PeakHealth

2024

Quality Playbook

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What is Quality?

Quality is defined by the National Academy of Medicine as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The process of quality improvement is standardization. Each action/task should be consistent, organized, efficient, and align across the continuum of care with everyone working toward the optimal goal of providing the best quality of care for Peak Members.

What is HEDIS®?

HEDIS stands for Healthcare Effectiveness Data and Information Set. HEDIS is a health quality measurement tool utilized by National Committee for Quality Assurance (NCQA). This set of standardized quality measures helps the employer groups, contractors, and public compare the performance of a single organization to those of all healthcare organizations nationally.

HEDIS includes more than 88 measures across six domains of care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Reported Using Electronic Clinical Data Systems (ECDS)

HEDIS measures focus on prevention and screening, chronic care conditions across all body systems, access to care, satisfaction of care, utilization process of procedures, and the satisfaction of their health plan. Each year HEDIS comes out with technical specifications and Value Set Directory (VSD) that are published in the Fall for the upcoming year.

Medicare Stars Program

The Center for Medicare and Medicaid Services (CMS) developed the Star Ratings system to measure the quality a member enrolled in Medicare Advantage (Medicare Part C) and Medicare Part D receives from a CMS contracted health plan. This provides Medicare consumers with information to make the best healthcare decisions.

CMS uses a 5 Star Quality Rating System to measure the members' experience with their health plan and providers. Health plans that receive a 4 Star or higher will be able to offer improved benefits to their members to help them improve and achieve their quality goals. A health plan's Star Rating is comprised of the following:

1. HEDIS® Measures
2. Health Outcomes Survey (HOS)
3. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
4. Pharmacy Performance Part C and Part D

Health Outcomes Survey (HOS)

HOS is a patient-reported outcomes survey that measures how well a health plan manages the physical and mental health of its members. Each year a random sample of Medicare members is drawn and surveyed between August and November. Two years later, the baseline respondents are surveyed again.

HOS measures include:

1. Improving or maintaining physical health
2. Improving or maintaining mental health
3. Monitoring physical activity
4. Reducing the risk of falls
5. Improving bladder control

Consumer Assessment of Healthcare Providers & Systems (CAHPS®)

CAHPS is a survey that measures the member's experience with health plans and their services, including claims processing, member services, getting care quickly, and the provider network. This is an annual survey that is sent out from March through May. The information that is gathered will help health plans and providers make changes that enhance the patient's perception and drive better outcomes.

The Health Plan CAHPS Survey measures include the patient experience items:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- Enrollees' rating of their health plan
- Enrollees' rating of their health care
- Enrollees' rating of their personal doctor
- Enrollees' rating of their specialist

New in Measurement Year 2024

The Health Equity Index (HEI) will start to replace the Reward Factor in January 2024. HEI takes effect in 2027 using Measurement Year (MY) 2024 and Measurement Year (MY) 2025 performance on a subset of measures. The goal is to identify barriers to care and assist and support the members with resources to increase the quality of care.

Examples of barriers are lack of food, housing, transportation, and provider access as well as language and cultural barriers.

Your Role in the Quality Journey

1. Become familiar with the Medicare Star Rating System and the HEDIS Program.
2. Encourage your patients to complete surveys sent to them by CMS and their insurance plans.
3. Proactively schedule Annual Wellness and Preventive Exams to discuss the patient's physical and mental health needs and encourage preventive screenings based on the patient's demographics and chronic conditions, including:
    a. Screen for risk of falls, urinary incontinence, and depression.
4. Routinely screen for social determinants of health (SDoh) and refer to Peak Health's Case Management Program when appropriate.
5. Encourage patients to participate in fitness and exercise programs, and refer those patients with limited mobility to PT.
6. Discuss medication management and adherence. Refer to Peak Health's Case Management Program when appropriate.
7. Implement pre-visit planning processes to proactively identify quality care gaps.
8. Document all chronic conditions in the patient's medical record and capture the appropriate ICD-10-CM Diagnosis Code to claim every year, as appropriate.
9. Develop electronic health record standing order sets capturing applicable coding requirements for reporting codes i.e., CPT II and HCPCS codes.
10. Confirm reporting codes are being captured on claim and pass the clearinghouse edits as appropriate.
11. Educate all staff members on quality measures. Quality is a team approach!
12. Review changes to preventive schedules and quality measures each year.
13. Identify contributing factors to patient noncompliance, including:
    a. Cost of treatment
    b. Lack of trust
    c. Complexity of treatment plan
    d. Denial that the problem exists.
    e. Worried about outcomes
14. Develop an engagement plan for non-compliant patients.
    a. Utilize Peak Health Care Management Programs
    b. Implement follow-up plan to ensure test were completed and treatment completed.

HEDIS® Compliance Tip Sheets

Controlling High Blood Pressure (CBP)

Measure Type	Dynamic Star Measure
Measure Description	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Eligible Population	• Members 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. • The BP reading must occur *on or after* the date of the second diagnosis of hypertension. • BP readings taken by the member using a digital device and documented in the member's medical record are eligible for use in reporting. There is no requirement that there be evidence the BP was collected by a PCP or specialist. Do not include BP readings from: • Inpatient stay • ED • Diagnostic test or therapeutic procedure that requires change in diet or medication one day before.
Compliant Member	• The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. • Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg. • If no BP is recorded during the measurement year, assume that the member is "not controlled."
How to Submit to Peak Health	Submit CPT II codes via claim to identify numerator compliance. Most recent Systolic: • 3074F – Less than 130 Hg (<130 mm Hg) • 3075F – 130 -139 mm Hg Most recent Diastolic: • 3078F – Less than 80 mm Hg (<80 mm Hg) • 3079F – 80 – 89 mm Hg

Exclusion	Exclude members who meet any of the following criteria:
	• Hospice
	• Members who die any time during the measurement year
	• Palliative care any time during the measurement year
	• Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year.
	• pregnancy any time during the measurement year
	• Members 66–80 years of age as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded
	  ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year
	  ○ **Advanced Illness.** 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.
	  ▪ Dispensed dementia medication
	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	  ○ Enrolled in an Institutional SNP (I-SNP)
	  ○ Living long-term in an institution
	• Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

Best Practice	• Retake elevated blood pressures during office visits and submit appropriate compliant readings from all BP's taken. • Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. • Develop electronic health record (EHR) standing orders sets capturing applicable coding requirements (i.e. CPT II codes). • Implement process to refer patients to Peak's Care Management Uncontrolled HTN Program. • Provide ongoing outreach and follow up for non-compliant members.
Key Resources	• Peak Health Care Management Program Manual • Stars Coding Reference List • High Blood Pressure | cdc.gov

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure Type	Static Star Measure
Measure Description	• The percentage of males 21–75 years of age and females 40–75 years of age with cardiovascular disease who had at least one high-intensity or moderate-intensity statin medication during the measurement year.
Eligible Population	• Males 21–75 years and Females 40–75 years that have had an event identified or diagnosis during the prior to the measurement year. Events • Myocardial Infarction (MI) • CABG, PCI, or other revascularization procedure • Diagnosis of Ischemic Vascular Disease (IVD) during measurement year and the year prior. • One acute inpatient discharge with Ischemic Vascular Disease (IVD) diagnosis
Compliant Member	• Members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year
How to Submit to Peak Health	• One Pharmacy claim adjudicated at the point of sale.

Exclusion	Exclude members who meet any of the following criteria:
	• Cirrhosis
	• Myalgia, Myositis, Myopathy or Rhabdomyolysis
	• Dispensed at least one prescription for clomiphene
	• Hospice
	• Members who die any time during the measurement year
	• Palliative care any time during the measurement year
	• End-stage renal disease (ESRD) during the measurement year or the year prior
	• pregnancy or in vitro fertilization any time during the measurement year
	• Members 66–80 years of age as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded
	  ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year
	  ○ **Advanced Illness.** 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.
	  ▪ Dispensed dementia medication
	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	  ○ Enrolled in an Institutional SNP (I-SNP)
	  ○ Living long-term in an institution

Best Practice	• Ensure providers prescribe the moderate or high intensity Statin. • Document and submit cirrhosis, myalgia, myositis, myopathy, or rhabdomyolysis exclusion diagnosis via claim. • Discuss benefits of statins use and importance of adherence. • Consider statins with fewer drug interactions. Patients may be able to tolerate a different statin. • Members using samples, paying cash, or using discount cards will not generate a pharmacy insurance claim and will appear as non-compliant. • Provide ongoing outreach and follow up for non-compliant members.
Key Resources	• Peak Health Moderate/High Intensity Statin List • Stars Coding Reference List

Moderate and High Intensity Statins

Description	Prescription	Cost *At preferred pharmacies (Standard pharmacies copays will be higher)
High-intensity statin therapy	• Atorvastatin 40-80 mg	$0*
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Non-Formulary ($0*) if utilized as 2 prescriptions separately (amlodipine/atorvastatin)
High-intensity statin therapy	• Rosuvastatin 20-40 mg	$0*
High-intensity statin therapy	• Simvastatin 80 mg	$0*
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	$0*
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	$0*
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Non-Formulary ($0*) if utilized as 2 prescriptions separately (amlodipine/atorvastatin)
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	$0*
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	$0*
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	$0*
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	$0*
Moderate-intensity statin therapy	• Lovastatin 40 mg	$0*
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	$0*
Moderate-intensity statin therapy	• Pitavastatin 1-4 mg	$0* Required Step Therapy (trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin)

Glycemic Status Assessment for Patients with Diabetes >9% (GSD)

<table>
<tr><th>Measure Type</th><th>Dynamic Star Measure</th></tr>
<tr><td>Measure Description</td><td>The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c]) was less than 9.0 %. during the measurement year.</td></tr>
<tr><td>Eligible Population</td><td>Diabetic members aged 18-75 years old who were identified as diabetic using the following:
Claims
Members 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.
OR
Pharmacy Data
Members 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.</td></tr>
<tr><td>Compliant Member</td><td>Member is compliant if the most recent HbA1c level is less than 9%.</td></tr>
<tr><td>How to Submit to Peak Health</td><td>Submit CPT II codes via claim to identify compliance.
<table><tr><td>HbA1c <7%</td><td>3044F</td></tr><tr><td>HbA1c ≤7.0 to < 8%</td><td>3051F</td></tr><tr><td>HbA1c ≥8 to ≤9%</td><td>3052F</td></tr></table></td></tr>
<tr><td>Exclusion</td><td>Hospice
Members who die any time during the measurement year
Palliative care any time during the measurement year
Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. BOTH frailty and advanced illness criteria to be excluded
Frailty. At least two indications of frailty with different dates of service during the measurement year
Advanced Illness. 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.
Dispensed dementia medication
Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
Enrolled in an Institutional SNP (I-SNP)
Living long-term in an institution</td></tr>
<tr><td>Best Practice</td><td>Develop electronic health record (EHR) standing orders sets capturing applicable coding requirements (i.e. CPT II codes).
Implement process to refer non-compliant patients to Diabetes Education
Provide ongoing outreach and follow up for non-compliant members.</td></tr>
<tr><td>Resources</td><td>Diabetes Research, Education, Advocacy | ADA Stars Coding Reference List</td></tr>
</table>

Eye Exam for Patients with Diabetes (EED)

Measure Type	Static Star Measure
Measure Description	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Eligible Population	Diabetic members aged 18-75 years old who were identified as diabetic using the following: Claims • Members 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. **OR** Pharmacy Data • Members 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.
Compliant Member	Screening or monitoring for diabetic retinal disease. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year. • Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.
How to Submit to Peak Health	• Optometrist or Ophthalmologist submit Diabetic Eye Exam via claim. • Submit the appropriate CPT II codes when **documentation of eye exam is the medical record**: 2022F, 2023F, 2024F, 2025F, 2026F, & 2033F. (refer to Stars Coding Reference List)
Exclusion	• Hospice • Members who die any time during the measurement year • Palliative care any time during the measurement year • Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year ○ **Advanced Illness.** 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. ▪ Dispensed dementia medication • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: ○ Enrolled in an Institutional SNP (I-SNP) ○ Living long-term in an institution
Best Practice	• Implement standing referrals to eye care providers. • Assist patients with making appointment with eye providers. • Educate all diabetic patients on importance of eye care. • Develop electronic health record (EHR) standing orders sets capturing applicable coding requirements (i.e. CPT II codes). • Implement process to refer non-compliant patients to Diabetes Education • Provide ongoing outreach and follow up for non-compliant members.

Kidney Health Evaluation for Patients with Diabetes (KED)

Measure Type	Static Star Measure
Measure Description	The percentage of members 18–85 years of age with diabetes (type 1 and 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.
Eligible Population	Diabetic members aged 18-85 years old who were identified as diabetic using the following: Claims • Members 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. **OR** Pharmacy Data • Members 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.
Compliant Member	Members who received ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service: • At least one eGFR • At least one uACR 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 ○ uACR
How to Submit	• Lab claim for eGFR **AND** • Lab claim for uACR or submit claim for quantitative urine albumin test (82043) and urine creatinine test (82570)
Exclusion	• Hospice • Members who die any time during the measurement year • Palliative care any time during the measurement year • Members with a diagnosis of ESRD (End Stage Renal Disease) or dialysis any time during the member's history on or prior to December 31 of the measurement year • Members 66–80 years of age as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year ○ **Advanced Illness.** 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. ▪ Dispensed dementia medication • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: ○ Enrolled in an Institutional SNP (I-SNP) ○ Living long-term in an institution • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

Best Practice	• Develop electronic health record (EHR) standing order sets capturing applicable coding requirements (i.e. CPT II codes) • Provide in-office lab draws and urine collection. • Educate all diabetic patients on the importance of kidney health. • Provide ongoing outreach and follow-up for non-compliant members.

Transitions of Care Medication Reconciliation Post-Discharge

Measure Type	Static Star Measure
Measure Description	• The percentage of members 18 years and older that had an acute or nonacute inpatient discharge on or between January 1 and December 1 and had a documented medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Eligible Population	• Members 18 years and older that had an acute or nonacute inpatient discharge between January 1 and December 1 of the measure year.
Compliant Member	• 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). • Medication reconciliation is a review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. • If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge.
How to Submit to Peak Health	• Transition of Care Codes 99495 or 99496 **OR** • Submit Medication Reconciliation CPT II code 1111F on claim
Exclusion	• Hospice • Members who die any time during the measurement year • Discharges after December 1 of measurement year
Best Practice	• Implement process to do Transition of Care Visits on all inpatient discharges. • Develop electronic health record (EHR) standing orders sets capturing applicable coding requirements (i.e. CPT II codes). Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.
Resources	• Stars Coding Reference Sheet

Breast Cancer Screening (BCS-E)

Measure Type	Static Star Measure
Measure Description	• The percentage of members 50–74 years of age who had a mammogram to screen for breast cancer.
Eligible Population	• Members 52–74 years of age by the end of the measurement period.
Compliant Member	• One or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period. • 2024 Look-back period is October 1, 2022 – December 31, 2024
How to Submit to Peak Health	• Submit mammogram codes via claim. • Review chart for screenings done in look back period.

Exclusion	• Hospice
	• Members who die any time during the measurement year
	• Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period.
	• Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
	• Palliative care any time during the measurement year
	• Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded
	  ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year
	  ○ **Advanced Illness.** 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.
	  ▪ Dispensed dementia medication
	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	  ○ Enrolled in an Institutional SNP (I-SNP)
	  ○ Living long-term in an institution

Best Practice	• Implement pre-visit planning processes to proactively identify quality care gaps in preparation for patient's office visit. • Conduct comprehensive annual well care visits for all population and discuss importance of preventive screenings. • Conduct chart reviews to find evidence of mammograms in look-back period or exclusions. • Provide ongoing outreach and follow up for non-compliant members.
Resources	• Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

Colorectal Cancer Screening (Col-E)

Measure Type	Static Star Measure
Measure Description	• The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Eligible Population	• Members 46–75 years as of the end of the measurement period.
Compliant Member	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement period. • Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period. • CT colonography during the measurement period or the 4 years prior to the measurement period. • Colonoscopy during the measurement period or the 9 years prior to the measurement period.
How to Submit to Peak Health	• Submit appropriate procedure codes via claim. • Review chart for screenings done in look back period.

Exclusion	• Hospice
	• Members who die any time during the measurement year
	• Members who had colorectal cancer any time during the member's history through December 31 of the measurement year.
	• Members who had a total colectomy any time during the member's history through December 31 of the measurement period.
	• Palliative care any time during the measurement year
	• Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded
	  ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year
	  ○ **Advanced Illness.** 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.
	  ▪ Dispensed dementia medication
	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	  ○ Enrolled in an Institutional SNP (I-SNP)
	  ○ Living long-term in an institution

Best Practice	• Implement pre-visit planning processes to proactively identify quality care gaps in preparation for patient's office visit. • Conduct comprehensive annual well care visits for all population and discuss importance of preventive screenings. • Conduct chart reviews to find evidence of colorectal screening in look-back period or exclusions. • Provide ongoing outreach and follow up for non-compliant members.
Resources	• Recommendation: Colorectal Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

Osteoporosis Management in Women Who Had a Fracture

Measure Type	Static Star Measure
Measure Description	• The percentage of 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 (6 months) after the fracture.
Eligible Population	• Women 67-85 years of age by the measurement year who had a fracture identified by ED, Non-acute or acute inpatient stay, Outpatient, or observation during the intake period. ○ Intake period: July 1 of the year prior to the measurement year to June 30 of the measurement year.
Compliant Member	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria: • A BMD test, in any setting, on the IESD or in the 180-day period after the IESD. • If the IESD was an inpatient stay, a BMD test during the inpatient stay. • Osteoporosis therapy on the IESD or in the 180-day period after the IESD. • If the IESD was an inpatient stay, long-acting osteoporosis therapy during inpatient stay. • A dispensed prescription to treat osteoporosis on the IESD or in the 180-day period after the IESD. • Members who had a BMD test during the 730 days prior to the episode date. IESD- Index episode start date is the earliest episode date during the intake period that meets all eligible population criteria.
How to Submit to Peak Health	• Submit appropriate procedure codes for bone mineral density test via claim. • Review chart for screenings done in look back period.

Exclusion	• Hospice
	• Members who die any time during the measurement year
	• Palliative care any time during the measurement year
	• Members 67-80 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness. **BOTH** frailty and advanced illness criteria to be excluded
	  ○ **Frailty.** At least two indications of frailty with different dates of service during the measurement year
	  ○ **Advanced Illness.** 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.
	  ▪ Dispensed dementia medication
	• Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the intake period through the end of the measurement year.
	• Medicare members 67 years of age and older as of December 31 of the measurement year who meet either of the following:
	  ○ Enrolled in an Institutional SNP (I-SNP)
	  ○ Living long-term in an institution

Best Practice	• Review admission/discharge list for patients with recent fractures. • Implement pre-visit planning processes to proactively identify quality care gaps in preparation for patient's office visit. • Conduct comprehensive annual well care visits for all population and discuss importance of preventive screenings. • Provide ongoing outreach and follow up for non-compliant members. • Review chart for BMD testing done in the prior 24 months of fracture date.

Medication Adherence for Diabetic Medication

Measure Type	Dynamic Star Measure
Measure Description	• Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Eligible Population	• Members 18 years and older that had at least two fills of their diabetes medication. • Diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)- 4 Inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.
Compliant Member	• Percent of plan members with a prescription for diabetes medication who adhere to their prescribed drug therapy with a proportion of days covered (PDC) at 80 percent or higher. • The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category.
How to Submit to Peak Health	• Pharmacy claim only
Exclusion	• Hospice • Members with a diagnosis of ESRD (End Stage Renal Disease) or dialysis any time during the member's history on or prior to December 31 of the measurement year. • One or more prescriptions for insulin
Best Practice	• Educate patient about the importance of taking medication as prescribed. • Discourage "pill splitting" or taking medication every other day unless prescribed by their providers. • Ensure scripts are rewritten if dosage changed. • Encourage 90 day fills for chronic long-term medications. • Provide ongoing outreach and follow up for non-compliant members. • Have staff ask about refills at each office visit.
Resources	• Stars Coding Reference Sheet

Medication Adherence for Hypertension (RAS antagonists)

Measure Type	Dynamic Star Measure
Measure Description	• Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Eligible Population	• Members 18 years and older that had at least two fills of their prescribed drug therapy for renin angiotensin system (RAS) antagonists. • renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.
Compliant Member	• Percent of plan members with a prescription for renin angiotensin system (RAS) antagonists medication who adhere to their prescribed drug therapy with a proportion of days covered (PDC) at 80 percent or higher. • The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category.
How to Submit to Peak Health	• Pharmacy claim only
Exclusion	• Hospice • Members with a diagnosis of ESRD (End Stage Renal Disease) or dialysis any time during the member's history on or prior to December 31 of the measurement year. • One or more prescriptions for sacubitril/valsartan
Best Practice	• Educate patient about the importance of taking medication as prescribed. • Discourage "pill splitting" or taking medication every other day unless prescribed by their providers. • Ensure scripts are rewritten if dosage changed. • Encourage 90 day fills for chronic long-term medications. • Provide ongoing outreach and follow up for non-compliant members. • Have staff ask about refills at each office visit.
Resources	• Preferred Pharmacy List

Medication Adherence for Cholesterol (Statins)

Measure Type	Dynamic Star Measure
Measure Description	• Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Eligible Population	• Members 18 years and older that had at least two fills of their prescribed drug therapy for statin cholesterol medications.
Compliant Member	• Percent of plan members with a prescription for statin cholesterol medications medication who adhere to their prescribed drug therapy with a proportion of days covered (PDC) at 80 percent or higher. • The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category.
How to Submit to Peak Health	• Pharmacy claim only
Exclusion	• Hospice • Members with a diagnosis of ESRD (End Stage Renal Disease) or dialysis any time during the member's history on or prior to December 31 of the measurement year.
Best Practice	• Educate patient about the importance of taking medication as prescribed. • Discourage "pill splitting" or taking medication every other day unless prescribed by their providers. • Ensure scripts are rewritten if dosage changed. • Encourage 90 day fills for chronic long-term medications. • Provide ongoing outreach and follow up for non-compliant members. • Have staff ask about refills at each office visit.
Resources	• Preferred Pharmacy List

Statin Use in Persons with Diabetes (SUPD)

Measure Type	Static Star Measure
Measure Description	• The percentage of diabetic members 40-75 years of age who take the most effective cholesterol lowering drug.
Eligible Population	• Members 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period.
Compliant Member	• Members who received a statin medication fill anytime during the measurement year.
How to Submit to Peak Health	• One Pharmacy claim adjudicated at the point of sale.
Exclusion	Exclude members who meet any of the following criteria: • Cirrhosis • Myopathy or Rhabdomyolysis • Hospice • End-stage renal disease (ESRD) during the measurement year or the year prior • pregnancy or in vitro fertilization any time during the measurement year • Lactation • Pre-Diabetes • Polycystic Ovarian Syndrome (PCOS)
Best Practice	• Document and submit cirrhosis, myopathy, or rhabdomyolysis exclusion diagnosis via claim. • Discuss benefits of statins use and importance of adherence. • Consider statins with fewer drug interactions. Patients may be able to tolerate a different statin. • Members using samples, paying cash, or using discount cards will not generate a pharmacy insurance claim and will appear as non-compliant. • Provide ongoing outreach and follow up for non-compliant members.
Key Resources	• Peak Health Statin List • Preferred Pharmacy List

CPT® Code Reference List

2024 Stars Coding Tip Sheet	
Annual Wellness Visit (AWV) & Initial Preventive Physical Exam (IPPE)	
G0402	Initial Preventive Physical Exam (member first 12 months of enrollment in Medicare Part B)
G0438	Annual Wellness visit, Initial (can be completed after first 12 months of enrollment in Medicare Part B)
G0439	Annual Wellness Visit, Subsequent (can be completed on annual basis after initial AWV)
G0468	FQHC Visit, IPPE or AWV
Screening - Fall Risk	
3288F	Falls Risk assessment documented
1100F	Patient screened for future fall risk; documentation of 2 or more falls in past year or any fall with injury past year
1101F	Patient screened for future fall risk; documentation of no falls in past year or 1 fall without injury in the past year
HBA1c Control	
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
3046F	Most recent hemoglobin A1c level greater than 9.0% Not **Compliant**
Eye Exam for Patients with Diabetes	
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
2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **with** evidence of retinopathy
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **without** evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **with** evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **without** evidence of retinopathy
Controlling High Blood Pressure	
3074F	Most recent systolic blood pressure less than 130 mmHg
3075F	Most recent systolic blood pressure 130-139 mmHg
3077F	Most recent systolic blood pressure greater than or equal to 140 mmHg **Not Compliant**
3078F	Most recent diastolic blood pressure less than 80 mmHg
3079F	Most recent diastolic blood pressure 80-89 mmHg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mmHg **Not Compliant**
Transition of Care – Medication Reconciliation	
1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Statin Use in Persons With Diabetes (SUPD) Exclusions (Exclusion list is not comprehensive)	
Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69
Polycystic Ovarian Syndrome	E28.2
End-Stage Renal Disease	I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Prediabetes	R73.03, R73.09
Myopathy, Myositis	G72.0, G72.89, G72.9, M60.80, M60.9
Rhabdomyolysis	M62.82
Pregnancy and/or Lactation	O09.00, O48.0, Z33.1, Z34.00, others
Disclaimer: This document is intended as a guide and is not all inclusive. Always refer to the National Guidelines for complete coding and technical specifications. Coding may be subject to change on National Guidelines and/or updates.	

Peak Health's Preferred Pharmacy List

Tier 1 and 2 medications are covered at a $0 copay at **Preferred Pharmacies and via Mail Order*** for 30- and 90-day supplies.

Northern WV Preferred Pharmacies	Southern WV Preferred Pharmacies
• Medical Center Pharmacy* • Mountaineer Pharmacy* • Medical Park Pharmacy • United Pharmacy • WVU Specialty Pharmacy & Home Infusion* • New Martinsville Pharmacy • Carl Walkers Drugstore • Rivesville Pharmacy • Moundsville Pharmacy • Mace's Pharmacy • Walgreens • Costco*	• Marshall Pharmacy- Byrd Clinical Center • Marshall Pharmacy- PROACT • Marshall Pharmacy- Marshall University Medical Center • The Pharmacy @ HIMG • St. Mary's Medical Center Outpatient Pharmacy • Walgreens • Costco*

*Mail Order Options

2024 Peak Benefit Coverage

Medicare Advantage Cheat Sheet					
Product	Vista - WVU	Vista - Marshall	Summit - WVU	Summit - Marshall	*Notes*
Premium	$0	$0	$18	$18	*To be paid to Peak monthly by the member*
OTC	$ 75.00	$ 75.00	$ 120.00	$ 120.00	*Max plan benefit coverage amount*
Flex Card	$ 250.00	$ 300.00	$ 300.00	$ 350.00	*Max plan benefit coverage amount*
In Network MOOP	$ 7,000.00	$ 7,000.00	$ 6,250.00	$ 6,250.00	*In Network MOOP*
Combined MOOP	$ 10,500.00	$ 10,500.00	$ 9,550.00	$ 9,550.00	
OON Cost Share	35%	35%	35%	35%	*Member Coinsurance*
Inpatient Care					
Inpatient Hospital - Acute Days 1-90	$ 200.00	$ 225.00	$ 350.00	$ 350.00	*Vista -First two days of admission,there is no copay. If a member stays in the hospital longer than 2 days, they have the copay shown for days 1-3, then a $0 copay up till 90 days. Summit - there is a single copay per stay*
Inpatient Hospital - Behaviorial Health	$ 425.00	$ 425.00	$ 400.00	$ 400.00	
Skilled Nursing Facility					
Must have a 3 day inpatient stay to be eligible for SNF Admission Benefit period for SNF starts the day of admission and ends when a member has been out of a SNF for 60 days. Plans cover up to 100 days per benefit period					
SNF Days 1-20	$ -	$ -	$ -	$ -	
SNF Days 21-100	$ 196.00	$ 196.00	$ 196.00	$ 196.00	*Copay per day*
Specialized Care					
Hospice	$ -	$ -	$ -	$ -	*Hospice benefits are paid directly by Medicare, not Peak, check EOC*
Home Health	$ -	$ -	$ -	$ -	*No copay or coinsurance, PA required*
Outpatient Care					
Outpatient Hospital Services	$ 275.00	$ 275.00	$ 250.00	$ 250.00	*Max Copayment*
Observation Services	$ 175.00	$ 275.00	$ 200.00	$ 250.00	*Copay per stay*
Dialysis Services	20%	20%	20%	20%	
Partial Hospitalization /Intensive Outpatient Services	$0	$0	$0	$0	*No copay*
Ambulatory Surgical Center	$ 225.00	$ 225.00	$ 200.00	$ 200.00	*Max Copayment*
Emergency and Urgent Care					
Emergency Services - Out Patient Hospital	$ 80.00	$ 90.00	$ 75.00	$ 85.00	*Copay is waived if admitted. Also waived if admitted within 24 hours for the same medical condition.*
Urgently Needed Services	$ 30.00	$ 25.00	$ 25.00	$ 25.00	
Worldwide Emergency Coverage	$ 95.00	$ 95.00	$ 95.00	$ 95.00	*Must be paid upfront by member and then filed to Peak Health.*
Office Visits					
PCP	$ -	$ -	$ -	$ -	*Services done in the PCP Office will have no copay, such as in house labs , office visits and xrays. If labs or films are sent to labs,hosps, or other providers, cost share will apply*
Specialist	$ 25.00	$ 25.00	$ 20.00	$ 20.00	
Acupuncture	$ 25.00	$ 25.00	$ 20.00	$ 20.00	
Chiropractic - Routine Care	$ 25.00	$ 25.00	$ 20.00	$ 20.00	*Applies to all billed services except spinal manipulations*
Chiropractic - Medicare	$ 15.00	$ 15.00	$ 15.00	$ 15.00	*This applies to spinal manipulations only*
Podiatry Services	$ 25.00	$ 25.00	$ 20.00	$ 20.00	
Behavioral Health and Substance Abuse					
Beh Health - Individual Session	$ 40.00	$ 40.00		$ 35.00	
Beh Health - Group Session	$ 40.00	$ 40.00	$ 30.00	$ 35.00	
Opioid Treatment	$ 35.00	$ 35.00	$ 25.00	$ 35.00	
Substance Abuse - Individual Session	$ 40.00	$ 40.00	$ 40.00	$ 40.00	
Substance Abuse - Group Session	$ 40.00	$ 40.00	$ 40.00	$ 40.00	

Therapies and Rehab					
Physical Therapy and Speech	$ 30.00	$ 20.00	$ 20.00	$ 20.00	
Occupational Therapy	$ 30.00	$ 20.00	$ 20.00	$ 20.00	
Cardiac Rehab	$ 10.00	$ 10.00	$ 10.00	$ -	
Intensive Cardiac Rehab	$ 10.00	$ 10.00	$ 10.00	$ -	
Pulmonary Rehab	$ 10.00	$ 10.00	$ 10.00	$ -	
SET for PAD Services	$ 10.00	$ 10.00	$ 10.00	$ -	*PAD = Peripheral Artery Disease - see OneNote for details, copay per session*
Ambulance Services					
Ground Ambulance	$ 290.00	$ 250.00	$ 250.00	$ 225.00	*Copay for one way trip , non emergent trips must have PA*
Air Ambulance	$ 290.00	$ 290.00	$ 250.00	$ 225.00	*Copay for one way trip , non emergent trips must have PA*
Radiology					
Outpatient X Ray Services	$ 25.00	$ 25.00	$ 20.00	$ 15.00	*Max Copayment*
Diagnostic Radiology Procedures (CT and MRI)	$ 225.00	$ 225.00	$ 200.00	$ 190.00	*Max Copayment*
Therapeutic Radiology Procedures	$ 60.00	$ 60.00	$ 50.00	$ 50.00	
Diagnostic Bone Density	$ -	$ -	$ -	$ -	
Diagnostic Mammography	$ -	$ -	$ -	$ -	
Lab Services					
Lab Services	$ 25.00	$ 25.00	$ -	$ -	
Diagnostic Services					
Diagnostic Procedures	$ 25.00	$ 25.00	$ 20.00	$ -	
Diagnostic Colonoscopies	$ -	$ -	$ -	$ -	
DME and Supplies					
Check MA Proir Auth List on services					
DME	15%	15%	15%	15%	*Member Coinsurance*
Prosthetics	20%	20%	20%	20%	*Member Coinsurance*
Medical Supplies	20%	20%	20%	20%	*Member Coinsurance*
Diabetic Supplies	$0	$0	$0	$0	*$0 copay for glucometers, test strips, lancets, control solution, replacement batteries, platforms, lens shield, a continuous glucose monitoring device and non-invasive vagus nerve stimulator from a preferred diabetic supplier.*
Definitions					
Maximum Copayment per Day	*If a member receives multiple services at the same location on the same day, the maximum copay would apply.*				
Surgical and Outpatient Copays	*Copays normally apply to the facility claim.*				
PCP	*The following provider specialties are considered PCP:* *Family Medicine* *General Practice* *Geriatric Medicine* *Internal Medicine* *If speciality is a NP or PA, the claim will pay as a PCP speciality*				

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