

# 2027 Quality Program

## Program Guide for Primary Care Providers

Released November 2026

hmsa

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# Acronyms Used in this Guide

**APRN:** advanced practice registered nurse
**CMS:** Centers for Medicare & Medicaid Services
**DTaP:** diphtheria, tetanus, and acellular pertussis
**ED:** emergency department
**EFT:** electronic funds transfer
**FEP:** federal employee program
**FFS:** fee for service
**GET:** general excise tax
**GMI:** glucose management indicator
**HepB:** hepatitis B
**HiB:** *Haemophilus Influenzae* type B
**HMO:** health maintenance organization
**IPV:** inactivated polio vaccine
**LOB:** line of business
**MM:** member months
**MMR:** measles, mumps, and rubella
**PA:** physician assistant
**PCP:** primary care provider
**PCV:** pneumococcal conjugate vaccine
**PPO:** preferred provider organization
**Tdap:** tetanus, diphtheria toxoids, and acellular pertussis
**VZV:** chickenpox; varicella zoster virus

# Program Introduction

## Welcome to the HMSA 2027 Quality Program

At HMSA, improving the health and well-being of our members and communities remains at the center of everything we do. Primary care providers play a vital role in delivering high-quality, coordinated care, and we value their commitment to improving health outcomes across Hawaii.

The Quality Program is for eligible primary care providers serving our Medicare, QUEST, and commercial members. It builds on our longstanding commitment to supporting providers through a transparent, data-driven approach that recognizes and rewards high-quality care.

This guide provides an overview of program eligibility, payment and scoring methodologies, measure specifications, and other important program requirements. We encourage providers to review the guide carefully and use the available tools and resources throughout the year to support their success in the program.

Thank you for your dedication to our members and your continued commitment to delivering exceptional care for the people of Hawaii.

# Primary Care Providers

## Program Eligibility

To participate in the program, a provider must meet the following criteria:

- Have a fully executed Participating Provider Agreement for:
    - HMSA's commercial LOB at the end of the measurement year to earn commercial Quality Payments.
    - HMSA's QUEST LOB at the end of the measurement year to earn QUEST Quality Payments.
    - HMSA's Medicare Advantage LOB at the end of the measurement year to earn Medicare Advantage Quality Payments.
- Be a PCP credentialed with HMSA as an internist, general practitioner, family physician, pediatrician, naturopath, advanced practice registered nurse, or physician assistant under the supervision of a program-eligible PCP.
- Use Certified Electronic Health Record Technology to document and communicate clinical care. PCPs who cannot meet this requirement must be approved to participate in the program.
- Submit at least one claim to HMSA for each applicable LOB during the measurement year. For example, a provider must submit at least one Medicare Advantage claim during the measurement year to be eligible to earn a Medicare Advantage quality payment.

### Exclusions

Providers who are solely contracted with HMSA as specialists or urgent care providers are not eligible to participate in the program.

Pediatricians are not eligible to participate in the Medicare Advantage program.

Eligible PCP types exclude PAs or APRNs with a psych subspecialty in the HMSA system.

## Pay-To Entity

Member attribution and quality measure scoring are based on claims data and tied to the TIN identified on the PCP's claim. For purposes of the Quality Program, the provider group (or provider, in the case of a single physician practice) associated with that TIN is referred to in this guide as the "pay-to entity."

## Payment Conditions

If a PCP meets the eligibility requirements and the PCP's pay-to entity earns a Quality Payment, the Quality Payment check and remittance report will be sent to the payee(s) designated by the provider or group administrator to receive HMSA payments.

If a PCP or medical group has an electronic funds transfer account for claims payments, HMSA will direct all payments to that EFT account. Providers cannot have an EFT account for claims payments and also receive program payments by check.

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# Member Attribution to PCPs

HMSA continues to refine its attribution model to support strong patient-provider relationships and provide PCPs with transparent and timely information about their patient panels.

The Quality Program uses the following claims-based attribution approach for members with an HMSA commercial PPO, HMO, QUEST, or Medicare Advantage plan:

1. Each month, a member will be attributed to a PCP using a rolling 18-month claims lookback for eligible PCP specialties. Eligible claims will be counted at the pay-to entity level, while attribution will be assigned to an individual provider within the pay-to entity. Only the CPT codes in Appendix B are used to calculate attribution. Services performed in urgent care settings are excluded from the attribution calculation.
2. The member will first be attributed to the pay-to entity associated with the PCP the member saw most frequently. In the event of a tie, the member will be attributed to the pay-to entity associated with the PCP the member saw most recently.
3. The member will then be attributed to the provider within that pay-to entity whom the member saw most frequently. In the event of a tie, the member will be attributed to the provider the member saw most recently.

PCPs cannot add, transfer, or remove members from their panels because attribution is based on claims. New HMSA members, including newborns, will be attributed to a PCP after a qualifying claim for services is submitted. A member's selection of a PCP, or HMSA's assignment of a PCP to a member, is not used to determine attribution under the claims-based attribution approach. Members with more than one HMSA plan will be attributed to only one provider.

PCPs and the pay-to entity must participate in the line of business associated with the member's plan. BlueCard members will not count toward a PCP's attribution.

**Example:**
Attribution Month: January 2027
Claims lookback based on date of service: July 1, 2025 – Jan. 31, 2027
Attribution for January 2027 will be reflected in the care gap rosters as of Jan. 31, 2027, and once all claims-based attribution criteria have been met.

# Access to Primary Care

Access to primary care is an important principle of the program. A PCP has the right not to accept or schedule visits with patients, subject to the terms of the applicable participating provider agreement. However, HMSA's Quality Program or a patient's attribution to another PCP should not be the reason for denying the patient access to care.

HMSA monitors member complaints about PCP access to care and will initiate a corrective action process for a PCP when HMSA receives the first complaint.

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# Payments Available in the Quality Program

PCP performance in the Quality Program will be aggregated at the pay-to entity level. All measures will be scored and paid at the pay-to entity level. Pay-to entities will receive payments based on the schedule and criteria below.

| PAYMENT TYPE | CRITERIA FOR PAYMENT | FREQUENCY/TIMING OF PAYMENT |
|---|---|---|
| Commercial and QUEST: Quality Payments | After the 2027 measurement year (MY2027), each pay-to entity's annual aggregated performance on quality measures will be scored. | Dollars earned will be paid by the end of May 2028. |
| Medicare Advantage: Stars Quality Domain Quality Payments | After MY2027, a pay-to entity's annual performance will be scored for each plan in which the pay-to entity participates.<br><br>A preliminary payment will be based on the pay-to entity's aggregated Quality Measure scores in the Stars Quality Domain using projected cut points for the measurement year.<br><br>A final true-up payment will be based on the pay-to entity's aggregated Quality Measure scores in the Stars Quality Domain using CMS-published cut points for MY2027 for Star Rating 2029. | Based on the pay-to entity's aggregated scores, a preliminary payment will be paid by the end of May 2028. A final true-up payment will be paid in Q4 2028 after CMS publishes the cut points. |
| Medicare Advantage: Health Plan Star Rating Incentive | In the event CMS determines that HMSA has earned an overall Star Rating of 4 or more Stars for one or more of its plan contracts, pay-to entities will be eligible for an incentive, gated by their own performance in the Stars Quality Domain for the Medicare Advantage line of business during the measurement year.<br><br>For each plan that earns 4 or more Stars, the incentive will be scored and paid at the pay-to level. | If achieved, this incentive for the measurement year will be paid in Q4 2028 after CMS publishes Star Ratings. |

# Quality Payments and Measures

## Quality Payments

In addition to FFS payments for all Covered Services, pay-to entities will be eligible to earn Quality Payments based on their performance on an applicable set of quality measures. Measures will be scored at the pay-to entity level by LOB and based on performance during the 2027 measurement year.

## Measurement Responsibility

Pay-to entities are scored on all measures for which their PCPs' attributed patient panels are eligible, regardless of PCP specialty type. Results will be aggregated at the pay-to entity level.

Quality measures were selected based on their clinical importance and focus on patient care goals, including prevention, well-being, access to care, patient-centeredness, and population health management.

The following tables summarize the quality measures and applicable LOBs. See Appendix A for details about each Quality Measure.

### Commercial and QUEST Quality Measures

| MEASURE | LINE OF BUSINESS | HIGH-LEVEL DEFINITION |
|---|---|---|
| Child and Adolescent Well-care Visits | Q | The percentage of attributed patients 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an ob-gyn practitioner during the measurement year. |
| Childhood Immunization Status | Q | The percentage of attributed patients 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three *Haemophilus influenza* type B (HiB); three hepatitis B (HepB), one chickenpox (VZV); four pneumococcal conjugate (PCV) vaccines administered. DTaP, IPV, HiB, and PCV vaccines administered prior to 42 days after birth cannot be counted. |
| Controlling High Blood Pressure | C Q | The percentage of attributed patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose most recent BP was adequately controlled (<140/90 mm Hg) during the measurement year. |
| Glycemic Status Assessment for Patients with Diabetes (<8.0%) | C Q | The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was <8.0% during the measurement year. |
| Screening for Depression and Follow-up Plan | Q | The percentage of attributed patients 12 years of age and older with an eligible encounter during the measurement year screened for depression using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented. |
| Well-Child Visits in the First 15 Months of Life | Q | The percentage of attributed patients who had the following number of well-child visits with a PCP: Six or more well-child visits for children who turned 15 months old during the measurement year. |
| Well-Child Visits in the First 30 Months of Life | Q | The percentage of attributed patients who had the following number of well-child visits with a PCP: Two or more well-child visits for children who turned 30 months old during the measurement year. |

**C = COMMERCIAL Q = QUEST**

## Medicare Advantage Quality Measures

| MEASURE | HIGH-LEVEL DEFINITION |
|---|---|
| Breast Cancer Screening | The percentage of attributed patients 40-74 years of age who had a mammogram to screen for breast cancer. |
| Care for Older Adults – Functional Status Assessment | The percentage of attributed patients 66 years and older who had a functional status assessment during the measurement year. |
| Care for Older Adults – Medication Review | The percentage of attributed patients 66 years and older who had a medication review during the measurement year. |
| Colorectal Cancer Screening | The percentage of attributed patients 45 – 75 years of age who had an appropriate screening for colorectal cancer. |
| Concurrent Use of Opioids and Benzodiazepines | The percentage of attributed patients 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement year. |
| Controlling High Blood Pressure | The percentage of attributed patients 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose recent BP was adequately controlled (<140/90 mm Hg) during the measurement year. |
| Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening | The percentage of attributed patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. |
| Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on Positive Screen | |
| Eye Exam for Patients with Diabetes | The percentage of attributed patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam from an ophthalmologist or optometrist. |
| Follow-up After Emergency Department Visit for People with Multiple High-risk Chronic Conditions | The percentage of emergency department (ED) visits for attributed patients 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit. |
| Glycemic Status Assessment for Patients with Diabetes (≤9.0%) | The percentage of attributed patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was ≤9.0% during the measurement year. |
| Kidney Health Evaluation for Patients with Diabetes | The percentage of attributed patients 18-85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year. |
| Medication Adherence for Cholesterol (Statins) | The percentage of attributed patients 18 years of age or older who were adherent to statins. |

| | |
|---|---|
| Medication Adherence for Diabetes | The percentage of attributed patients 18 years of age or older who were adherent across the following classes of diabetes medications: Biguanides, sulfonylureas, thiazolidinediones, DPP-IV inhibitors, GLP-1 receptor agonists, meglitinides, and SGLT2 inhibitors. |
| Medication Adherence for Hypertension (RAS Antagonist) | The percentage of attributed patients 18 years of age or older who were adherent to RAS antagonists including ACE inhibitors, ARBs, or Direct Renin inhibitors. |
| Medication Therapy Management – Comprehensive Medication Review | The percentage of attributed patients 18 years or older who are enrolled into a Medication Therapy Management program and received a Comprehensive Medication review during the measurement year. |
| Osteoporosis in Women with a Fracture | The percentage of attributed women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (six months) after the fracture. |
| Plan All-Cause Readmission | For attributed patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays). |
| Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults | The percentage of attributed patients 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement year. |
| Statin Use for Patients with Diabetes | The percentage of attributed patients 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement year. |
| Transitions of Care: Notification of Inpatient Admission | The percentage of discharges for attributed patients 18 years of age and older who had the following: Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). |
| Transitions of Care: Receipts of Discharge Information | The percentage of discharges for attributed patients 18 years of age and older who had the following: Receipts of Discharge Information. Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days). |
| Transitions of Care: Patient Engagement After Inpatient Discharge | The percentage of discharges for attributed patients 18 years of age and older who had the following: Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. |
| Transitions of Care: Medication Reconciliation Post-discharge | The percentage of discharges for attributed patients 18 years of age and older who had the following: Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). |

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# Patient Population and Member Eligibility

## Patient Population Identification

### COMMERCIAL

Members enrolled in HMSA's commercial PPO and HMO plans will be included in the Quality Measures. Federal Employee Program (FEP) and BlueCard members will not be included.

If a member is enrolled in an HMSA commercial plan and another HMSA plan, the member will be counted in only one quality measure set:

- If the member also has HMSA QUEST coverage, the member will be counted in the QUEST quality measure set.
- If the member also has HMSA Medicare Advantage coverage, the member will be counted in the Medicare Advantage quality measure set.

### QUEST

Members enrolled in HMSA QUEST will be included in the quality measures, including QUEST members who are aged, blind, or disabled.

If an HMSA QUEST member is enrolled in another HMSA plan, the member will be counted in only one quality measure set:

- If the member also has HMSA commercial coverage, the member will be counted in the QUEST quality measure set.
- If the member also has HMSA Medicare Advantage coverage, the member will be counted in the Medicare Advantage quality measure set.

### MEDICARE ADVANTAGE

Members enrolled in an HMSA Medicare Advantage plan will be included in the quality measures.

If a member is enrolled in an HMSA Medicare Advantage plan and another plan, the member can be counted for only one of the quality measure sets as follows:

- If an HMSA Medicare Advantage member also has coverage under an HMSA commercial plan, the member will be counted for the Medicare Advantage plan quality measure set.
- If an HMSA Medicare Advantage member also has coverage under an HMSA QUEST plan, the member will be counted for the Medicare Advantage plan quality measure set.

## Member Eligibility

To be included in a pay-to entity's Quality Measure score calculation, members must be attributed to PCPs within the pay-to entity based on HMSA's claims-based attribution logic for December 2027.

# Quality Payments Overview – Commercial and QUEST

Quality Payments may be made in May 2028 to the pay-to entity based on the pay-to entity's Quality Measure score for the Commercial and QUEST measures during measurement year 2027. The quality measures and relevant time frames for measurement year 2027 are as follows:

| QUALITY MEASURE | MEASUREMENT PERIOD | PAYMENT PERIOD | QUALITY PAYMENT |
|---|---|---|---|
| Quality Measures: Commercial & QUEST | January 1 through December 31, 2027 | January 1 through December 31, 2027 | May 2028 |

The Quality Program for the Commercial and QUEST LOBs is based on:

- Measure set and specifications of the 2027 quality measure set. For more quality measure details, please see Appendix A. The 2027 thresholds and per-gap dollar amounts are available below and on the Provider Resource Center.
- Attributed member panel per claims-based attribution logic.
- The numerator and denominator for each quality measure is determined at the pay-to entity level by aggregating the eligible, attributed patients of PCPs of a pay-to entity.

The following steps demonstrate how HMSA will calculate payment for the 2027 quality measures.

**STEP 1: Determine Your Quality Score (By Measure)**
**STEP 2: Evaluate Your Score Against Targets and Determine the Per-Gap Dollar Amount**
**STEP 3: Multiply the Per-Gap Dollar Amount Against Gaps Closed (Numerator)**

Payments begin when a pay-to entity has reached the Target 1 Rate which is set at the 25th percentile benchmark and will be based on a per-gap dollar amount, with higher payments awarded as performance reaches established thresholds. The thresholds align with NCQA Quality Compass benchmarks at the 25th, 50th, 75th, 90th, and 95th percentiles.

Providers' individual quality performance and the pay-to entity's aggregated quality performance will be available for review via a final performance report that will be sent to the payee(s) that the provider or group administrator has designated for HMSA payments.

Please find below the 2027 Quality Target Rates and corresponding Per-Gap Amounts for the following measures:

## Commercial

| MEASURE NAME | TARGET 1 RATE 25TH PERCENTILE | TARGET 2 RATE 50TH PERCENTILE | TARGET 3 RATE 75TH PERCENTILE | TARGET 4 RATE 90TH PERCENTILE | TARGET 5 RATE 95TH PERCENTILE |
|---|---|---|---|---|---|
| Controlling High Blood Pressure (CBP) | 65.45% | 70.80% | 75.51% | 79.34% | 81.31% |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | 64.30% | 70.73% | 74.94% | 77.38% | 79.39% |
| **MEASURE NAME** | **TARGET 1 PER-GAP AMOUNT** | **TARGET 2 PER-GAP AMOUNT** | **TARGET 3 PER-GAP AMOUNT** | **TARGET 4 PER-GAP AMOUNT** | **TARGET 5 PER-GAP AMOUNT** |
| Controlling High Blood Pressure (CBP) | $37 | $42 | $45 | $48 | $50 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | $40 | $45 | $48 | $50 | $52 |

## QUEST

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| MEASURE NAME | TARGET 1 RATE 25TH PERCENTILE | TARGET 2 RATE 50TH PERCENTILE | TARGET 3 RATE 75TH PERCENTILE | TARGET 4 RATE 90TH PERCENTILE | TARGET 5 RATE 95TH PERCENTILE |
|---|---|---|---|---|---|
| Child and Adolescent Well-Care Visits (WCV) | 51.64% | 57.06% | 62.45% | 69.73% | 72.50% |
| Childhood Immunization Status (CIS) | 56.24% | 62.71% | 67.00% | 72.03% | 75.66% |
| Controlling High Blood Pressure (CBP) | 65.94% | 70.32% | 73.36% | 76.89% | 78.93% |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | 59.34% | 64.48% | 67.88% | 70.84% | 72.60% |
| Screening for Depression and Follow-Up Plan (SCDF) | 31.44% | 55.56% | 71.01% | 84.24% | 98.57% |
| Well-Child Visits in the First 15 Months of Life (W15) | 60.94% | 65.84% | 70.24% | 73.95% | 77.57% |
| Well-Child Visits in the First 30 Months of Life (W30) | 70.63% | 75.25% | 79.73% | 84.47% | 87.27% |

| MEASURE NAME | TARGET 1 PER-GAP AMOUNT | TARGET 2 PER-GAP AMOUNT | TARGET 3 PER-GAP AMOUNT | TARGET 4 PER-GAP AMOUNT | TARGET 5 PER-GAP AMOUNT |
|---|---|---|---|---|---|
| Child and Adolescent Well-Care Visits (WCV) | $80 | $85 | $87 | $89 | $90 |
| Childhood Immunization Status (CIS) | $110 | $115 | $117 | $119 | $120 |
| Controlling High Blood Pressure (CBP) | $37 | $42 | $45 | $48 | $50 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | $40 | $45 | $48 | $50 | $52 |
| Screening for Depression and Follow-Up Plan (SCDF) | $8 | $13 | $15 | $17 | $18 |
| Well-Child Visits in the First 15 Months of Life (W15) | $140 | $145 | $147 | $149 | $150 |
| Well-Child Visits in the First 30 Months of Life (W30) | $75 | $80 | $82 | $84 | $85 |

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# Commercial and QUEST Quality Payment Examples

The examples below are for illustrative purposes only.

### Example 1:

## STEP 1: Determine Your Quality Score by Measure

Group A has members in the following measures: Controlling High Blood Pressure and Glycemic Status Assessment for Patients with Diabetes (<8.0%).

| COMMERCIAL MEASURES | NUMERATOR | DENOMINATOR |
|---|---|---|
| Controlling High Blood Pressure | 149 | 200 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | 63 | 75 |

For the Controlling High Blood Pressure measure, Group A has 200 attributed members across its PCPs in the denominator. Of those members, 149 had a most recent blood pressure reading that was adequately controlled (<140/90 mm Hg).

- 149 numerator ÷ 200 denominator = 0.745

This results in a 74.50% quality score for Group A's Controlling High Blood Pressure measure in the commercial LOB.

## STEP 2: Evaluate Your Score Against Targets and Determine the Per-Gap Dollar Amount

| MEASURE NAME | TARGET 1 RATE 25TH PERCENTILE | TARGET 2 RATE 50TH PERCENTILE | TARGET 3 RATE 75TH PERCENTILE | TARGET 4 RATE 90TH PERCENTILE | TARGET 5 RATE 95TH PERCENTILE |
|---|---|---|---|---|---|
| Controlling High Blood Pressure (CBP) | 65.45% | **70.80%** | 75.51% | 79.34% | 81.31% |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | 64.30% | 70.73% | 74.94% | 77.38% | 79.39% |
| **MEASURE NAME** | **TARGET 1 PER-GAP AMOUNT** | **TARGET 2 PER-GAP AMOUNT** | **TARGET 3 PER-GAP AMOUNT** | **TARGET 4 PER-GAP AMOUNT** | **TARGET 5 PER-GAP AMOUNT** |
| Controlling High Blood Pressure (CBP) | $37 | **$42** | $45 | $48 | $50 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | $40 | $45 | $48 | $50 | $52 |

Group A's quality score for the Controlling High Blood Pressure measure is 74.50%. This meets the Target 2 Rate and qualifies Group A for the Target 2 Per-Gap Dollar Amount:

- Target 2 Rate: 70.80%
- Target 2 Per-Gap Dollar Amount: $42

## STEP 3: Multiply the Per-Gap Dollar Amount by Gaps Closed (Numerator)

Commercial
Quality Score: 74.50%
Target 2 Rate: 70.80%
Target 2 Per-Gap Dollar Amount: $42

Group A's Controlling High Blood Pressure quality score is 74.50% so they met the Target 2 Rate and qualified for the Target 2 Per-Gap Dollar Amount.

Gaps Closed (Numerator) x Target Per-Gap Dollar Amount = **Total Payment**

149 x $42 = **$6,258**

Group A's Controlling High Blood Pressure payment is **$6,258.00**.

## Example 2:

### STEP 1: Determine Your Quality Score (By Measure)

Group B has members that appear in the following measures: Controlling High Blood Pressure, Child and Adolescent Well-care Visits, Glycemic Status Assessment for Patients with Diabetes - <8.0%, Well-child Visits in the First 30 Months of Life, Well-Child Visits in the First 30 Months of Life (15 Months), Childhood Immunization Status, and Screening for Depression and Follow-up Plan.

| QUEST MEASURES | NUMERATOR | DENOMINATOR |
|---|---|---|
| Child and Adolescent Well-Care Visit | 57 | 80 |
| Childhood Immunization Status | 155 | 300 |
| Controlling High Blood Pressure | 72 | 100 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% | 165 | 200 |
| Screening for Depression and Follow-up Plan | 68 | 125 |
| Well-child Visits in the First 30 Months of Life (30 Months) | 177 | 300 |
| Well-child Visits in the First 30 Months of Life (15 Months) | 181 | 220 |

Regarding the Child and Adolescent Well-Care Visit measure, Group B has 80 attributed members across their PCPs in the denominator. Of those members, 57 members have had at least one comprehensive well-care visit with a PCP or an ob-gyn practitioner.

- 57 numerator ÷ 80 denominator = 0.7125

This equates to 71.25% quality score for Group B's Child and Adolescent Well-Care Visit measure in the QUEST line of business.

### STEP 2: Evaluate Your Score Against Targets and Determine the Per-Gap Dollar Amount

| MEASURE NAME | TARGET 1 RATE 25TH PERCENTILE | TARGET 2 RATE 50TH PERCENTILE | TARGET 3 RATE 75TH PERCENTILE | TARGET 4 RATE 90TH PERCENTILE | TARGET 5 RATE 95TH PERCENTILE |
|---|---|---|---|---|---|
| Child and Adolescent Well-Care Visits (WCV) | 51.64% | 57.06% | 62.45% | **69.73%** | 72.50% |
| Childhood Immunization Status (CIS) | 56.24% | 62.71% | 67.00% | 72.03% | 75.66% |
| Controlling High Blood Pressure (CBP) | 65.94% | 70.32% | 73.36% | 76.89% | 78.93% |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | 59.34% | 64.48% | 67.88% | 70.84% | 72.60% |
| Screening for Depression and Follow-Up Plan (SCDF) | 31.44% | 55.56% | 71.01% | 84.24% | 98.57% |
| Well-Child Visits in the First 15 Months of Life (W15) | 60.94% | 65.84% | 70.24% | 73.95% | 77.57% |
| Well-Child Visits in the First 30 Months of Life (W30) | 70.63% | 75.25% | 79.73% | 84.47% | 87.27% |
| **MEASURE NAME** | **TARGET 1 PER-GAP AMOUNT** | **TARGET 2 PER-GAP AMOUNT** | **TARGET 3 PER-GAP AMOUNT** | **TARGET 4 PER-GAP AMOUNT** | **TARGET 5 PER-GAP AMOUNT** |
| Child and Adolescent Well-Care Visits (WCV) | $80 | $85 | $87 | **$89** | $90 |
| Childhood Immunization Status (CIS) | $110 | $115 | $117 | $119 | $120 |

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| | | | | | |
|---|---|---|---|---|---|
| Controlling High Blood Pressure (CBP) | $37 | $42 | $45 | $48 | $50 |
| Glycemic Status Assessment for Patients with Diabetes - <8.0% (GSD) | $40 | $45 | $48 | $50 | $52 |
| Screening for Depression and Follow-Up Plan (SCDF) | $8 | $13 | $15 | $17 | $18 |
| Well-Child Visits in the First 15 Months of Life (W15) | $140 | $145 | $147 | $149 | $150 |
| Well-Child Visits in the First 30 Months of Life (W30) | $75 | $80 | $82 | $84 | $85 |

Group B's quality score in the Child and Adolescent Well-Care Visit measure for the QUEST line of business is 71.25%. Group B's quality score meets Target 4 Rate and qualifies for Target 4 Per-Gap Dollar Amount.

- Target 4 Rate: 69.73%
- Target 4 Per-Gap Dollar Amount: $89

## STEP 3: Multiply the Per-Gap Dollar Amount Against Gaps Closed (Numerator)

QUEST
Quality Score: 71.25%
Target 4 Rate: 69.73%
Target 4 Per-Gap Dollar Amount: $89

Group B's Child and Adolescent Well-Care Visit performance rate is 71.25% so they met the Target 4 Rate and qualified for the Target 4 Per-Gap Dollar Amount, so the group met the Target 4 Rate and qualified for the Target 4 Per-Gap Dollar Amount.

Gaps Closed (Numerator) x Target 4 Per-Gap Dollar Amount = **Total Payment**

57 x $89 = **$5,073**

Group B's Child and Adolescent Well-Care Visit payment is **$5,073.00**.

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# Quality Payments Overview: Medicare Advantage

A Quality Payment may be paid to the pay-to entity in 2028 based on the pay-to entity's performance during the 2027 measurement year under the Stars Quality Domain Quality Program. Pay-to entities may also earn an incentive under the Health Plan Star Rating Incentive, based on their performance in the Stars Quality Domain Quality Program.

| QUALITY MEASURE | MEASUREMENT PERIOD | QUALITY PAYMENT |
|---|---|---|
| Stars Quality Domain | Jan. 1 through Dec. 31, 2027 | Preliminary Payment: May 2028<br>True-Up Payment: Nov. 2028 |
| Health Plan Star Rating | Jan. 1 through June 2027 | Q4 2028 |

Providers' individual quality performance and the pay-to entity's aggregated quality performance will be available for review via a final performance report that will be sent to the payee(s) that the provider or group administrator has designated for HMSA payments.

## Medicare Advantage: Stars Quality Domain

Scoring will occur at the pay-to entity level for Quality Measures in the Medicare Advantage Stars Quality Domain for measurement year 2027, Star Rating 2029. The scoring methodology closely aligns with the Centers for Medicare & Medicaid Services (CMS) scoring methodology for Medicare Advantage Health Plan Star Ratings, as described in the "Stars Quality Domain Payment Formula" section below.

Pay-to entities may receive a preliminary payment in May 2028 of up to 50% of their maximum potential payment, based on a preliminary performance score. A true-up payment will be issued in Nov. 2028, which will equal the difference between the preliminary payment paid to the pay-to entity and the Quality Payment earned by the pay-to entity based on its final performance score for the measurement year using December 2027 attribution.

The Stars Quality Domain is based on:

- Measure set and specifications of the 2027 program measure set. For measure details, please see Appendix A. The 2027 measure cut points are available in the Provider Resource Center.
- Attributed member panel count: A pay-to entity will accrue all the member months a member has with HMSA in their max pay potential if the member is attributed to a provider within the pay-to entity in December 2027. For 2027, a member may contribute a maximum of twelve member months. The max pay potential PMPM will be applied to each member month based on the line of business in which the member is enrolled for that month, if applicable.
- The overall Star Rating is determined at the pay-to entity level by aggregating the eligible, attributed patients of PCPs of a pay-to entity.
- The overall Star Rating of a pay-to entity reflects the collective performance of the pay-to entity with regard to members under all Medicare Advantage contracts that HMSA has with CMS.

The Maximum PMPM per Star Rating is set forth below:

| Quality Measures: Stars Quality Domain | | |
|---|---|---|
| OVERALL STAR RATING^ | OVERALL RAW SCORE | MAXIMUM PMPM |
| Medicare Advantage (4 Stars) | Raw Score: 4.00 – 4.24 | Quality payment equivalent to $8.00 per MA attributed member months |
| Medicare Advantage (4.5 Stars) | Raw Score: 4.25 – 4.74 | Quality payment equivalent to $12.00 per MA attributed member months |

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| | | |
|---|---|---|
| Medicare Advantage (5 Stars) | Raw Score: ≥4.75 | Quality payment equivalent to $18.00 per MA attributed member months |

^The Overall Star Rating is determined as set forth below in Step 1.

Pay-to entities who earn a Overall Raw Score of less than 4.00 will not earn a Quality Payment under the Medicare Advantage Stars Quality Domain.

HMSA will calculate the dollars earned for the Stars Quality Domain as follows:

### STEP 1: Calculate Star Rating for Quality Domain for each Pay-to Entity

For each measure the Performance Rate = Numerator/Denominator. The numerator and denominator for each measure will include members under all Medicare Advantage contracts that HMSA has with CMS, subject to the requirements set forth in Appendix A.

Assign a Star Rating for each measure by comparing the Performance Rate to the Star cut points for each measure. Measure cut points are available in the HMSA Provider Resource Center. Preliminary measure cut points identified by HMSA will be used to determine a pay-to entity's preliminary performance score; and the CMS-issued measure cut points will be used to determine a pay-to entity's final performance score.

For each measure, pay-to entities can earn 1-5 Stars, in whole star increments. If the pay-to entity has zero members in the denominator the measure will not be scored and will not be assigned a Star.

To calculate the Overall raw score, multiply the Star Rating for each measure by the measure weight and calculate the weighted average across all measures. The raw score will be truncated at two decimal places.

To determine each pay-to entity's Overall Star Rating for the Stars Quality Domain Quality Program, compare the raw score to the thresholds below. For example, a raw score of 4.15 is 4 stars.

| RAW SCORE | STAR RATING |
|---|---|
| ≥ 4.75 | 5 stars |
| 4.25-4.74 | 4.5 stars |
| 4.00-4.24 | 4 stars |
| 3.25-3.99 | 3.5 stars |
| 2.75-3.24 | 3 stars |
| 2.25-2.74 | 2.5 stars |
| 1.75-2.24 | 2 stars |
| 1.25-1.74 | 1.5 stars |
| 0.75-1.24 | 1 star |
| 0.25-0.75 | 0.5 stars |
| < 0.25 | 0 stars |

### STEP 2: Dollars Earned For Stars Quality Domain

If an eligible pay-to entity reaches 4 stars, the pay-to entity will earn = MM x $8.00 PMPM.

If an eligible pay-to entity reaches 4.5 stars, the pay-to entity will earn = MM x $12.00 PMPM.

If an eligible pay-to entity reaches 5 stars, the pay-to entity will earn = MM x $ $18.00 PMPM.

## Medicare Advantage: Health Plan Star Rating Incentive

In the event CMS determines that HMSA has earned an overall rating of 4 stars or higher for one or more of its contracts in 2027, pay-to entities will be eligible for an incentive, gated by their performance for measurement year 2027 in the Stars Quality Domain Quality Program as shown below.

| PAY-TO ENTITY'S OVERALL STAR RATING | HEALTH PLAN'S STAR RATING PER MEDICARE ADVANTAGE CONTRACT | | | |
|---|---|---|---|---|
| | <4 Stars | 4 Stars | 4.5 Stars | 5 Stars |
| <4 Stars | $0 | $0 | $0 | $0 |
| 4 Stars | $0 | $5 PMPM | $5 PMPM | $5 PMPM |
| 4.5 Stars | $0 | $5 PMPM | $7.50 PMPM | $7.50 PMPM |
| 5 Stars | $0 | $5 PMPM | $7.50 PMPM | $10 PMPM |

As shown in the table above, the amount of the incentive will vary depending on the Star Rating of HMSA for each of the Medicare Advantage contracts that HMSA has with CMS, and the Overall Star Rating of the pay-to entity under the Stars Quality Domain.

In the event a pay-to entity is eligible for a Health Plan Star Rating Incentive, the amount of the incentive will be calculated using the member months of attributed members under the specific Medicare Advantage contract for which HMSA's Star Rating was earned. For example, if one of the HMSA contracts achieves a 4-star rating or higher, pay-to entities will receive a PMPM payment for the members under that contract if the pay-to entity also achieved a rating of 4 stars of higher in the Stars Quality Domain.

This incentive for the 2027 measurement year will be paid in Q4 2028 after CMS publishes Star Ratings.

# Review Requests

Pay-to entities participating in the 2027 Quality Program may use the Review Request form to:

- Submit a supplemental data request with supporting medical record evidence to close a care gap, as permitted by measure specifications.
- Submit an exclusion request with supporting medical record evidence to remove a member from a denominator, as permitted by measure specifications.
- Request a review of their numerator score or Quality Measure payment.
- Request an exception from an aspect of the program.

The Review Request Form may be found online in the Provider Resource Center at hmsa.com/prc/working-with-hmsa/2027-quality-program/. The Review Request process should not be used for disputes or disagreements arising from the rights, duties, or obligations of the parties under an applicable participating provider agreement.

Review Requests for scoring and payment may be submitted throughout the measurement year. HMSA must receive a request in writing no later than 30 days after the final performance report is sent to the designated payee(s). Submit the completed form and supporting documents by mail, fax, or email to:

**HMSA**
**6-QM**
**Attn: Quality Management**
**P.O. Box 860**
**Honolulu, HI 96808-0860**

**Fax: (808) 948-5680**
**Email: PSInquiries@hmsa.com**

Once HMSA receives a pay-to entity's request and all supporting documentation necessary to evaluate the provider's request, HMSA will review the request and issue a written decision within 90 business days. If the pay-to entity disagrees with HMSA's decision, the dispute resolution provisions under the applicable participating provider agreement shall apply.

# Additional Information

## Claims

PCPs must submit accurately coded claims to HMSA in a timely manner and in accordance with the applicable participating provider agreement. Claims must be supported by accurate documentation of the service or supply provided.

PCPs should continue to use HMSA's HHIN+ system for information about member eligibility and benefits.

## Audits and Refunds

HMSA reserves the right to audit Quality Program payments to ensure that providers meet all requirements, duties, and obligations for payment and that all payments are correct and appropriate.

If a Quality Payment is issued to a pay-to entity who does not meet a requirement, duty, or obligation for payment, or if a Quality Payment is issued in error, the payment will be considered an overpayment. For example, in the event a pay-to entity receives a preliminary payment based on a preliminary performance score of 4 or more Stars, then subsequently earns a final performance score of less than 4 Stars, the preliminary payment will be an overpayment.

HMSA reserves the right to recover overpayments and the terms of the applicable participating provider agreement shall apply.

## Amendment to Program Guide

This Program Guide may be amended by HMSA by providing at least sixty (60) calendar days' prior written notice to providers, except that HMSA may amend this Program Guide immediately as necessary to comply with applicable law. If an amendment is required by applicable law, then HMSA shall make good-faith efforts to provide prior written notice of such amendment. HMSA reserves the right to terminate this Program Guide at any time by providing providers at least sixty (60) calendar days' prior written notice.

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# Appendix A – PCP Quality Measure Details

## Commercial and QUEST Quality Measures

### Child and Adolescent Well-Care Visit

#### Description

The percentage of patients 3-21 years of age who had at least one comprehensive well-care visit with a PCP during the measurement year.

#### Numerator

One or more well-care visits or encounters for well-care during the measurement year.
The well-care visit must occur with a PCP, but the practitioner does not have to be the member's attributed practitioner.

**Note:** Telehealth visits no longer satisfy numerator credit for this measure.

#### Denominator

Patients 3-21 years of age as of the last day of the measurement year.

#### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

### Childhood Immunization Status (All individual immunizations)

#### Description

The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.

#### Numerator

**DTaP**

Children with any of the following on or before their second birthday meet criteria:

- At least four DTaP vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the diptheria, tetanus, or pertussis vaccine.
- Encephalitis due to the diptheria, tetanus, or pertussis vaccine.

**IPV**

Children with any of the following on or before their second birthday meet criteria:

- At least three IPV vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the IPV vaccine.

**MMR**

Children with any of the following meet criteria:

- At least one MMR vaccination on or between the child's first and second birthday.
- All of the following on or before the child's second birthday (on the same or different date of service).
    - History of measles illness.
    - History of mumps illness.
    - History of rubella illness.

**HIB**

Children with any of the following on or before their second birthday meet criteria:

- At least three HiB vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine.

**Hepatitis B**

Children with any of the following on or before their second birthday meet criteria:

- At least three Hepatitis B vaccinations with different dates of service.
- History of Hepatitis B illness.
- Anaphylaxis due to the Hepatitis B vaccine.

**VZV**

Children with any of the following meet criteria:

- At least one VZV vaccination on or between the child's first and second birthday.
- History of varicella zoster (chicken pox) illness on or before the child's second birthday.
- Anaphylaxis due to the VZV vaccine.

**Pneumococcal Conjugate**

Children with either of the following on or before their second birthday meet criteria:

- At least four pneumococcal conjugate vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal conjugate vaccine.

### Denominator

Children who turn 2 years of age during the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients who had a contraindication to a childhood vaccine on or before their second birthday.
- Patients who had an organ and bone marrow transplant on or before their second birthday.

## Controlling High Blood Pressure

### Description

The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

### Numerator

The most recent BP reading (<140/90 mm Hg) taken during the measurement year. Exclude BPs taken in an acute inpatient setting or during an ED visit.

The patient is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

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

### Denominator

Patients 18-85 years of age who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

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### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care during the measurement year.
- Patients who had an encounter for palliative care any time during the measurement year.
- Patients with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant any time during the patient's history on or before December 31 of the measurement year.
- Patients with a diagnosis of pregnancy any time during the measurement year.
- Patients 66 – 80 years of age as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following criteria:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year prior to the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.
- Patients 81 years of age and older as of the end of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

## Glycemic Status Assessment for Patients with Diabetes (<8.0%)

### Description

The percentage of patients 18-75 years of age with diabetes (types 1 or 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: HbA1c or GMI <8.0% for commercial and QUEST.

### Numerator

Identify the most recent glycemic status assessment (HbA1c or GMI) during the measurement year. The patient is numerator compliant if the most recent glycemic status assessment has a result of <8.0%.

If the result of the most recent glycemic status is greater or is missing a result, or if a glycemic status assessment was not done during the measurement year, the patient will not receive numerator credit.

If there are multiple glycemic status assessments on the same date of service, use the lowest result.

### Denominator

Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

There are two ways to identify patients (18-75 years old) with diabetes:

- Claim/Encounter Data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care during the measurement year.
- Patients who had an encounter for palliative care any time during the measurement year.
- Patients 66 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following criteria:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year prior to the measurement year:
        - Advanced illness on at least two different dates of service.

- A dispensed dementia medication.

## Screening for Depression and Follow-up Plan

### Description

The percentage of attributed patients 12 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.

### Numerator

Patients 12 years of age and older who were screened for depression during the measurement year using an age-appropriate screening tool, and if positive, a follow-up plan is documented.

### Denominator

Patients 12 years of age or older at the beginning of the measurement year who had an encounter with an eligible PCP type** during the measurement year.

***Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, PAs, and APRNs; and naturopathic physicians. Eligible PCP types will exclude PAs or APRNs with a psych subspecialty in the HMSA system.*

### Exclusions

Patients who meet any of the following criteria:

- Patients who have been diagnosed with bipolar disorder.

## Well-child Visits in the First 15 Months of Life

### Description

The percentage of patients who had the following number of well-child visits with a PCP:

**Well-Child Visits in the First 15 Months.** Children who turned 15 months old during the measurement year: Six or more well- child visits.

### Numerator

Six or more well-child visits on different dates of service on or before the 15-month birthday. Visits must be at least 14 days apart.

The well-child visit must occur with a PCP, but the practitioner does not have to be the patient's attributed practitioner.

**Note:** Telehealth visits no longer satisfy numerator credit for this measure.

### Denominator

Children who turned 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

## Well-child Visits in the First 30 Months of Life

### Description

The percentage of patients who had the following number of well-child visits with a PCP:

**Well-Child Visits for Age 15-30 Months.** Children who turned 30 months old during the measurement year: Two or more well-child visits.

^

### Numerator

Two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. Visits must be at least 14 days apart.

The well-child visit must occur with a PCP, but the practitioner does not have to be the patient's attributed practitioner.

**Note:** Telehealth visits no longer satisfy numerator credit for this measure.

### Denominator

Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

# Medicare Quality Measures

## Breast Cancer Screening

### Description

The percentage of patients 40-74 years of age who had a mammogram to screen for breast cancer.

### Numerator

One or more mammograms any time on or between October 1 two years before the measurement year and the last day of the measurement year.

### Denominator

Patients 42-74 years of age as of the last day of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement.
- Patients who had a bilateral mastectomy or both right and left unilateral mastectomies anytime during their history through the last day of the measurement year. Any of the following meet criteria:
    - Bilateral mastectomy.
    - Unilateral mastectomy with a bilateral modifier.
    - History of bilateral mastectomy.
    - Any combination that indicates a mastectomy of both the left and right side on the same date of service or different dates of service:
        - Left mastectomy:
            - Unilateral mastectomy with a left-side modifier (same procedure).
            - Unilateral mastectomy of the left breast found in clinical data.
            - Absence of the left breast.
            - Left unilateral mastectomy.
        - Right mastectomy:
            - Unilateral mastectomy with a right-side modifier (same procedure).
            - Unilateral mastectomy of the right breast found in clinical data.
            - Absence of the right breast.
            - Right unilateral mastectomy.

- Patients who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during their history through the last day of the measurement year.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following to be excluded:
    - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year before the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.

## Care for Older Adults — Functional Status Assessment

### Description

The percentage of attributed patients 66 years of age and older who had a functional status assessment during the measurement year.

### Numerator

At least one functional status assessment during the measurement year.

Do not include services provided in an acute inpatient setting.

### Denominator

Patients 66 years of age and older as of the last day of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

## Care for Older Adults — Medication Review

### Description

The percentage of attributed patients 66 years and older who had a medication review during the measurement year.

### Numerator

Either one of the following meets criteria:

- Both of the following during the same visit during the measurement year with the prescribing practitioner or pharmacist:
    - At least one medication review.
    - The presence of a medication list in the medical record.
- Transitional care management services during the measurement year.

Do not include services provided in an acute inpatient setting.

### Denominator

Patients 66 years of age and older as of the last day of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

^

# Colorectal Cancer Screening

## Description

The percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer.

## Numerator

Patients with one or more screenings for colorectal cancer. Any of the following meet criteria:

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

## Denominator

Patients 46-75 years of age as of the last day of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients who had colorectal cancer at any time during the patient's history through December 31 of the measurement year.
- Patients who had a total colectomy any time during the patient's history through December 31 of the measurement year.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following to be excluded:
    - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year before the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.

# Concurrent Use of Opioids and Benzodiazepines

## Description

The percentage of attributed patients, 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement year.

## Numerator

Patients with less than two prescription claims for any benzodiazepines with different dates of service (DOS) and less than 30 cumulative days of concurrent use of opioids and benzodiazepines.

## Denominator

Patients 18 years or older with at least two prescription claims for opioid medications with different DOS at least 15 cumulative days' supply of opioids during the measurement year and an Index Prescription Start Date (IPSD) that occurs at least 30 days prior to the end of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients diagnosed with cancer or cancer-related pain treatment during the measurement year.
- Patients diagnosed with sickle cell disease during the measurement year.

# Controlling High Blood Pressure

## Description

The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

## Numerator

The most recent BP reading (<140/90 mm Hg) taken during the measurement year. Exclude BPs taken in an acute inpatient setting or during an ED visit.

The patient is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

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

## Denominator

Patients 18-85 years of age who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant any time during the patient's history on or before December 31 of the measurement year.
- Patients with a diagnosis of pregnancy any time during the measurement year.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66 – 80 years of age as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following criteria:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year prior to the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.
- Patients 81 years of age and older as of the end of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

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# Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening

## Description

The percentage of attributed patients 12 years of age and older who were screened for clinical depression using a standardized instrument.

## Numerator

Patients with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement year.

## Denominator

Patients 12 years of age and older at the start of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients with a history of manic episodes or bipolar disorder any time during the patient's history through the last day of the year prior to the measurement year.
- Patients with depression that starts during the year prior to the measurement year.

# Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on Positive Screen

## Description

The percentage of attributed patients 12 years of age and older who received follow-up care within 30 days of a positive depression screen finding.

## Numerator

Patients who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A diagnosis of encounter for exercise counseling.
- A dispensed antidepressant medication.
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
    - For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

## Denominator

Patients 12 years of age and older with a positive finding for depression between Jan. 1 and Dec. 1 of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients with a history of manic episodes or bipolar disorder any time during the patient's history through the last day of the year prior to the measurement year.
- Patients with depression that starts during the year prior to the measurement year.

# Eye Exam for Patients With Diabetes

## Description

The percentage of patients 18-75 years of age with diabetes (type 1 or 2) who had a retinal eye exam from an ophthalmologist or optometrist.

## Numerator

Screening or monitoring diabetic retinal disease. This includes patients with diabetes who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional from the year prior to the measurement year.

## Denominator

Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. There are two ways to identify patients (18-75 years old) with diabetes:

- Claim/Encounter Data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Patients with bilateral absence of eyes any time during the patient's history through the last day of the measurement year.
- Patients with bilateral eye enucleation any time during the patient's history through the last day of the measurement year:
    - Unilateral eye enucleation with a bilateral modifier.
    - Two unilateral eye enucleations with service dates 14 days or more apart.
    - Left unilateral eye enucleation and right unilateral eye enucleation on the same or different dates of service.
    - A unilateral eye enucleation and a left unilateral eye enucleation with service dates 14 days or more apart.
    - A unilateral eye enucleation and a right unilateral eye enucleation with service dates 14 days or more apart.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following to be excluded:
    - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year before the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.

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# Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions

## Description

The percentage of emergency department (ED) visits for attributed patients 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.

## Numerator

Patients who had a follow-up visit that occured on the date of the ED visit through seven days after their emergency department visit (eight total days).

Any of the following meet criteria for a follow-up visit:

- An outpatient visit, telephone visit, e-visit or virtual check-in.
- Transitional care management services.
- Case management visits.
- Complex care management services.
- An outpatient or telehealth behavioral health visit.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit.
- Electroconvulsive therapy.
- A telehealth visit.
- Substance use disorder counseling and surveillance.

## Denominator

Patients 18 years of age and older who visited the emergency department who have multiple high-risk chronic conditions.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

# Glycemic Status Assessment for Patients With Diabetes (≤9.0%)

## Description

The percentage of patients 18-75 years of age with diabetes (types 1 or 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year HbA1c or GMI ≤9.0%.

## Numerator

Identify the most recent glycemic status assessment (HbA1c or GMI) during the measurement year. The patient is numerator compliant if the most recent glycemic status assessment has a result of ≤9.0%.

If the result of the most recent glycemic status is greater or is missing a result, or if a glycemic status assessment was not done during the measurement year, the patient will not receive numerator credit.

If there are multiple glycemic status assessments on the same date of service, use the lowest result.

## Denominator

Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

There are two ways to identify patients (18-75 years old) with diabetes:

- Claim/Encounter Data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during

the measurement year or the year prior to the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or had an encounter for palliative care any time during the measurement year.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following to be excluded:
  - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
  - Either of the following during the measurement year or the year before the measurement year:
    - Advanced illness on at least two different dates of service.
    - A dispensed dementia medication.

## Kidney Health Evaluation for Patients With Diabetes

### Description

The percentage of patients 18-85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

### Numerator

Patients who received **both** an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate lab test).
- At least one uACR (Urine Albumin Creatinine Ratio lab test) identified by either of the following:
  - Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.
  - A uACR

### Denominator

Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. There are two ways to identify patients (18-85 years old) with diabetes:

- Claim/Encounter Data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care or had an encounter for palliative care any time during the measurement year.
- Patients with evidence of ESRD anytime during the member's history on or before the end of the measurement year.
- Patients who had dialysis any time during the member's history on or prior to the last day of the measurement year.
- Medicare patients 66 years of age and older by the end of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year.
- Patients 66 – 80 years of age as of the end of the measurement year with both frailty and advanced illness. They

must meet BOTH of the following to be excluded:
    - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year before the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.
- Patients 81 years of age and older as of the end of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

# Medication Adherence for Cholesterol (Statins)

## Description

The percentage of patients 18 years of age or older who were adherent to statins.

## Numerator

The number of patients in the denominator with a proportion of days in the treatment period covered (PDC) of 80% or higher for the targeted drug class(es).

## Denominator

Patients with at least two fills with unique dates of service for medications in the targeted drug class(es) during the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients who have been diagnosed with ESRD at any time during the measurement year.

# Medication Adherence for Diabetes

## Description

The percentage of patients 18 years or older who were adherent across the following classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DPP-IV inhibitors, GLP-1 receptor agonists, meglitinides, and SGLT2 inhibitors.

## Numerator

The number of patients in the denominator with a proportion of days in the treatment covered (PDC) of 80% or higher for the targeted drug class(es).

## Denominator

Patients with at least two fills with unique dates of service for medications in the targeted drug class(es) during the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients who have been diagnosed with ESRD at any time during the measurement year.
- Patients with one or more prescription claims for insulin during the treatment period.

# Medication Adherence for Hypertension (RAS Antagonist)

## Description

The percentage of attributed patients, 18 years or older, who were adherent to RAS antagonists including ACE inhibitors, ARBs, or Direct Renin inhibitors.

## Numerator

The number of patients in the denominator with a proportion of days in the treatment period covered (PDC) of 80% or higher for the targeted drug class(es).

### Denominator

Patients with at least two fills with unique dates of service for medications in the targeted drug class(es) during the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients who have been diagnosed with ESRD at any time during the measurement year.
- Patients with one or more prescription claims for sacubitril/valsartan (Entresto) during the treatment period.

## Medication Therapy Management – Comprehensive Medication Review

### Description

The percentage of attributed patients 18 years of age or older who are enrolled into a Medication Therapy Management program and received a Comprehensive Medication Review during the measurement year.

### Numerator

The number of patients in the denominator who received a Comprehensive Medication Review during their period of Medication Therapy Management enrollment.

### Denominator

Patients 18 years of age or older, who were enrolled in a Medication Therapy Management program for at least 60 days during the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

## Osteoporosis Management in Women Who Had a Fracture

### Description

The percentage of attributed women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (six months) after the fracture.

### Numerator

The percentage of women who receive appropriate testing or treatment for osteoporosis in the specified time frames.

### Denominator

Women age 67-85 who have suffered a fracture between July 1 of the previous measurement year and June 30 of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients receiving palliative care during the measurement year.
- Patients who had an encounter for palliative care any time during the measurement year.
- Medicare patients 67 years of age and older by the end of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 67-80 years of age and older as of the end of the measurement year with frailty and advanced illness. They must meet BOTH of the following to be excluded:

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    - Frailty: At least two indications of a frailty diagnosis with different dates of service during the measurement year.
    - Either of the following during the measurement year or the year before the measurement year:
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.
- Patients 81 years of age and older as of the end of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

# Plan All-Cause Readmission

## Description

For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).

## Numerator

Patients with at least one acute readmission (inpatient and observation stays) for any diagnosis within 30 days of the index discharge date.

## Denominator

Patients 18 years of age and older who had an acute inpatient or observation stay discharge between January 1 and December 1 of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

# Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

## Description

The percentage of attributed patients 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement year.

## Numerator

Patients on 2 or more unique ACH medications with less than 30 cumulative days during the measurement year.

## Denominator

Patients 65 years or older, with at least two prescription claims with different DOS of the same medication in the targeted drug class(es) (ACH) during the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year

# Statin Use for Patients With Diabetes

## Description

The percentage of attributed patients 40-75 years old who were dispensed at least two fills of diabetes medication and received a statin medication fill during the measurement year.

## Numerator

The percentage of patients who received at least one prescription claim for a statin medication with a DOS during the measurement year.

### Denominator

The patients 40-75 years, with at least two prescription claims on different DOS for any diabetes medication during the measurement year and an IPSD that occurs at least 90 days prior to the end of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients diagnosed with ESRD any time during the measurement year.
- Patients diagnosed with rhabdomyolysis or myopathy at any time during the measurement year.
- Patients with pregnancy or lactation at any time during the measurement year or at least one prescription claim for a medication indicated for fertility during the measurement year.
- Patients diagnosed with cirrhosis at any time during the measurement year.
- Patients diagnosed with pre-diabetes at any time during the measurement year.
- Patients diagnosed with Polycystic Ovary Syndrome (PCOS) at any time during the measurement year.

## Transitions of Care: Notification of Inpatient Admission

### Description

The percentage of discharges for attributed patients 18 years of age and older who had the following: Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).

### Numerator

Percentage of discharges of patients that received notifications of inpatient admission through two days after the admission (three total days).

### Denominator

Patients 18 years of age and older who had an acute or a nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

## Transitions of Care: Receipts of Discharge Information

### Description

The percentage of discharges for attributed patients 18 years of age and older who had the following: Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days).

### Numerator

Percentage of patients for whom discharge information was received on the day of discharge through two days after discharge (three total days).

### Denominator

Patients 18 years of age and older who had an acute or a nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

### Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

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# Transitions of Care: Patient Engagement After Inpatient Discharge

## Description

The percentage of discharges for attributed patients 18 years of age and older who had the following: Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

## Numerator

Percentage of patients who had a patient engagement after inpatient discharge within 30 days after discharge.

## Denominator

Patients 18 years of age and older who had an acute or a nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

# Transitions of Care: Medication Reconciliation Post-Discharge

## Description

The percentage of discharges for attributed patients 18 years of age and older who had the following: Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

## Numerator

Percentage of patients who had medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

## Denominator

Patients 18 years of age and older who had an acute or a nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

## Exclusions

Patients who meet any of the following criteria:

- Patients who died any time on or before the last day of the measurement year.
- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.

# Appendix B – Claims-Based Attribution CPT Codes

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|---|---|
| 90460 - IM ADMIN 1ST/ONLY COMPONENT | 99385 - 0132 PREV VISIT NEW AGE 18-39 |
| 90461 - IM ADMIN EACH ADDL COMPONENT | 99386 - 0132 PREV VISIT NEW AGE 40-64 |
| 90471 - IMMUNIZATION ADMIN | 99387 - 0132 INIT PM E/M NEW PAT 65+ YRS |
| 90472 - IMMUNIZATION ADMIN EACH ADD | 99391 - 0135 PER PM REEVAL EST PAT INFANT |
| 90473 - IMMUNE ADMIN ORAL/NASAL | 99392 - 0143 PREV VISIT EST AGE 1-4 |
| 90474 - IMMUNE ADMIN ORAL/NASAL ADDL | 99393 - 0143 PREV VISIT EST AGE 5-11 |
| 90480 - ADMN SARSCOV2 VAC 1/ONLY CMP | 99394 - 0143 PREV VISIT EST AGE 12-17 |
| 96380 - ADMN RSV MONOC ANTB IM CNSL | 99395 - 0132 PREV VISIT EST AGE 18-39 |
| 96381 - ADMN RSV MONOC ANTB IM NJX | 99396 - 0132 PREV VISIT EST AGE 40-64 |
| 97550 - 0195 CAREGIVER TRAING 1ST 30 MIN | 99397 - 0132 PER PM REEVAL EST PAT 65+ YR |
| 98975 - 0412 RTM 1ST SET-UP&PT EDUCAJ EQP | 99401 - 0219 PREV MED CNSL INDIV APPRX 15 |
| 98976 - 0412 RTM DEV SPLY RESP SYS 16-30D | 99402 - 0219 PREV MED CNSL INDIV APPRX 30 |
| 98977 - 0412 RTM DEV SPLY MSCSKL 16-30 D | 99403- 0219 PREV MED CNSL INDIV APPRX 45 |
| 98980 - 0412 RTM TX MGMT 1ST 20 MIN | 99404- 0219 PREV MED CNSL INDIV APPRX 60 |
| 98981 - 0412 RTM TX MGMT EA ADDL 20 MIN | 99408 - 0136 AUDIT/DAST 15-30 MIN |
| 99188 - 0921 APP TOPICAL FLUORIDE VARNISH | 99409 - 0136 AUDIT/DAST OVER 30 MIN |
| 99202 - 0101 OFFICE O/P NEW SF 15 MIN | 99411 - 0219 PREVENTIVE COUNSELING GROUP |
| 99203 - 0101 OFFICE O/P NEW LOW 30 MIN | 99424 - 0407 PRIN CARE MGMT PHYS 1ST 30 |
| 99204 - 0101 OFFICE O/P NEW MOD 45 MIN | 99425 - 0407 PRIN CARE MGMT PHYS EA ADDL |
| 99205 - 0101 OFFICE O/P NEW HI 60 MIN | 99426- 0407 PRIN CARE MGMT STAFF 1ST 30 |
| 99211 - 0101 OFF/OP EST MAY X REQ PHY/QHP | 99427 - 0407 PRIN CARE MGMT STAFF EA ADDL |
| 99212 - 0101 OFFICE O/P EST SF 10 MIN | 99455- 3003 WORK RELATED DISABILITY EXAM |
| 99213 - 0101 OFFICE O/P EST LOW 20 MIN | 99459 - 0407 PELVIC EXAMINATION |
| 99214 - 0101 OFFICE O/P EST MOD 30 MIN | 99460- 0120 INIT NB EM PER DAY HOSP |
| 99215 - 0101 OFFICE O/P EST HI 40 MIN | 99461 - 0120 INIT NB EM PER DAY NON-FAC |
| 99238 - 0102 HOSP IP/OBS DSCHRG MGMT 30/ LT | 99462 - 0120 SBSQ NB EM PER DAY HOSP |
| 99239 - 0102 HOSP IP/OBS DSCHRG MGMT GT 30 | 99463 - 0120 SAME DAY NB DISCHARGE |
| 99304 - 0102 1ST NF CARE SF/LOW MDM 25 | 99464 - 0120 ATTENDANCE AT DELIVERY |
| 99305 - 0102 1ST NF CARE MODERATE MDM 35 | 99465 - 0120 NB RESUSCITATION |
| 99306 - 0102 1ST NF CARE HIGH MDM 50 | 99491 - 0407 CHRNC CARE MGMT PHYS 1ST 30 |
| 99307 - 0102 SBSQ NF CARE SF MDM 10 | 99497- 0407 ADVNCD CARE PLAN 30 MIN |
| 99308 - 0102 SBSQ NF CARE LOW MDM 20 | 99499 - 0101 UNLISTED E&M SERVICE |
| 99309 - 0102 SBSQ NF CARE MODERATE MDM 30 | G0008- ADMIN INFLUENZA VIRUS VAC |
| 99310 - 0102 SBSQ NF CARE HIGH MDM 45 | G0009- ADMIN PNEUMOCOCCAL VACCINE |
| 99315 - 0102 NF DSCHRG MGMT 30 MIN/LESS | G0010 - ADMIN HEPATITIS B VACCINE |
| 99316 - 0102 NF DSCHRG MGMT 30 MIN+ | G0101 - 2030 CA SCREEN;PELVIC/BREAST EXAM |
| 99341 - 0109 HOME/RES VST NEW SF MDM 15 | G0102- 0156 PROSTATE CA SCREENING; DRE |
| 99342 - 0109 HOME/RES VST NEW LOW MDM 30 | G0320 - 0372 TWO-WAY AUDIO AND VIDEO HHS |
| 99344 - 0109 HOME/RES VST NEW MOD MDM 60 | G0402 - 0132 INITIAL PREVENTIVE EXAM |
| 99345 - 0109 HOME/RES VST NEW HIGH MDM 75 | G0438- 0219 PPPS, INITIAL VISIT |
| 99347 - 0109 HOME/RES VST EST SF MDM 20 | G0439 - 0219 PPPS, SUBSEQ VISIT |
| 99348 - 0109 HOME/RES VST EST LOW MDM 30 | G2014- 0109 POST-D/C CARE PLAN OVERS 30M |
| 99349 - 0109 HOME/RES VST EST MOD MDM 40 | G2211 - 0101 COMPLEX E/M VISIT ADD ON |
| 99350 - 0109 HOME/RES VST EST HIGH MDM 60 | G3002- 0407 CHRONIC PAIN MGMT 30 MINS |
| 99381 - 0135 INIT PM E/M NEW PAT INFANT | S0610 - 2029 ANNUAL GYNECOLOGICAL EXAMINA |
| 99382 - 0143 INIT PM E/M NEW PAT 1-4 YRS | S0612- 2029 ANNUAL GYNECOLOGICAL EXAMINA |
| 99383 - 0143 PREV VISIT NEW AGE 5-11 | S0613- 2030 ANN BREAST EXAM |
| 99384 - 0143 PREV VISIT NEW AGE 12-17 | |