology**.
4. **Establish a standing order** to obtain mammograms for eligible patients.
5. **Document the date of patients' most recent mammogram and/or mastectomy status** in medical records, so it is easier to monitor when screening is next due.

Data source for measure: Claims, Electronic Clinical Data System, Medical Record, Supplemental Data Submission

COLORECTAL CANCER SCREENING

Hybrid measure

MEASURE DEFINITION

Assesses adults, age 50–75, who had appropriate screening for colorectal cancer with any of the following tests:

- **Annual** fecal occult blood test
- Stool DNA test **every 3 years**
- Flexible sigmoidoscopy OR computed tomography colonography **every 5 years**
- Colonoscopy **every 10 years**.

✓ Recommended CPT codes for colorectal cancer screenings

Code	Screening	Timeframe
CPT: 44388-94, 44397, 44401-08	Colonoscopy	Past 9 years
CPT: 45330-35, 45337-38, 45340-42	Flexible sigmoidoscopy	Past 4 years
CPT: 74261, 74262, 74263	Computerized tomography (CT) colonography	Past 4 years
CPT: 81528	Fecal immunochemical test (FIT)-DNA (Cologuard®) test	Past 2 years
CPT: 82270, 82274	Fecal occult blood test (FOBT)	Current year

Exclude these patients from the measure

Use the codes below if patients meet the following criteria:

Code	Definition
Z85.038	History of colorectal cancer
B500	Total colectomy
G9988, G9999	Received hospice or palliative care during the measurement year

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. **Develop a systematic approach to identify and provide recommendations** to every member. **Apply a health equity lens** to ensure underserved populations also benefit.
2. **Provide FOBT, FIT, or Cologuard tests** to members who need to be screened.
3. **Assess and address existing barriers** to colorectal cancer screening (for example, access to care, cost, aversion to discussions related to the colon).
4. **Identify trends** regarding which patients have missed eligible screenings.
5. **Document patient's date and type of most recent colorectal cancer screening** in medical records.
6. **Set care gap "alerts"** in your electronic medical record.
7. **Request screening results be sent to you** if completed by a specialty office for quick visibility.

Data source for measure: Claims, Electronic Clinical Data System, Medical Record, Supplemental Data Submission

CONTROLLING HIGH BLOOD PRESSURE

Hybrid measure

MEASURE DEFINITION

Percent of Medicare Advantage patients, age 18–85, who had **a diagnosis of hypertension** and whose blood pressure was adequately controlled (<140/90 mm Hg).

✓ Recommended CPT II codes

CPT II Codes	Definition
3074F, 3075F	Systolic < 140
3077F	Systolic ≤ 140
3078F	Diastolic < 80
3079F	Diastolic between 80 – 89
3080F	Diastolic ≥ 90

Exclude these patients from the measure

Use the codes below if patients meet the following criteria:

Code	Definition
N17, N18, N19	Have evidence of end-stage renal disease or had a kidney transplant or dialysis in the current year
Many applicable codes	Have a diagnosis of pregnancy during the current year
99221-99223, 99231-99239	Have a non-acute, inpatient admission during the current year
T2042-T2046, Q5004, Q5005, Q5006, Q5007, Q5008	Are in hospice care
Many applicable codes	Have an advanced illness or frailty

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. Distribute **guidance on correct procedure for blood pressure reading** to help providers ensure they are taking accurate measures.
2. **Document blood pressure readings at every visit—including telehealth visits—** to understand a patient's normal range and progress towards target blood pressure levels.
3. Consider a **referral to a cardiologist** when blood pressure goals cannot be attained, or for complicated patients.

Data source for measure: Claims, Electronic Clinical Data System, Medical Record, Supplemental Data Submission

EYE EXAM FOR PATIENTS WITH DIABETES

Hybrid measure

MEASURE DEFINITION

Percent of Medicare Advantage patients, age 18-75, with type 1 or type 2 diabetes who had a retinal eye exam performed during the measurement year.

✓ Recommended CPT II codes for diabetic eye exams

CPT II Codes	Definition
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy

Exclude these patients from the measure

Patients are excluded if they:

- Did not have a diagnosis of diabetes during the measurement year or the year prior, and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.
- Received hospice services any time during the measurement year.
- Are age 66 and older with advanced illness and frailty.
- Have passed away during the measurement year.
- Received palliative care during the measurement year.

Note: Blindness is not an exclusion for a diabetic eye exam.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. **Connect with eye care professionals** to refer patients who need support making appointments and to receive reports of retinal exams in a timely manner.
2. **Ensure patients with positive retinopathy are receiving a retinal or dilated eye exam** from an eye care professional annually, and every two years for patients without evidence of retinopathy.
3. Consider **working with a mobile vendor** to offer bulk screenings at your locations.
4. When reporting eye exams, **manage hypertensive retinopathy the same as diabetic retinopathy**.
5. **Document date of service, eye exam results, and eye care professional's name** with credentials in the patient's medical history to meet HEDIS qualification. Note:
    a. An eye exam result documented as "unknown" does not meet criteria.
    b. If the name of the eye care professional is unknown, document that an "optometrist" or "ophthalmologist" conducted the exam.

Data source for measure: Claims, Medical Record

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

Administrative measure

MEASURE DEFINITION

Percent of emergency department (ED) visits for patients 18 years and older, who:

- Have multiple high-risk chronic conditions and
- Had a follow-up service **within seven days** of the ED visit.

✓Recommended CPT codes

Not applicable.

Exclude these patients from the measure

Patients are excluded if they:

- Are admitted to an acute or non-acute inpatient facility within seven days after the ED visit, regardless of the principal diagnosis for admission.
- Received hospice services anytime during the measurement year.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. **Reserve appointment slots** for patients with ED visits, so they can be seen within seven days of their discharge.
2. **Contact the patient as soon as the discharge notification is received** to schedule a follow-up visit.
3. **Include visits that occur on the date of the ED visit** for this HEDIS measure. Note: Visits that meet the criteria for follow-up include:
    - Outpatient
    - Telephone or telehealth
    - Transitional care management services
    - Case management
    - Complex care management services
    - Observation
    - Domiciliary or rest home

Data source for measure: Claims

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES

Hybrid measure

MEASURE DEFINITION

Percent of Medicare Advantage patients, age 18-75, with diabetes whose most recent HbA1c level is lower than 9%.

✓ Recommended codes

Codes	Definition
CPT: 83036	Hemoglobin; glycosylated (A1C)
CPT: 83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
LOINC: 4548-4	Hemoglobin A1C/Hemoglobin total in blood
LOINC: 4549-2	Hemoglobin A1C/Hemoglobin total in blood by electrophoresis
LOINC: 17856-6	Hemoglobin A1C/Hemoglobin total in blood by HPLC
LOINC: 96595-4	Hemoglobin A1C/Hemoglobin total in DBS
CPTII: 3044F	Most recent HbA1c level < 7%
CPTII: 3046F	Most recent HbA1c level > 9%
CPTII: 3051F	Most recent HbA1c level ≥ 7% and ≤ 8%
CPTII: 3052F	Most recent HbA1c level > 8% and ≤ 9%

Exclude these patients from the measure

Patients are excluded if they:

- Did not have a diagnosis of diabetes during the measurement year or the year prior, and a diagnosis of gestational diabetes, steroid-induced diabetes, or polycystic ovarian syndrome.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty.
- Have passed away during the measurement year.
- Received palliative care during the measurement year.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. Implement procedures to **set care gap "alerts"** in electronic medical records and then reach out to those who are overdue for their HbA1c test.
2. **Order laboratory tests ahead** of a patient's appointment.

Data source for measure: Claims, Electronic Clinical Data System, Medical Record, Supplemental Data Submission

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Administrative measure

MEASURE DEFINITION

The percent of Medicare Advantage patients, age 18-85, with type 1 or type 2 diabetes who received an annual kidney health evaluation, including a blood test for kidney function (estimated glomerular filtration rate [eGFR]) ***and*** a urine test for kidney damage (urine albumin-creatinine ratio [uACR]) during the measurement year.

✓Recommended codes

Codes	Definition
CPT: 80047-8	Multi-test Laboratory panels; Basic metabolic panel (calcium, ionized)
CPT: 80050	Basic Metabolic Panel (BMP) (No GFR)
CPT: 82043	Microalbumin (Protein) Level
CPT: 82570	Urine test: Protein/Creatinine Ratio

Exclude these patients from the measure

Patients are excluded if they:

- Present evidence of end-stage renal disease (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or before December 31 of the measurement year.
- Received palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty.
- Have passed away during the measurement year.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider groups can make an impact

1. Implement procedures to **set care gap "alerts"** in electronic medical records and then reach out to those who are overdue for their test.
2. Order laboratory tests ahead of a patient's appointment.

Data source for measure: Claims, Electronic Clinical Data System, Supplemental Data Submission

MEDICATION RECONCILIATION POST-DISCHARGE

Hybrid measure

MEASURE DEFINITION

Assesses whether adults 18 and older who were discharged from an inpatient facility, between January 1 and December 1 of the measurement year, had their medications reconciled within 30 days.

✓ Recommended CPT II codes

CPT II Codes	Definition
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.

Exclude these patients from the measure

Patients are excluded if they received hospice care during the measurement year or if they passed away within 30 days post-discharge.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. Develop **procedures to ensure that a prescribing practitioner, clinical pharmacist, or registered nurse conducts medication reconciliation**. This could include setting a notification on patients' records to conduct a medical reconciliation within 30 days of a recorded inpatient discharge.
2. **Ensure your patients' medical records are being updated to include**:
    - Discharge summary indicating the provider is aware of the patient's hospitalization or discharge.
    - The date medication reconciliation was performed.
    - Current medications with evidence of medication reconciliation, including at least one of the following notes:
        - The provider reconciled the current medications and those prescribed at discharge.
        - A status update on the discharge medications (for example, no change in medication since discharge, same medications at discharge, discontinued all discharge medications).
        - No medications were prescribed or ordered upon discharge.

Data source for measure: Claims, Medical Record

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Administrative measure

MEASURE DEFINITION

Percent of female patients who broke a bone and got a bone mineral density screening or treatment for osteoporosis within 6 months.

✓ Recommended codes

CPT Codes:	Definition
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (e.g., hips, pelvis, spine)
77080	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
HCPCS Medication Therapy Codes:	
J0897	Injection, denosumab, 1 mg
J1740	Injection, ibandronate sodium, 1 mg
J3110	Injection, teriparatide, 10 mcg
J3111	Injection, romosozumab-aqqg, 1mg
J3489	Injection, zoledronic acid, 1mg

Exclude these patients from the measure

Patients are excluded if they:

- Had a bone mineral density test two years before the fracture.
- Received osteoporosis therapy one year before the fracture.
- Received hospice care during the measurement year.
- Are age 81 or older with frailty.
- Are ages 67-80 with advanced illness and frailty.
- Have passed away during the measurement year.
- Received palliative care between July 1 of the year prior to the measurement year through the end of the measurement year.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. **Develop a systematic approach to identify patients eligible** for bone mass density screening:
    - Female patients starting at age 65 to reduce the risk of fractures.
    - Postmenopausal women younger than 65 if they are at high risk.

Data source for measure: Claims

PLAN ALL-CAUSE READMISSIONS

Administrative measure

MEASURE DEFINITION

Percentage of members 18 and older discharged from an acute hospital or observation stay who were readmitted (acute, unplanned) to a hospital within 30 days, either for the same condition as their recent hospital stay or a different reason (any diagnosis). Patients may have been readmitted back to the same hospital or to a different one.

✓ Recommended codes

Not applicable.

Patients are excluded from this measure if they:

- Received hospice care at any time during the measurement year.
- Have a primary diagnosis of pregnancy on the discharge claim.
- Had a primary diagnosis of a condition originating in the perinatal period on the discharge claim.
- Died during hospital stay.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. **Implement a post-discharge process** to track, monitor, and follow up with patients.
2. **Develop transitional care management** for patients who are at high risk for readmissions.
3. **Reserve appointment slots** for patients who are discharged from the hospital, so they can be seen within seven days of discharge.

Data source for measure: Claims, Medical Record

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE

Administrative measure

MEASURE DEFINITION

Percent of males, age 21–75, and females, age 40–75, 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.

✓ Recommended codes

Not applicable.

Exclude these patients from the measure

Patients are excluded if they:

- Are diagnosed with myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.
- Received hospice services or palliative care anytime during the measurement year.
- Are age 66 and older with advanced illness and frailty.
- Any of the following during the measurement year or the year prior:
    - Have a pregnancy diagnosis, IVF, or at least one prescription for clomiphene
    - End-stage renal disease or dialysis diagnosis
    - Cirrhosis diagnosis.

BEST PRACTICES FOR IMPROVING OUTCOMES

How provider organizations can make an impact

1. Systematically review patients who are not getting a statin and ensure there is an appropriate diagnosis code on file to document the exclusion (refer to exclusions above).
2. **Educate patients on the importance of complying** with statin therapy during every touchpoint with them (for example, during in-person and remote appointments, through letters and electronic communications).

Data source for measure: Claims

TRANSITIONS OF CARE

This Star measure reviews the average of the rates for the four transitions of care (TRC) measures.

TRC Measure	Definition
Medication Reconciliation Post-Discharge	Medication reconciliation, in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record and conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 total days).
Notification of Inpatient Admission	Administrative reporting is not available for this indicator. Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through two days after the admission (three total days).
Patient Engagement After Inpatient Discharge	Patient engagement provided within 30 days after discharge. Any of following meets compliance: Outpatient, telephone, e-visit, virtual check-in, or transitional care management services. *Note:* Patient engagement that occurs on the date of discharge is not compliant.
Receipt of Discharge Information	Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days). *Note:* Administrative reporting for Notification of Inpatient Admission and Receipt of Discharge Information is **not** available.

✓ Recommended CPT codes

Codes	Definition
CPTII: 1111F	Medication reconciliation intervention
CPT: 99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
CPT: 99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email, or in person) and decision-making of at least moderate complexity and a face-to-face visit within 14 days of discharge.
CPT: 99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email, or in person) and decision-making of at least high complexity and a face-to-face visit within seven days of discharge.

Exclude these patients from the measure

Patients are excluded if they:

- Are in hospice or using hospice services
- Discharged after December 1 of the measurement year

TRANSITIONS OF CARE, CONTINUED

BEST PRACTICES

How provider organizations can make an impact

1. **Implement procedures to help providers more accurately comply** with the reporting requirements for this measure. This could include:
    - Automated push notifications to flag when required fields are missing.
    - Distributing guidance to providers on mandatory information.
    - Scheduling telehealth calls immediately after discharge to conduct the medication reconciliation.

All Transition of Care Documentation

1. All evidence submitted for the transition of care measures should:
    - Include the **date stamp** of when the documentation was received. Any documentation that does not include a time frame or date stamp does not meet criteria.
    - Be collected via medical record review. Otherwise, it will not be accepted.

Notification of Admission

2. Update the patient's outpatient medical record with documentation that the primary care provider practice has received notification of inpatient admission within two days of admission.
    - For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable. This documentation must:
        - Clearly apply to the admission event.
        - Include the timeframe for the planned inpatient admission.
    - Notification must be from an inpatient practitioner, hospital staff, or emergency department. Notification of admission by the patient or the patient's family to the primary care provider or ongoing care provider does not meet criteria for this measure.

Receipt of Discharge

3. The receipt of discharge information may be included in the following documents:
    - A discharge summary
    - A summary of care record
    - Structured fields in an electronic health record

Data source for measure: Claims, Electronic Clinical Data System, Medical Record, Supplemental Data Submission

PART D MEASURES: PRESCRIPTION DRUG EVENTS

Prescription drug event (PDE) measures focus on medication management at health plans with a Part D program. The measures give special attention to medication adherence for select health conditions, like diabetes and elevated cholesterol. The data submitted to CMS is standardized and only covers paid claims.

Star Measure	Description
Medication Adherence for Diabetes Medications	Percent of patients with a prescription for diabetes medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.
Medication Adherence for Hypertension (RAS antagonists)	Percent of patients with a prescription for a blood pressure medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.
Medication Adherence for Cholesterol (Statins)	Percent of patients with a prescription for a statin medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.
Statin Use in Persons with Diabetes (SUPD)	Percent of patients, age 40-75 years old, who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period.
Concurrent Use of Opioids and Benzodiazepines	Percent of patients, 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement period. For this measure, the fewer patients the better. The purpose of this measure is to assess appropriate use due to the serious safety concerns related to these medications.
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults	Percent of patients, 65 years or older, with concurrent use of two or more unique anticholinergic medications during the measurement period. For this measure, the fewer patients the better. The purpose of this measure is to assess appropriate use due to the serious safety concerns related to these medications.

Exclude these patients from the measure

Patients are excluded if any of the following apply:

- Received hospice services or palliative care anytime during the measurement year.
- An ESRD diagnosis or dialysis coverage dates.
- One or more prescriptions for insulin (only for the diabetes measure).
- One or more prescriptions for sacubitril/valsartan (only for the hypertension measure).
- Rhabdomyolysis and myopathy (only for the SUPD measure).
- Pregnancy (only for the SUPD measure).
- Lactation and fertility (only for the SUPD measure).
- Cirrhosis (only for the SUPD measure).
- Pre-diabetes (only for the SUPD measure).
- Polycystic ovary syndrome (only for the SUPD measure).

MEMBER EXPERIENCE SURVEYS

Member satisfaction measures come from the following two anonymous surveys that CMS conducts annually with Medicare beneficiaries:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey
- Health Outcomes Survey (HOS)

In this section, we:

- Describe both surveys and provide the measure definitions.
- Indicate the measures that providers may impact.
- Provide best practice advice to help close gaps in care.

CAHPS

This survey gauges a Medicare patient's perceptions of health care, and measures how they rate interactions with their providers and health plan. There are ten domains in the CAHPS survey. The ones that pertain to the patient experience at the provider level include:

- Care Coordination
- Getting Appointments and Care Quickly
- Getting Needed Care
- Getting Needed Prescription Drugs

The other domains that are CAHPS measures:

- Annual Flu Vaccine
- Customer Service
- Doctors Who Communicate Well
- Rating of Drug Plan
- Rating of Health Care Quality
- Rating of Health Plan

HOS

HOS assesses Medicare members' perceptions of their health care conditions and general state of well-being. Health plans are measured based upon aggregate responses from a random sample of patients and the results are publicly reported. The HOS survey is conducted annually from August to November and include the following categories and measures:

Functional Health Measures

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health

Effectiveness of Care Measures

- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

THE CAHPS SURVEY

Many of the questions in the CAHPS survey are tied to the patients' experience with their providers. In addition to impacting CAHPS scores, **positive patient experiences** correlate with:

- Improved office staff and provider experience.
- Greater adherence to medical advice, which leads to better health outcomes.
- Likelihood of staying with their practice and recommending to family and friends.

Care Coordination

Patients rate how familiar providers are with their medical history, how providers follow-up with them after tests, and how they coordinate care with specialists in the previous six months.

CAHPS SURVEY QUESTIONS

Care coordination questions (based on 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?
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?
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?
How often did your personal doctor talk about all the prescription medicines you were taking?
Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
How often did your personal doctor seem informed and up to date about the care you got from specialists?
Recommended best practices
Know patient medical history & stay up to date on specialty care • Develop a process to use hospital EMRs during patient visits. • Use keywords to indicate to the patient that you are aware of their medical history.   ○ Example: "I was **reviewing your records** from your specialist visit and am up to date on your care."
Communicate test results • Inform patients about when and how they should expect to receive their test results. • Develop a process to return all patient results (+/-) via phone call, patient portal, or secure text messaging.

Talk about prescription medicines
• Ensure that all providers, nurses, and medical assistants use keywords to communicate to the patient about their prescription medicines.
  ○ Example: "Mr. Jones, thank you for confirming why you are here to see us today. Now, I would like to **talk to you about your prescription medicines**."
  ○ It is important that **you review each medicine** with the patient and not just ask, "Have any of your prescription medicines changed?"
• Select the top two most prescribed medicines (such as antibiotics, antihypertensives, anticoagulants, or antidepressants) and create a process to call patients shortly after the visit (ideally within 5 days) to ensure the prescription has been filled and to answer any questions about the newly prescribed medicine.

Help manage care • Appoint a team member to coordinate specialist visits and testing with the patient to ensure they have an appointment before leaving the office. This may require coordination with specialty offices and diagnostic testing facilities to secure backline or best phone numbers.

Access to Care: Getting Appointments and Care Quickly

Patients rate how often they were able to get an appointment and necessary care within the last six months. They also rate how quickly they were seen once in the office.

Getting appointments and care quickly questions (Based on the last six months)
When you needed care right away, how often did you get care as soon as you needed?
Not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
How often did you see the person you came to see within 15 minutes of your appointment time?
Recommended best practices
Create delay alerts and wait time communication boards • Contact patients by phone, email, or text when there are expected delays. • Post a "Wait Time Communication" board at the front desk to inform patients of any wait times or delays for each provider.
Standardize visits • Develop consensus of visit frequency and duration for each schedule type to ensure patient hours run without delay.

Access to Care: Getting Needed Care

Patients rate the ease of getting an appointment or tests and how long it takes to see a specialist, within the past 6 months.

Getting needed care questions (based on the last six months)
How often was it easy to get the care, tests, or treatment you needed?
How often did you get an appointment to see a specialist as soon as you needed?
Recommended best practices
Increase access capacity • Same-day appointments: Increase the number of open appointments by a minimum of 2 per day per provider to support open access scheduling. • Consider adding evening or weekend appointment times.
Referral process and access to specialists • Determine the most referred-to specialty and meet with that group to develop a standard communication channel and expectations to enhance communication, access, and to share documentation, notes, and patient data.

Getting Needed Prescription Drugs

Patients rate how easy it was to fill prescriptions that they were prescribed within the previous six months.

Getting needed prescription drugs questions (based on the last six months)
How often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
How often was it easy to use your prescription drug plan to fill a prescription at a local pharmacy?
How often was it easy to use your prescription drug plan to fill prescriptions by mail?
Recommended best practices
Use the prescription drug formulary to understand member benefits • Provide 90-day fill prescriptions.
Set expectations on prior authorizations • Submit prior authorizations early and inform the patient about resolution time if an authorization is needed.
Educate the patient on mail order options and offer to help set it up
Preferred pharmacies • Direct patients to Blue Cross Blue Shield of Massachusetts preferred pharmacies to ensure they are receiving the best benefit available.

HEALTH OUTCOMES SURVEY (HOS)

Member experience survey

HOS looks to describe Medicare members' perceptions of their health care conditions and general state of well-being. Health plans are measured based upon aggregate responses from a random sample of patients, and the results are publicly reported. The HOS survey is conducted annually from August to November and includes the following categories and measures:

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Effectiveness of Care Measures

- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

Monitoring Physical Activity

This measure assesses the percent of patients who discussed exercise with their doctor and were advised to start, increase, or maintain physical activity during the year.

Tips for positive interactions

- Develop a plan with your patients to improve physical health. Check in with them to discuss their progress on this plan.
- Educate them on topics, such as strength training, exercise, and nutrition.
- Ask patients if they have pain, and if so, is it affecting their ability to complete daily activities? Identify ways to improve the patient's pain.

Improving Bladder Control

This measure assesses the percent of patients with a urine leakage problem in the last six months who discussed treatment options with a provider.

Tips for positive interactions

- Incontinence can be a difficult subject to approach, but it is important to discuss with your patient during each visit.
- Screen all patients for urinary incontinence and discuss treatment options no matter the frequency or severity.

Reducing the Risk of Falling

This measure assesses the percent of patients with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls.

Tips for positive interactions

- Discuss balance problems, falls, difficulty walking, and other risk factors for falls.
- Perform a test, like the Get Up and Go (GUG) test to assess the patient's balance.
- Recommend the use of a walker or cane, if appropriate.
- Perform bone density screenings, especially for patients at risk.

CONTACT US

Working together to improve quality

We are committed to working with you on improving the health of our members. If you have questions about this information or would like to know more, please contact:

ADAM LICURSE, MD

Senior Medical Director
Population Health & Analytics, Health & Medical Management
Adam.Licurse@bcbsma.com

HEIDI PARRILLA, PHD

Associate Director
Medicare Stars
Heidi.Parrilla@bcbsma.com

JASON RUDA, MS, CPXP (CERTIFIED PATIENT EXPERIENCE PROFESSIONAL)

Associate Director
CAHPS Strategy & Improvement
Jason.Ruda@bcbsma.com

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