STARS

Best Practice Guide

Alignment Healthcare

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FILE SUBMISSION

AS OFTEN AS POSSIBLE

Alignment can utilize and receive supplemental data to help drive HEDIS gap closure and improve overall rates. In some cases, Alignment can also accept medical record documentation in an effort to assist the IPA in generating supplemental data.

TIMEFRAME

Supplemental Data Files

- Accepted through February 14th for the previous Performance Year for all gaps
- Files are processed on a weekly basis unless otherwise noted (i.e., during a system update)
- Please request a copy of the preferred supplemental file format from your Medicare Star Provider Relations Specialist

Medical Records

- Medical Records received between January - April of the current Performance Year will be processed following HEDIS season in June. Other records will be received and updated monthly
- For hybrid reporting measures, medical records will be accepted until December of the Performance Year unless patient is included in the health plan's sample. Medical records for patients included in a hybrid sample will typically be accepted through April for the previous Performance Year, dependent on published NCQA timeframes
- For administrative reporting measures, medical records will typically be accepted through February 14th for the previous reporting year

NAMING CONVENTION

HEDIS file

- IPA_STARs_Suppl_YYYYMMDD (.xlsx format)

Medical Record file

- PatientID#_LastName_FirstName_DOB (DDMMYY)

SUBMISSION PROCCESS

1. Use Alignment's required file layout
2. Use correct file naming convention
3. Upload the file on sFTP site
4. Notify via e-mail for confirmation and feedback
5. In cases where a supplemental file or medical record is incomplete or missing a field, an error notification will be sent via email. Please fix the field and re-submit onto the sFTP site

ANNUAL WELLNESS VISIT (AWV)

ANNUALLY

Yearly appointment to discuss and reassess preventative care plan with patient. The AWV is also used to recapture all chronic conditions and address all open gaps in care.

Demographic: All Members

BEST PRACTICES

- Review open gaps in care to see what preventative screenings the patient is due for in current year and discuss importance of completion with patient
- Send patient lab requisition for standing orders and FOBT kit (if applicable) prior to appointment to encourage completion before appointment date; results can be reviewed during visit

HOW TO CODE

Report the Annual Wellness Visit for all Medicare Patients:

HCPCS:

G0438 - Initial Visit
G0439 - Subsequent Visit

CPT:

99381-99387 - New Patient
99391-99397 - Established Patient

ICD-10:

Z00.00 - No Abnormal Findings
Z00.01 - With Abnormal Findings

DOCUMENTATION

- Height, weight, blood pressure, vitals, and other applicable measurements
- Review past medical and family history
- Assess risk factors for preventable diseases and treatment options
- Review Health Risk Assessment
- Demographic data
- Self-assessment of health status
- Psychosocial and behavioral health risks
- Activities of daily living
- Pain assessment
- Review medications
- Update list of providers and prescriptions
- Look for signs of cognitive impairment

SPECIAL NEEDS PLAN (SNP) CARE MANAGEMENT

ANNUALLY

Conduct a patient's health risk assessment (HRA). The results of this review are used to help the patient get the care they need.

BEST PRACTICES

- Perform HRAs during the patient's annual visit to the PCP
- Follow up with patients who were not able to complete a HRA during their visit and complete telephonically
- Ensure that patient's contact information is up-to-date
- Review the HRA to evaluate what care is needed for the patient

BREAST CANCER SCREENING (BCS)

EVERY 2 YEARS

Refer the patient to complete a mammogram at any in-network radiology facility every 2 years. Document in the medical record if the patient has already completed a mammogram, including the date and result (month and year).

Demographic: Females; 50 - 74 years old

BEST PRACTICES

- Patients who received a mammogram in another country during the acceptable timeframe can be documented (must include the screening name, the screening date, and the result) and the supplemental file
- Patient's refusal will not make them ineligible for this measure
- Send/mail referral for mammogram prior to appointment to encourage completion before appointment date; results can be reviewed during visit
- Provide referrals/authorizations for mammogram during Annual Wellness Visit (if applicable, i.e., not completed prior)

- Follow-up with patient via mailing/phone call to ensure they complete their mammogram
- Promote importance of completing screening during Breast Cancer Awareness Month (October)
- Address individual patient concerns and barriers (i.e., fear of positive results, cultural customs)

HOW TO CODE

HCPCS:

G0202 - Screening mammography

CPT:

77065-77067 - Mammography

EXCLUSION CODES

ICD-10:

Z90.13 - History of Bilateral Mastectomy
Z90.11 - History of Right Mastectomy
Z90.12 - History of Left Mastectomy

DOCUMENTATION

- Document if patient has history of bilateral mastectomy
- Document patient self-reported history of mammogram - include the month and year that the mammogram was completed
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

COLORECTAL CANCER SCREENING (COL)

FREQUENCY VARIES

Patients due for a colorectal cancer screening should complete one of the following tests:

- FOBT (yearly)
- CT Colonography (every 5 years)
- Fit-DNA (every 3 years)
- Flexible Sigmoidoscopy (every 5 years)
- Colonoscopy (every 10 years)

Document in the medical record if the patient has already completed one of these tests, including the date and result.

Demographic: 50 - 75 years old

BEST PRACTICES

- Patients who received a colonoscopy in another country during the acceptable timeframe can be documented (must include the screening type, the screening date, and the results) and send the supplemental file

- Patient's refusal will not make them ineligible for this measure. Recommend a FIT-DNA or FOBT if the member refuses a colonoscopy Send/mail FOBT kit (if applicable) to patient prior to appointment to encourage completion before appointment date; results can be reviewed during visit
- Stock FOBT kits in offices to provide to the patient at the point of visit
- Encourage colonoscopy when appropriate and provide referral/ authorization during Annual Wellness Visit
- Document patient self-reported history data (must include month and year completed) and send supplemental file
- Address individual patient concerns and barriers (i.e., fear of positive results, cultural customs)
- Call patient to remind them of the importance of completing colon cancer screening

HOW TO CODE

Report Colorectal Cancer Screenings:

CPT:

45378 – Colonoscopy, flexible; diagnostic

HCPCS:

G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

G0105 – Colorectal cancer screening; colonoscopy on individual at high risk

G0104 – Colorectal cancer screening; flexible sigmoidoscopy

G0328 – Colorectal cancer screening; fecal occult blood test (FOBT)

DOCUMENTATION

- Document patient self-reported history of colorectal cancer screening- include the month and year that the FOBT or colonoscopy was completed
- Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information

CONTROLLING BLOOD PRESSURE (CBP)

EVERY VISIT

Ensure patients with hypertension have Blood Pressure that is adequately controlled (<140/90 mm HG).

Demographic: 50 - 75 years old

BEST PRACTICES

- Patients can self-report blood pressure during telehealth and e-visit
- Blood Pressures can be captured during a telehealth visit, e-visit, and virtual check ins
- Document the patient's self-reported blood pressure. Any digital device may be used by the patient, but non-digital devices are not acceptable
- Telephonic disease management can be conducted for hypertensive patients

- Ensure patient is properly positioned (i.e., sitting, feet flat on the ground, elbow at about heart level)
- Encourage office staff to take patient's blood pressure at the beginning and end of the appointment. The lowest in-range reading will be accepted to fulfill the measure
- Speak to patients about the health risk of hypertension (if applicable) and develop treatment plan
- Ensure CPT-II codes for BP readings are coded and submitted for every visit
- Submit supplemental files on a routine basis; ideally a monthly reconciliation
- Set follow-up appointments for patients with reading above 140/90 to ensure blood pressure is in healthy range before end of the year

HOW TO CODE

CPT-II:

3074F – Most recent systolic blood pressure less than 130 mm Hg

3075F – Most recent systolic blood pressure 130-139 mm Hg

3077F – Most recent systolic blood pressure greater than or equal to 140 mm Hg

3078F – Most recent diastolic blood pressure less than 80 mm Hg

3079F – Most recent diastolic blood pressure 80-89 mm Hg

3080F – Most recent diastolic blood pressure greater than or equal to 90 mm Hg

DOCUMENTATION

- Include all Blood Pressure readings taking during the visit in progress notes
- Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information

CARE FOR OLDER ADULTS- MEDICATION REVIEW (COA-M)

ANNUALLY

Annual review of medications by prescribing practitioner or clinical pharmacist. Documentation in the medical record should include the patient's complete medication list, and a notation that a review was completed.

Demographic: Special Needs Plan (SNP) enrollees who are 66 years or older

BEST PRACTICES

- Review and document patient's current medication list
- Ensure both CPT codes are reported for compliance

HOW TO CODE

Report that a medication review was completed:

CPT-II:

1159F – Medication list documented in medical record

1160F – Review of all medications by a prescribing physician or clinical pharmacist documented in the medical record

DOCUMENTATION

- Complete medication list documented in medical records
- Include verbiage “Current Medications”
- Notate that a review was completed
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

CARE FOR OLDER ADULTS- PAIN ASSESSMENT (COA-P)

ANNUALLY

Conduct annual pain assessment. Documentation in the medical record should include evidence of a comprehensive pain assessment or pain management plan, and the date it was performed. Pain assessment tools include, but are not limited to:

- Numeric rating scales (verbal or written)
- Face, Legs, Activity, Cry Consolability (FLACC) scale
- Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
- Pain Thermometer
- Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)
- Visual analogue scale
- Brief Pain Inventory
- Chronic Pain Grade
- PROMIS Pain Intensity Scale
- Pain Assessment in Advanced Dementia (PAINAD) Scale

Demographic: Special Needs Plan (SNP) enrollees who are 66 years or older

BEST PRACTICES

- Conduct and document pain assessment (i.e., face scale, numeric scale) and physical exam
- Report appropriate code for pain assessment
- Select appropriate code dependent on presence of pain

HOW TO CODE

Report that pain was assessed:

CPT-II:

1125F – Pain severity quantified; pain present

1126F – Pain severity quantified; no pain present

DOCUMENTATION

- Ensure complete documentation that supports patient pain level was properly assessed
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

CARE FOR OLDER ADULTS- FUNCTIONAL STATUS (COA-F)

ANNUALLY

Conduct annual functional status assessment. Documentation in the medical record should include evidence of a complete functional status assessment and the date it was performed. Standardized functional status assessment tools include, but are not limited to:

- SF-36®
- Assessment of Living Skills and Resources (ALSAR)
- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
- Bayer ADL (B-ADL) Scale
- Barthel Index
- Edmonton Frail Scale
- Extended ADL (EADL) Scale
- Groningen Frailty Index
- Independent Living Scale (ILS)
- Katz Index of Independence in ADL
- Kenny Self-Care Evaluation
- Klein-Bell ADL Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales
- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

In addition to the standardized tools listed above, notation that at least 3 of the following 4 components being assessed will also fulfill the measure:

- Cognitive status
- Ambulation status
- Hearing, vision and speech (i.e., sensory ability)
- Other functional independence (e.g., exercise, ability to perform job)

Demographic: Special Needs Plan (SNP) enrollees who are 66 years or older

BEST PRACTICES

- Document that ADL's/IADL's were assessed
- Consider implementing standardized functional status assessments (i.e., Barthel index)
- Report appropriate code for assessment

HOW TO CODE

Report that functional status was assessed:

CPT-II:

1170F – Functional status assessed

DOCUMENTATION

- Ensure complete documentation that supports functional status was properly assessed
- Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information

OSTEOPORSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

WITHIN 6 MONTHS OF FRACTURE

Refer elderly female patients with a recent fracture for a bone mineral density test (BMD) or, if appropriate, prescribe a bisphosphonate, such as Alendronate 70 mg weekly, to treat or prevent osteoporosis.

Demographic: Female enrollees between the ages of 67 - 85 years old who suffered a fracture

BEST PRACTICES

- Leverage medication mail order to deliver osteoporosis treatment to the patient
- When clinically appropriate, refer/encourage members suspected or at risk for Osteoporosis to complete DEXA scan every two years during AWV (regardless of having a fracture). When clinically appropriate, refer/encourage patients suspected of or at risk for Osteoporosis to complete DEXA scan every two years during AWV (regardless of having a fracture)
- Outreach to patient to assist scheduling for DEXA
- Encourage PCP follow-up and prescription of Osteoporosis medication or DEXA within 6 months of fracture, when clinically appropriate
- Submit supplemental files on a routine basis
- Consider investing in portable machines for use in the office or home setting

HOW TO CODE

Report that functional status was assessed:

CPT:

77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton

77081 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton

DOCUMENTATION

- Ensure complete documentation of medication list or BMD test report.
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

DIABETES CARE-RETINAL EYE EXAM (CDC-E)

ANNUALLY OR EVERY OTHER YEAR, DEPENDING ON DIAGNOSIS

Refer/encourage patients to complete diabetic retinal eye exam with an optometrist or ophthalmologist:

- Annually if positive for diabetic retinopathy
- Every other year if the patient had a negative retinal or dilated eye exam in the year prior

Demographic: 18 - 75 years old diagnosed with diabetes (Type 1 or Type 2)

BEST PRACTICES

- Refer diabetic patients to Optometrist/Ophthalmologist to complete an eye exam during Annual Wellness Visit
- Document patient self-reported history data (must include month and year completed, provider specialty, and result pos/neg) and send supplemental file
- Report appropriate CPT code if patient had an exam in the prior year with a negative result

- Outreach to patients that are overdue for eye exams
- Consider investing in portable machines for use in the office or home setting

HOW TO CODE

CPT-II:

Report if a retinal eye exam was performed during the visit:

2022F - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy

2023F - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy

Report if a retinal eye exam was performed in the prior year and was negative:

3072F - Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)

DOCUMENTATION

- Any one of the following will meet criteria:
    1. A note or letter prepared by an ophthalmologist, optometrist, PCP, or other health care professional indicating the exam was completed, the date, and the results
    2. Patient self-reported history of retinal eye exam, including the date the exam was completed and results
    3. A chart or photograph indicating fundus photography was performed, and evidence that results were reviewed by an optometrist or ophthalmologist
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

KIDNEY HEALTH EVALUATION FOR PATIENT WITH DIABETES (KED)

EACH VISIT APPLICABLE

Refer patient to lab for both an estimated glomerular filtration rate (eGFR) test and urine albumin-creatinine ratio (uACR) test during the measurement year.

Demographic: 18 - 75 years old diagnosed with diabetes (Type 1 or Type 2)

BEST PRACTICES

- Telephonic disease management can be provided to out-of-control diabetics
- Ensure AWV includes appropriate lab work
- Call or send letters to patients that are overdue for lab tests
- Follow-up with patient to discuss results

- Provide lab requisition to patient to complete labs prior to Annual Wellness Visit or routine appointment. Physician can discuss results with patient on appointment date

HOW TO CODE

Report the results of the microalbuminuria test:

CPT-II

Estimated Glomerular Filtration Rate Lab Test:

80047 - Basic Metabolic Panel (Calcium, Ionized)

80048 - Basic Metabolic Panel (Calcium, total)

80050 - General Health Panel (AMA)

80053 - Comprehensive Metabolic Panel, or chemical screen

80069 - Renal Function Panel

82565 - Creatinine

Urine Creatinine Lab Test:

82570 - Microalbumin with creatinine ratio, random urine

82043 - Quantitative Urine Albumin Lab Test

DOCUMENTATION

- Ensure complete documentation that clearly states results of both a glomerular filtration rate (eGFR) test and a urine albumin-creatinine ratio (uACR) test being completed
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

DIABETES CARE-HEMOGLOBIN A1C MONITORING (CDC-H)

EACH VISIT AS APPLICABLE

Perform routine blood testing to monitor HbA1c. Results should be < 9% in last test of the year.

Demographic: 18 - 75 years old diagnosed with diabetes (Type 1 or Type 2)

BEST PRACTICES

- Telephonic disease management can be provided to out-of-control diabetics
- Ensure AWV includes appropriate lab work
- Provide lab requisition to patient to complete labs prior to Annual Wellness Visit or routine appointment. Physician can discuss results with patient on appointment date
- For patients with results >9, a retest is needed before end of the calendar year

- Follow-up with patient to discuss results
- Enroll patient in any available chronic disease management programs if uncontrolled

HOW TO CODE

Report the results of the hemoglobin A1c test:

CPT-II:

3044F – Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)

3045F – Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM) (Remove)

3046F – Most recent hemoglobin A1c (HbA1c) level greater than 9.0% (DM)

3051F - Most recent hemoglobin A1c (HbA1c) greater than or equal to 7.0% and less than 8.0 %

3052F - Most recent hemoglobin A1c (HbA1c) less than or equal to 8.0% and less than or equal to 9.0%

83037 - HbA1c Lab Test

DOCUMENTATION

- Ensure documentation clearly states results of hemoglobin A1c test and day test was performed
- Document plan for continual patient care if results are out-of-range
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

EACH VISIT APPLICABLE

Patients with a diagnosis of atherosclerotic cardiovascular disease should be dispensed at least one high-intensity or moderate-intensity statin medication. Patients should remain on a high or medium-intensity statin medication for at least 80% of the treatment period.

Demographic: Males 21–75 years of age and Females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD)

BEST PRACTICES

- A 90- or 100-day supply of most generic cholesterol, high blood pressure, and diabetes medications, that are on Tier 6 of our formulary, are available at a $0 copay

- Improve medication adherence by converting 30-day supply prescriptions to 90- or 100-day supply prescriptions, and authorizing refill requests as soon as possible at the member's pharmacy of choice
- Talk to the patient about their Rx refill barriers
- Enroll patient in Disease Management Program when applicable

HIGH AND MODERATE INTENSITY STATIN MEDICATIONS

High-intensity statin therapy

- Atorvastatin 40-80 mg
- Amlodipine-atorvastatin 40-80 mg
- Ezetimibe-atorvastatin 40-80 mg
- Rosuvastatin 20-40 mg
- Simvastatin 80 mg
- Ezetimibe-simvastatin 80 mg

Moderate-intensity statin therapy

- Atorvastatin 10-20 mg
- Amlodipine-atorvastatin 10-20 mg
- Ezetimibe-atorvastatin 10-20 mg
- Rosuvastatin 5-10 mg
- Simvastatin 20-40 mg
- Ezetimibe-simvastatin 20-40 mg
- Niacin-simvastatin 20-40 mg
- Sitagliptin-simvastatin 20-40 mg
- Pravastatin 40-80 mg
- Lovastatin 40 mg
- Niacin-lovastatin 40 mg
- Fluvastatin XL 80 mg
- Fluvastatin 40 mg bid
- Pitavastatin 2–4 mg

DOCUMENTATION

- Document medication and dosage in patient medication list
- Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information

STATIN THERAPY FOR PATIENTS WITH DIABETES (SUPD)

EACH VISIT APPLICABLE

Patients with diabetes who do not have clinical atherosclerotic cardiovascular disease should be dispensed at least one statin medication of any intensity during the measurement year. Patients should remain on a high or medium-intensity statin medication for at least 80% of the treatment period.

Demographic: 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill

BEST PRACTICES

- Patients should be given a 90 day Rx and informed about low or no-cost options as well as mail-order Rx services; including discussion of generics available
- Talk to the patient about their Rx refill barriers
- Enroll patient in Disease Management Program when applicable

DOCUMENTATION

- Document medication and dosage in patient medication list
- Document frailty and advanced illness where applicable, see “Frailty” and “Advanced Illness” sections for additional information

ADVANCED ILLNESS

EACH VISIT AS APPLICABLE

Some measures allow for exclusions based on Advanced Illness.

BEST PRACTICES

Ensure that all of the patient's diagnosis are coded during each visit.

Common Advanced Illness Diagnoses

- Malignant neoplasm of the pancreas
- Malignant neoplasm of the brain
- Malignant neoplasm of the lymph nodes
- Malignant neoplasm of respiratory organs
- Malignant neoplasm of digestive organs
- Malignant neoplasm of renal organs
- Malignant neoplasm of skin
- Malignant neoplasm of the nervous system
- Leukemia
- Dementia
- Huntington's disease
- Lou Gehrig's disease
- Parkinson's disease
- Alzheimer's disease
- Congestive heart failure
- Chronic respiratory failure
- Cirrhosis of liver
- Chronic kidney disease
- End stage renal disease
- Pressure ulcers

*For a complete list, please email **Stars@ahcusa.com**

DOCUMENTATION

Some measures allow for exclusion based on advanced illness.

To be excluded with an advanced illness diagnosis, the patient must be 66 years of age or older during the performance year, meet frailty criteria (reference 'Frailty' section), and during the performance year or the year prior have an Advanced Illness diagnosis reported at least twice for outpatient, ED, observation, or nonacute inpatient encounters, once for acute inpatient encounters, or a dispensed dementia medication.

Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information.

FRAILTY

EACH VISIT APPLICABLE

Some measures allow for exclusions based on Frailty.

BEST PRACTICES

Ensure that all of the patient's diagnosis are coded during each visit.

MOST COMMON FRAILTY DIAGNOSES

- Difficulty in walking, not elsewhere classified – R26.2 (ICD-10-CM)
- Muscle weakness (generalized) – M62.81 (ICD-10-CM)
- Weakness – R53.1 (ICD-10-CM)
- Other malaise – R53.81 (ICD-10-CM)
- Other fatigue – R53.83 (ICD-10-CM)
- Age-related physical debility – R54 (ICD-10-CM)
- Underweight – R63.6 (ICD-10-CM)
- Bed confinement status – Z74.01 (ICD-10-CM)
- Other reduced mobility – Z74.09 (ICD-10-CM)
- History of falling – Z91.81 (ICD-10-CM)
- Dependence on wheelchair – Z99.3 (ICD-10-CM)
- Dependence on supplemental oxygen – Z99.81 (ICD-10-CM)
- Other abnormalities of gait and mobility – R26.89 (ICD-10-CM)

*For a complete coding list, please email **Stars@ahcusa.com**

DOCUMENTATION

- Some measures allow for exclusion based on frailty
- To be excluded with a frailty diagnosis reported during the performance year, the patient must be 81 years of age or older during the performance year (applicable for ART and OMW only), or 66 years of age or older and meet Advanced Illness criteria (see 'Advanced Illness' section)

TRANSITIONS OF CARE (TRC)

Ensure patients that were discharged from an inpatient admission have proper documentation of the following (these can be documented in any outpatient medical record):

1. Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)
    - Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes the date when the documentation was received
2. Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days)
    - Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structed fields in an EHR and include ALL of the following:
        - The practitioner responsible for the patient's care during the inpatient stay
        - Procedures or treatment provided
        - Current medication list
        - Testing results, or documentation of pending test or no tests pending
        - Instructions to the PCP or ongoing care provider for patient care

3. Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
    - Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge:
        - Outpatient visit, including office visits and home visit
        - Telephone visits
        - A synchronous telehealth visit where real-time interaction occurred between the patient and provider using audio and video communication
4. Medication Reconciliation Post Discharge. Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 total days).
    - Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed

Demographic: 18 years and older who have been discharged from an inpatient facility between January 1st - December 1st of the measurement year

BEST PRACTICES

- Notification of Admission
    - Ensure that when the patient is admitted, the date of when the PCP office is notified of the admission is included in the medical record (needs to be within 2 days of admission)
- Receipt of Discharge Information
    - Include the discharge summary notes or the summary care notes in the patient's chart
    - Ensure that the health plan is notified when the patient is discharged from the hospital
- Patient Engagement After Inpatient Discharge
    - If patients are uncomfortable for in person visits, schedule an e-visit or a virtual check in

- Schedule patient for follow-up post-discharge as soon as you are notified of discharge and no later than 7 days post-discharge
- After discharge contact the patient and schedule a follow up appointment with them or their caregiver
- When conducting a post-discharge follow up, capture the engagement with the patient as well as the medication reconciliation in one visit

- Medication Reconciliation Post Discharge
  - Medication Reconciliation can be completed telephonically with patient post discharge
  - Use patient-reported medications to complete reconciliation if unable to acquire the discharge summary
  - Complete the medication reconciliation within 31 days post-discharge using the discharge summary and patient's most recent medication list even if unable to reach the patient and code appropriately
  - Upload the discharge summary to the outpatient chart within 31 days to fulfill requirements if reconciliation was done at the time of discharge
  - Ensure proper coding of 1111F code any time a medication reconciliation takes place post-discharge
  - Encourage patient to develop and maintain a list of the medications they are currently taking to keep with them at all times
  - Opportunity for retrospective chart review if appointment took place within 30 days post discharge and MRP was documented but not coded
  - Ensure appropriate provider type is completing medication reconciliation
  - PCPs should date stamp the date that discharge summaries are received to provide evidence that they were filed in the outpatient charts within 31 days
  - During the post-discharge visit, ensure documentation references the discharge, and states the reconciliation has been completed.
    A medication list or review alone does not meet measure requirements

HOW TO CODE

For a list of codes, please contact the Star Team at **Stars@ahcusa.com**.

FOLLOW UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH RISK CHRONIC CONDITIONS (FMC)

WITHIN 7 DAYS OF EACH ED VISIT

Ensure patients who have high risk and chronic conditions have a follow-up visit within 7 days of an emergency department visit.

Demographic: 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit

BEST PRACTICES

- Schedule a follow up visit with the patient within 7 days of the discharge
- Ensure that the health plan is notified when the patient is discharged from the emergency department

- Flag patients in EHR who have multiple high-risk and chronic conditions
- Patients must have 2 or more of the following chronic conditions:
  - COPD & Asthma
  - Alzheimer's Disease and Related Disorders
  - Chronic Kidney Disease (CKD)
  - Depression
  - Heart Failure
  - Acute Myocardial Infarction
  - Atrial Fibrillation
  - Stroke and Transient Ischemic Attack (TIA)

HOW TO CODE

For a list of codes, please contact the Star Team at **Stars@ahcusa.com**.

PLAN ALL CAUSE READMISSION (PCR)

FOLLOW UP AFTER ACUTE INPATIENT AND OBVSERVATION STAYS

Frequent follow-up interventions via phone calls, telehealth, and home visits can support decreased unplanned readmission rates within 30-days.

Demographic: 18+ years old

BEST PRACTICES

- Explain discharge instructions and ask patients to repeat them back
- Share outpatient care options and locations with patients (e.g., urgent care and post-operative care)
- Have conversations with patients about transportation and home safety
- Follow up with provider offices to confirm that patients were seen within the first week post discharge

HOW TO CODE

No additional coding is required since measure calculations are based on admission claims data.

CTM RATE

JANUARY 1 – DECEMBER 31

- CTMs are complaints received by CMS that are sent to the plan for resolution
- CMS calculates a Star Rating based on the number of CTMs per average membership

HOW CTM IS CALCULATED

Calculated using the following calculation:

Complaint Rate =

$$\left(\frac{\text{Number of complaints attributed to IPA YTD}}{\text{Number of members in IPA *1000*30}}\right) \div \text{Number of Days in Period}$$

APPEALS AND GRIEVANCE RATE

JANUARY 1 – DECEMBER 31

- Appeals and grievances are complaints received by the plan. Appeals and grievances can be related to quality of care, referral/authorizations, access to care, etc.

HOW APPEALS AND GRIEVANCE RATE IS CALCULATED

Calculated using the following calculation:

Complaint Rate =

$$\left(\frac{\text{Number of complaints attributed to IPA YTD}}{\text{Number of members in IPA}*1000*30}\right) \div \text{Number of Days in Period}$$

FLU SHOT

EARLY FALL - EARLY SPRING

Patients are asked whether they received an influenza shot since the prior July.

Demographic: All Members

BEST PRACTICES

- Remind patients that the flu shot is available at no cost
- Help patients find a flu shot location
- Capture any barriers to getting the flu shot

HOW TO CODE

While this measure is a survey measure, submitting correct codes to the health plan can help indicate whether your patients have barriers to getting the flu vaccine.

CPT:
90630, 90653, 90654, 90655, 90656, 90660, 90672, 90673, 90674 ,90682, 90685, 90686, 90687, 90688, 90756, 90662, 4037F, 4274F, 4035F, 1030F, 90689, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039, 90657, 90658, 90661

Generic Product Identifier (GPI):
17100020046E620, 17100020023E620, 17100020025E620, 17100020821800, 17100020021E620, 17100020082E620. 17100020251800, 17100020086E520

PATIENT SATISFACTION WITH GETTING CARE QUICKLY

EACH VISIT

Patients rate how often they were able to schedule an appointment and get care as soon as they needed for both urgent and routine care. Patients also rate how often they saw the person they came to see within 15 minutes of their appointment time.

Demographic: All Members

BEST PRACTICES

- Ensure limited wait times and increase availability of urgent care appointments
- Offer the option of making appointments with a nurse practitioner or physician's assistant
- Set realistic expectations when making referral/scheduling appointment
- Encourage patients to make their appointments for routine care early on – before they leave your office, if possible

PATIENT SATISFACTION WITH HIS/HER CURRENT HEALTH CARE

EACH VISIT

On a scale of 0-10, patients rate the quality of their care in the last six months.

Demographic: All Members

BEST PRACTICES

- Ask questions to gauge the patient's current feeling about the care he/she is receiving
- Make efforts to confirm the patient understands services rendered
- Reaffirming what the patient says lets the patient know that they were heard, and their perspective was taken into consideration
- Use knowledge checks to confirm that the patient understands the important aspects of what has been explained

COORDINATION OF HEALTHCARE

EACH VISIT

Patients rate their physicians' familiarity with their medical history and prescriptions, how well physicians are following up with patients after test results are received and how well PCPs are managing care with specialists or other healthcare providers.

Demographic: All Members

BEST PRACTICES

- Ensure all medical records and other information about the patient's care is available upon request
- If follow up is needed, ensure to provide test results within a timely matter. If follow up is not needed, ensure that patient has been explicitly told that there will be no outreach from the office
- Set realistic expectations for office outreach, test results, and any kind of follow-up
- Review patient's current medication
- Ensure patient received help managing care
- Ensure the patient's PCP is informed and up to date about specialist care

GETTING NEEDED PRESCIPTION DRUGS

EACH VISIT

Patients rate how often it was easy to use their health plan to get prescribed medicines, fill a prescription at a local pharmacy and use their health plan to fill prescriptions by mail.

Demographic: All Members

BEST PRACTICES

- Review medications with all patients every visit; identify any opportunities for lower cost options, such as generics
- Encourage patients to bring in a list of medications, including over-the-counter medication, with every visit
- Ask patients about access barriers to obtaining medications

PATIENT SATISFACTION WITH GETTING NEEDED CARE

EACH VISIT

Patients rate how often it was easy to get appointments with specialists and how often it was easy to get the care, tests, or treatment they needed through their health plan.

Demographic: All Members

BEST PRACTICES

- Facilitate referral issuance and assist with the arrangement of specialist appointments
- Remind patients of the option of telehealth
- Remind patients of 24/7 concierge line to assist in finding a doctor

Introducing the ALWAYS Satisfied Patient System: Your guide to improving patient perception and CAHPS

Success Comes From Your Satisfied Patients

Our shared goal is ALWAYS providing high quality patient care. Every year, CMS may send your patient a CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey asking patients to rate their experiences and overall satisfaction **with the care you provided.** The answers to these questions will impact Alignment's Overall Star Rating, which may impact payment from your medical group.

Incorporating the ALWAYS Satisfied Patient System in your offices can help your patients always answer ALWAYS!

The ALWAYS Satisfied Patient System

- ✓ ALWAYS reserve daily time blocks for walk-in and urgent same-day appointment ensuring your patients that you are ALWAYS there for them
- ✓ ALWAYS provide the phone number for a 24/7 or after-hours Urgent Care facility on your answering service. The Alignment Health Plan Concierge team is also available 24/7 at **(833) 242-2223 (TTY: 711)**
- ✓ ALWAYS set expectations for in-office wait time by providing patients with estimated wait time and updated during check-in; this can improve perceived wait time.
- ✓ ALWAYS have the patient leave the office with something in-hand such as an appointment reminder card or copy of a referral to decrease delays in care and improve perception of getting care as soon as needed.
- ✓ ALWAYS have the office staff assist in scheduling a specialty appointment or follow-up visit prior to the patient leaving the office.
- ✓ ALWAYS review/update the patient's medication list at every visit – make sure the patient understands the prescribed medications and encourage adherence.
- ✓ ALWAYS set expectation with patients on receiving their test results. Set a practice goal to communicate test results to patients within 24 hours of receipt.
- ✓ ALWAYS ask the patient if they have any questions and address any additional concerns before the end of the appointment.

MENTAL STATUS ASSESSMENT

EACH VISIT

Providers should assess patient's mental status.

Demographic: All Members

BEST PRACTICES

- Be sure to screen for depression during every visit and appropriately triage to behavioral health services if needed.
- Remind patients of teledoc benefit

HOW TO CODE

CPT-II:

Report assessment of mental status:

2014F - Mental Status Assessment

PHYSICAL ACTIVITY ASSESSMENT

EACH VISIT

Patients are asked about physical health status over a period of time. They are also asked about discussing physical activity with their doctor.

Demographic: All Members

BEST PRACTICES

- Providers should assess patient's current level of physical activity and provide counseling as appropriate
- Talk to your patients about options for physical activity
- Alert patients to their Silver & Fit benefit through Alignment

HOW TO CODE

CPT-II:

Report patient's activity level was assessed:

1003F - Level of activity assessed

FALL RISK SCREENING

EACH VISIT

Patients are asked whether their doctor discussed falling or problems with balance or walking. They are also asked if their doctor suggested any fall prevention treatment.

Demographic: All Members

BEST PRACTICES

- Patients should have their fall risk assessed. Document history of falls
- Falls can be due to hazards in the home that may be simple to fix. Talk to your patients about their home and provide them with a copy of the AHC Fall Risk Checklist to review within their home
- Remind patients to get their vision and hearing checked regularly

HOW TO CODE

Report patient's Risk of Falling was assessed:

CPT-II:

1100F - Patient screened for future fall risk; documentation of 2 or more falls in the past year, or any fall with injury in the past year

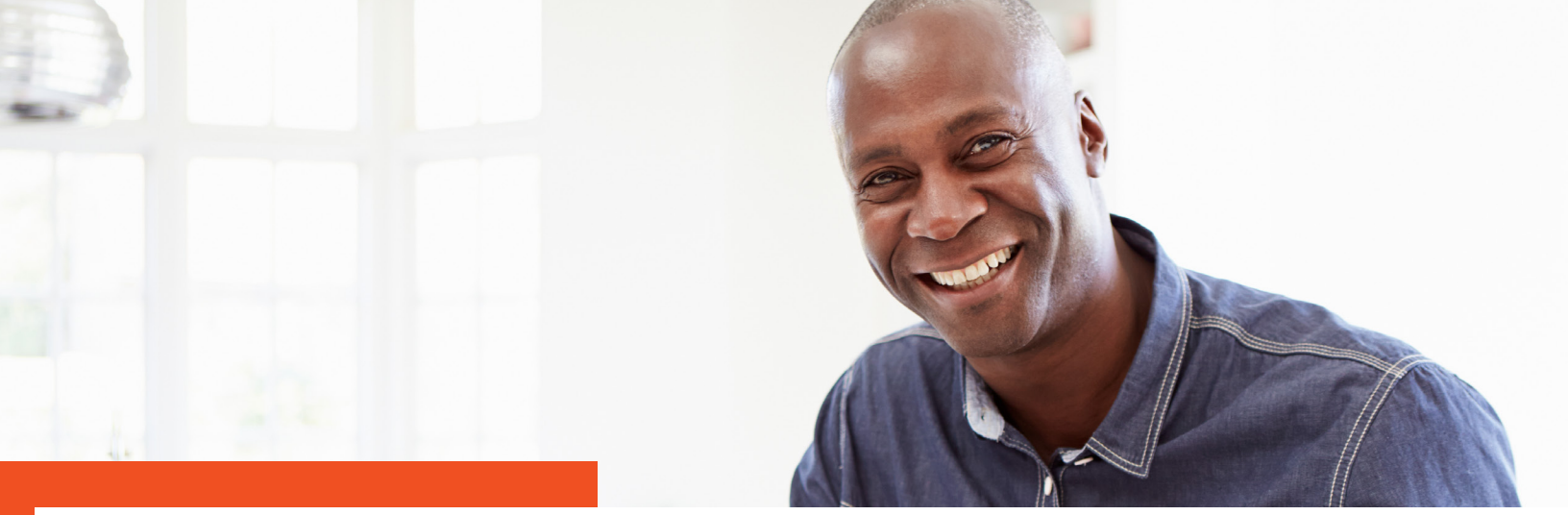
1101F - Documentation of no falls in the past year or only 1 fall without injury in the past year

3288F - Falls risk assessment documented

ICD-10:

Z91.81 - History of Falling

R29.6 - Repeated falls or tendency to fall



URINARY INCONTINENCE ASSESSMENT

EACH VISIT

Patients are asked about their experience with urinary incontinence and whether treatment options have been discussed with their doctor.

Demographic: All Members

BEST PRACTICES

- Patients should be assessed for urinary incontinence. Document presence or absence of urinary incontinence
- Discuss various treatment options with patient if urinary incontinence is discovered

HOW TO CODE

CPT-II:

Report patient's incontinence was assessed:

1090F - Presence or absence of urinary incontinence assessed

OSTEOPOROSIS TESTING IN OLDER WOMEN (OTO)

AT LEAST ONCE

Female enrollees 65+ years of age are asked if they ever received a bone density test to check for osteoporosis, which is sometimes referred to as "brittle bones".

Demographic: Female enrollees 65+ years old

BEST PRACTICES

- Outreach to patient to assist scheduling an osteoporosis screening test
- Document if/when patients received a bone density test to check for osteoporosis
- Consider investing in portable machines for use in the office or home setting

HOW TO CODE

CPT:

76977 - Ultrasound bone density measurement and interpretation peripheral site(s) and method

77078 - Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

77080 - Duel-energy X-rat absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

77081 - DXA, bone density study, 1 or more sites; appendicular skeleton (e.g., hips, pelvis, spine)

77085 - Dual-energy X-ray absorptiometry (DXA), bone density stufy, 1 or more sites

DOCUMENTATION

- Document frailty and advanced illness where applicable, see "Frailty" and "Advanced Illness" sections for additional information

Introducing the Healthy Outcomes System: Your guide to improving patient health outcomes and HOS

Success Comes From IMPROVING Your Patients Health

Our shared goal is IMPROVING patient health. Every year, CMS may send your patient a Health Outcomes Survey (HOS) asking patients to evaluate their health and **recall the health discussions they had with you**. The answers to these questions will impact Alignment's Overall Star Rating, which may impact payment from your medical group.

Practicing the Healthy Outcomes System can help your patients ALWAYS respond positively!

The Healthy Outcomes System

- ✓ IMPROVE physical health by establishing health interventions, such as monthly physical therapy, as part of their care plan.
- ✓ IMPROVE health habits with goal setting and action plans to help patients take active roles in improving their health. Set follow-up appointments for goal check-ins.
- ✓ IMPROVE emotional health by educating patients on staying positive, practicing mindfulness, getting enough sleep, eating healthy, limiting alcohol, and staying connected with loved ones.
- ✓ IMPROVE mental health by referring patients to behavioral health services when clinically appropriate.
- ✓ IMPROVE physical health by setting weight-loss, fitness, and mobility goals. Alignment's ACCESS On-Demand Concierge team is available 24/7 at **(833) 242-2223 (TTY: 711)** to provide a list of no-cost gym memberships to help patients reach these goals.
- ✓ IMPROVE self-sufficiency by referring patients with limited or decreased mobility to physical therapy to learn safe/effective exercises.
- ✓ IMPROVE patient understanding of how to control leakage of urine by educating them on treatment options such as medication, engagement in bladder training exercises, or surgery.
- ✓ IMPROVE patient safety by reducing fall risk! Encourage patients to remove throw rugs, clutter, and tripping hazards. Advise proactive solutions such as handrails on stairways, grab bars in bathrooms, non-slip shower mats, and use of nightlights throughout the home.
- ✓ IMPROVE financial well-being. Alignment's ACCESS On-Demand Concierge team is available 24/7 at **(833) 242-2223 (TTY: 711)** to provide patients with their Over-The-Counter allowance for help with obtaining personal care items, hearing aids, or other health supplies.


Alignment Healthcare