SUMMIT HEALTH

Provider Incentive Measure Guide

601 SW 2nd Avenue Portland, Oregon 97204

YourSummitHealth.com

2024 Summit Health Medicare Advantage Primary Care Incentive Program (MAPCIP) Summary

To be eligible for participation in the MAPCIP program, providers will:

- Be certified by the Oregon Health Authority as a PCPCH Tier 1-5.
- Perform one of the three required data submission activities. Further details are included below.
- Have a Medicare Advantage contract through **Summit Health** that is active and in good standing at the time incentives are disbursed. Note: “Good standing” includes participating in required compliance or Quality Program activities (e.g., timely submission of requested medical records for HEDIS risk adjustment reviews). If we receive any notification of a provider group's intent to terminate the agreement, that provider group will be ineligible to receive any incentive payment.

Payment components include:

- **Care Gap Incentive Payment (CGIP)** - performance based payment made to Provider, based on annual performance on quality measures, patient experience of care measures and/or utilization measures, as further defined below.
- **Access to Care Incentive Payment (ACIP**) - performance based payment made to Provider, based on annual performance of MAPCIP members having completed an annual physical and/or annual wellness visit during the Settlement Period, as further defined below.
- **PCPCH Capitation** - a risk stratified per member-per month capitation-based payment made to Provider based on the PCPCH tier designation by the Oregon Health Authority (OHA) and published on the OHA website.

Moda, Inc. shall pay a Care Gap Incentive Payment (CGIP) to reward performance for quality care and an Access to Care Incentive Payment (ACIP) using the following factors as guidance:

- Measurement will be based on a calendar year, beginning with January 1, 2024.
- The CGIP amount per member will be based upon total Numerator Percentage at the end of each calendar year for all measures.
- The CGIP and ACIP amounts will be calculated three months after the Settlement Period ends to allow for claims run-out, and payments will be made by June 30 of each year for the prior year Settlement Period.

Medicare Star Rating compliance will use HEDIS MY2024 criteria for the 2024 program. Should HEDIS guidelines change during the measurement year, the most recent version of HEDIS criteria will be used. For more information on Star Rating Measures, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.

Visit https://www.yoursummithealth.com/provider/resources/forms-documents to access the 2024 Summit Health MAPCIP.

Provider Engagement Incentive Measures

Measure	Weight	Description
Breast Cancer Screening (BCS)	1	Percent of female plan members ages 52-74 who had a mammogram during the past two years
Colorectal Cancer Screening (COL)	1	Percent of plan members ages 45-75 who had appropriate screening for colon cancer
Diabetes Care – HbA1C Controlled	3	Percent of plan members with diabetes who had an A1C lab test during the year that showed their average blood sugar is controlled (<8%)
Controlling High Blood Pressure (CBP)	3	Percent of plan members ages 18-85 who had a diagnosis of hypertension and whose blood pressure (BP) is adequately controlled (<140/90) during the measurement year
Statin Therapy for Patients with Cardiovascular Disease (SPC)	1	Percent of plan members with heart disease who were dispensed at least one high or moderate-intensity statin medication during the measurement year
Statin Therapy for Patients with Diabetes (SUPD)	1	Percent of plan members 40-75 years of age who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)	1	Percent of discharges for members 18 years of age and older who had evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
Annual Wellness Visit / Physical Exam	N/A[1]	Percent of plan members that have an annual wellness visit or physical exam with any of the following codes (G0402, G0403, G0404, G0405, G0438, G0439, G0468, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99397) during the measurement period

1. Annual Wellness Visit / Physical Exam is not a Star Measure. However, these preventive services can improve overall patient health and indirectly impact Star Measures.

Measure Details

Measure	Breast Cancer Screening (BCS)	Measure Target
Description	Percent of female plan members ages 50-74 who had a mammogram during the past two years	>79%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	Eligible women (denominator) had a mammogram to screen for breast cancer				
Denominator	Women MA enrollees 50-75 years of age				
Exclusions	• Members in hospice or using hospice services anytime 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 66 years of age and older as of December 31 of the measurement year who enrolled in an Institutional SNP any time during the measurement year or are living long-term in an institution any time during the measurement year • Members with frailty and advanced illness during the measurement year • Members receiving palliative care For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period (i.e., the measurement period and the year prior to the measurement period). No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period.				

Coding

CPT	77061, 77062, 77063, 77065, 77066, 77067 Exclusions: 19180, 19200, 19220, 19303-19307
HCPCS	G0202, G0204, G0206 Exclusions: G9054, M1017
ICD-10	Exclusions: Z90.13, Z90.11, Z90.12, Z51.5

Starting in 2024, the National Committee for Quality Assurance (NCQA) has transitioned the Breast Cancer Screening measure to Electronic Clinical Data Systems (ECDS) Reporting. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to member eligibility files, EHRs, clinical registries, Health information exchanges (HIEs), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

Submitting claims using the codes above will satisfy the updated BCS-E measure.

For more information on NCQA HEDIS ECDS Reporting, visit https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients in need of mammograms
    - Perform outreach by mail, telephone, or other method
    - Address recommended mammogram during patient encounter
    - Identify patients who had a mammogram during applicable time frame or who meet exclusion criteria and submit supplemental data
    - Review and document member history annually regarding breast cancer screening (which screening was done and a date)
- Use diagnosis codes to report exclusions. Correctly coding these conditions may prevent medical record requests.
- Review and evaluate clinic procedures to ensure mammograms are ordered and performed
    - Ensure processes are standardized for patient assessment, referrals, reminders, and tracking
    - Include Breast Cancer Screening as a standard care gap for review during Annual Wellness Visits

Measure	Colorectal Cancer Screening (COL)	Measure Target
Description	Percent of plan members ages 45-75 who had appropriate screening for colon cancer	>80%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	MA enrollee had appropriate screenings for colorectal cancer				
Denominator	MA enrollees ages 45-75				
Exclusions	• Members who had colorectal cancer or a total colectomy any time during the member's history through December 31 of the measurement year • Members in hospice or using hospice services anytime during the measurement year • Members who died any time during the measurement year • Members receiving palliative care • Members 66 years of age and older as of December 31 of the measurement year who enrolled in an Institutional SNP any time during the measurement year or are living long-term in an institution any time during the measurement year • Members with frailty and advanced illness during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The measurement year and the year prior to the measurement year				

Coding

CPT	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398, 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350, 74261, 74262, 74263, 81528, 82270, 82274 Exclusions: 44150-44153, 44155-44158, 4210-44212

HCPCS	G0104, G0105, G0121, G0328 Exclusions: G0182, G0213-G0215, G0231, M1017, S0271, Q5003-Q5008, Q5008, Q5010
ICD-10	Exclusions: C18.0 - C18.9, C19, C20, C21.2, C21.8, C78.5, Z51.5 Z85.038, Z85.048, L89.000-L89.026, L89.026, L89.029

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients in need of COL screening
    - Perform outreach by mail, telephone, or other method
    - Address recommended colorectal cancer screening during patient encounter
    - Identify patients who had a screening during applicable time frame and submit supplemental data
- Provide patients with all their COL screening options to increase likelihood of a completed screen
    - Fecal occult blood test (FOBT) during the measurement year
    - Flexible sigmoidoscopy during the measurement year or the four years before the measurement year
    - Colonoscopy during the measurement year or the nine years before the measurement year
    - CT colonography during the measurement year or the four years before the measurement year
    - FIT-DNA test during the measurement year or the two years before the measurement year
- Use diagnosis codes to report exclusions. Correctly coding these conditions may prevent medical record requests.
- Evidence of a colonoscopy may be recorded under surgical history; with at least the year it was done if the exact date is not known and the location of the colonoscopy procedure
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy), and the date when the screening was performed meets criteria
- Work with Summit Health to implement a FIT direct mail program

Measure	Diabetes Care – HbA1c Controlled	Measure Target
Description	Percent of plan members with diabetes who had an A1C lab test during the year that showed their average blood sugar is controlled (<8%)	>87%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	MA enrollees' most recent HbA1c level is less than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100 (*good control*).				
Denominator	Diabetic MA enrollees ages 18-75 with diabetes (type 1 and type 2)				
Exclusions	• Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year • Members in hospice or using hospice services anytime during the measurement year • Members who died any time during the measurement year • Members receiving palliative care • Members 66 years of age and older as of December 31 of the measurement year who enrolled in an Institutional SNP any time during the measurement year or are living long-term in an institution any time during the measurement year • Members with frailty and advanced illness during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The measurement year				

Coding

CPT	OP: 99201-99205, 99211-9215, 99241-99245, 99347 -99350, 99381-99387, 99391-99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345

	Test: 83036, 83037, 3044F, 3045F, 3046F
HCPCS	Exclusions: S0271, G0182
ICD-10	Exclusions: Z51.6

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider reports to identify diabetic patients or use an alternative patient registry to manage this population
- Schedule frequent follow-up appointments for members with diabetes
- Order routine HbA1c tests every three months for patients with HbA1c levels >9.0% and every six months for patients in the controlled range
- Refer patients to diabetes self-management (DSM) classes and provide honest communications regarding importance of managing diabetes
- Ensure accurate medical record documentation, which must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <9.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥9.0% or is missing, or if an HbA1c test was not performed during the measurement year.
- Respond timely if a request for medical record review is sent to meet the hybrid method of this measure. If your clinic is open to allowing Summit Health Plan remote electronic medical record (EMR) access, please notify the team to establish connection, as this would be the most efficient and cost-effective way to complete record retrieval and review.

Measure	Controlling High Blood Pressure (CBP)	Measure Target
Description	Percent of plan members ages 18-85 who had a diagnosis of hypertension and whose blood pressure (BP) is adequately controlled (<140/90) during the measurement year	>82%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	MA enrollees whose BP was adequately controlled (<140/90 mm Hg)				
Denominator	MA enrollees 18-85 years of age who had a diagnosis of hypertension (HTN)				
Exclusions	• Members in hospice or using hospice services anytime during the measurement year • Members who died any time during the measurement year • Members receiving palliative care • Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant on or prior to December 31 of measurement year • Members with a diagnosis of pregnancy during the measurement year • Members 66 years of age and older as of December 31 of the measurement year who enrolled in an Institutional SNP any time during the measurement year or are living long-term in an institution any time during the measurement year • Members with frailty and advanced illness during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The measurement year				

Coding

CPT	OP: 99201-99205, 99211-99215, 99241-99245, 99347 -99350, 9381-99387, 99391-99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345 Systolic <140: 3074F, 3075F

	Diastolic <90: 3079F, 3078F
HCPCS	G0402, G0438, G0439, G0463, T1015 Exclusions: S0271, S0311,G0182, G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046
ICD-10	I10, I11.9, I12.9, I13.10 Opt Exclusions: N17.8, N17.9, N18.4-N18.9, S85.4, S95.6, V45.11

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients with high blood pressure or use an alternative patient registry to manage this population
- Outreach to patients to schedule follow-up appointments and diagnostic tests
- Take blood pressure at multiple touch points throughout the visit if the initial reading is elevated, document each reading in the EHR
- Ensure staff is trained to maintain skills to take accurate blood pressure readings
- Ensure patients with an elevated blood pressure have scheduled follow-up visits to work towards a controlled blood pressure
- Coordinate care with specialists, such as endocrinologists, nephrologists and cardiologists
- Emphasize the importance of medication adherence and the benefits of controlled blood pressure
- Counsel patients on healthy lifestyle changes, such as improved diet and increased exercise and their effect on blood pressure control
- Ensure accurate medical record documentation, which must include a note indicating the date when the BP measurement was recorded and the result.
- Respond timely if a request for medical record review is sent to meet the hybrid method of this measure. If your clinic is open to allowing Summit Health Plan remote electronic medical record (EMR) access, please notify the team to establish connection, as this would be the most efficient and cost-effective way to complete record retrieval and review.

Measure	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Measure Target
Description	Percent of plan members with heart disease who were dispensed at least one high or moderate-intensity statin medication during the measurement year	>90%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	MA enrollees were dispensed at least one high or moderate-intensity statin medication during the measurement year				
Denominator	MA enrollee 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				
Exclusions	• Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year • Members who have in virto fertilization (IVF) during the measurement year or the year prior to the measurement year • Members dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year • Members with evidence of end-stage renal disease (ESRD) or dialysis during the measurement year or the year prior to the measurement year • Members with cirrhosis during the measurement year or the year prior to the measurement year • Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year • Members in hospice or using hospice services anytime during the measurement year • Members who died any time during the measurement year • Members receiving palliative care • Members 66 years of age and older as of December 31 of the measurement year who enrolled in an Institutional SNP any time during the measurement year or are living long-term in an institution any time during the measurement year • Members with frailty and advanced illness during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current				

	Medicare Star Rating Technical Note.
Continuous Enrollment	The measurement year and the year prior to the measurement year

Coding

CPT	33510-33519, 33521-33523, 33533-33536 Exclusions: 99377-99378
HCPCS	Exclusions: Q5004-Q5008, Q5010, S9126, T2042-T2046, G0182, M1017, Z51.5
ICD-10	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9I21.A1, I21.A9, I25.2 *Myalgia*: M79.1, M79.10–M79.12, M79.18 *Myositis*: M60.80–M60.819; M60.821–M60.829; M60.831–M60.839; M60.841–M60.849; M60.851–M60.859; M60.861–M60.869; M60.871–M60.879; M60.88–M60.9 *Myopathy*: G72.0, G72.2, G72.9 *Rhabdomyolysis*: M62.82

Qualifying medications

High Intensity Statin	Atorvastatin 40-80 mg Amlodipine-atorvastatin 40-80 mg Rosuvastatin 20-40 mg Ezetimibe-simvastatin 80mg Simvastatin 80 mg
Moderate Intensity Statin	Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimibe-simvastatin 20-40mg Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin 40-80 mg Pitavastatin 2-4 mg

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients with heart disease
- Prescribe at least one high-intensity or moderate-intensity statin medication during the measurement year to patients diagnosed with ASCVD
- Educate on the importance of statins and medication adherence and discuss patient-specific barriers to adherence
- Once patients demonstrate they tolerate statin therapy, encourage them to obtain 90 day supplies at their pharmacy or through mail order

Measure	Statin Therapy for Patients with Diabetes (SUPD)	Measure Target
Description	Percent of plan members 40-75 years of age who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period	>92%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	The number of member-years of MA enrollees 40-75 years old who received a statin medication fill during the measurement period				
Denominator	MA enrollees 40-75 years old with at least two diabetes medication fills during the measurement period				
Exclusions	• Members in hospice or using hospice services anytime during the measurement year • Members with evidence of end-stage renal disease (ESRD) or dialysis during the measurement year • Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year • Members with a diagnosis of pregnancy during the measurement year or the year • Members with liver disease during the measurement year • Members with pre-diabetes during the measurement year • Members with polycystic ovary syndrome during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The measurement year and the year prior to the measurement year				

Coding

CPT	Exclusions: 99377-99378
HCPCS	Exclusions: Q5004-Q5008, Q5010, S9126, T2042-T2046, G0182, M1017, Z51.5
ICD-10	

Qualifying medications	
High Intensity Statin	Atorvastatin 40-80 mg Amlodipine-atorvastatin 10-20 mg Ezetimbe-atorvastatin 40-80 mg Rosuvastatin 20-40 mg Simvastatin 80 mg Ezetimbe-simvastatin 80 mg
Moderate Intensity Statin	Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Ezetimbe-atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimbe-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
Low Intensity Statin	Simvastatin 10 mg Ezetimibe-simvastatin 10 mg Sitagliptin-simvastatin 10 mg Pravastatin 10-20 mg Lovastatin 20 mg Niacin-lovastatin 20 mg Fluvastatin 20-40 mg Pitavastatin 1 mg

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients with diabetes
- Educate on the importance of statins and medication adherence and discuss patient-specific barriers to adherence
- Develop a medication routine with each patient if they are on multiple medications that require them to be taken at different times, use pill boxes or other organization methods
- Advise patients to set up reminders and alarms for when medications are due
- Discuss potential side effects and ways to treat the side effects of medications
- Once patients demonstrate they tolerate statin therapy, encourage them to obtain 90-day supplies at their pharmacy or through mail order

Measure	Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)	Measure Target
Description	Percent of discharges for members 18 years of age and older who had evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge	>78%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	Documentationof patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge. Does not include patient engagement that occurs on the date of discharge				
Denominator	Number of discharges by MA enrollees 18 or older from acute or nonacute inpatient discharges on or between January 1 and December 31 of the measurement year				
Exclusions	• Members in hospice or using hospice services anytime during the measurement year • Members who died any time during the measurement year For a complete list of exclusions, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.				
Continuous Enrollment	The date of discharge through 30 days after discharge (31 total days)				

Coding

CPT	98966, 98967, 98968, 98969, 98970, 98971, 98972, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99444, 99455, 99456, 99457, 99458, 99483, 99495, 99496 Exclusions: 99377-99378
HCPCS	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015 Exclusions: Q5004-Q5008, Q5010, S9126T2042-T2046, G0182, M1017, Z51.5

ICD-10	

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients who need engagement after inpatient discharge
- Update workflows as needed for multidisciplinary communication and shared accountability. Standardize plans, procedures, forms, and training, as appropriate
- The full Transitions of Care measure includes 3 additional elements. To improve full compliance, ensure the completion the following additional sub-measures:
    - Notification of Inpatient Admission: Ensure documentation in your EHR of the reciept of notification of admission within the first day following the admission
    - Medication Reconciliaton Post-Discharge: Ensure documentation/coding in your EHR includes a Medication Reconcilation within 30 days of the discharge data
    - Receipt of Discharge information: Ensure documentation in your EHR of the reciept of notification of discharge within the first day following the admission
- Ensure documentation of the following includes dates of service for notification of inpatient admission, receipt of discharge information, patient engagement after discharge, and medication reconciliation post-discharge in the medical record
- In order to get notifications of admissions and discharges, connect to the Collective Medical Platform (formerly known as PreManage), talk to your Summit Provider Liaison for more information
- Summit Health has a team of clinicians dedicated to assisting high risk members during the transition from inpatient to their next level of care, which can include completing a medication reconciliation. If you have interest in partnering more closely with this team talk to your Summit Provider Liaison for more information.
- Ensure accurate medical record documentation, which must include a note indicating the date when the patient engagement occurred. Any of the following meet criteria:
    - An outpatient visit, including office visits and home visits
    - A telephone visit
    - A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication
    - An e-visit or virtual check-in (asynchronous telehealth) where two-way interaction, which was not real-time, occurred between the member and provider.
- If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria
- Respond timely if a request for medical record review is requested to meet the hybrid method of this measure. If your clinic is open to allowing Summit Health Plan remote electronic medical record (EMR) access, please notify the team to establish connection, as this would be the most efficient and cost-effective way to complete record retrieval and review.

Measure	Annual Wellness Visit / Physical Exam
Description	Percent of plan members that have an annual wellness visit or physical exam with any of the following codes (G0402, G0403, G0404, G0405, G0438, G0439, G0468, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99397) during the measurement period

Measure Target

>75%

Measure Specification

Telehealth Eligibility	Yes	No			
Data Source	HEDIS (Claims)	HEDIS Hybrid (Claims and MRR)	Prescription Drug Event	CAHPS Survey	HOS Survey
Numerator	MA Enrolless have annual physical or wellness visit				
Denominator	All MA enrollees ages 18+				
Exclusions	N/A				
Continuous Enrollment	N/A				

Coding

CPT	G0402, G0403, G0404, G0405, G0438, G0439, G0468, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99397
HCPCS	
ICD-10	

Strategies for Improvement

- Use the outreach rosters on the Summit Health provider progress reports to identify patients who need an annual wellness visit
- Schedule an annual wellness visit early in the year to maximize benefit
- Convert sick visits into comprehensive wellness exams whenever possible
- Schedule a “wellness day” to focus on AWVs
- Maximize member encounter – this may be the only visit of the year to address routine screenings and prescription drug regiment. This is a great time to complete the once-a-year screenings for kidney health screening, falls risk, improving Bladder Control and Monitoring Physical Activity
- Have patients complete their health risk assessment (HRA)

Frequently Asked Questions (FAQs)

1. **Where can additional information be found on the Star Measures?**

   For more information, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData. Please reference the most recent:

   - Technical Notes for Star Measures
   - Display Measure Notes for display measures

2. **Are patients ages 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long term in an institution, patients ages 66-80 with frailty and advanced illness OR patients ages 81 and older with frailty excluded from measures?**

   Yes, members with above conditions and according to Frailty Value Set as indicated by the NCQA are excluded from select measures. For more information, visit https://blog.ncqa.org/improving-care-advanced-illness-frailty/.

3. **What are other ways, in addition to the eight incentive measures, that clinics can improve patient health and impact Star Measures?**

   Appendix A provides a list of additional Stars measures that providers can influence. For more measure details, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.

4. **How did Summit Health determine the Measure Targets indicated in the Provider Incentive Measure Guide?**

   The Measure Targets indicated on the Measure Detail pages in this Provider Incentive Measure Guide are based on SY 2024 published cut points for achieving 5 Stars on the measures. These measure targets do not reflect the gap closure percentage formulas for the CGIP nor the formula for the ACIP.

   For more details on the SY 2024 cut points, visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData and reference the most current Medicare Star Rating Technical Note.

   For more details on the formulas for the CGIP and ACIP, reference the Primary Incentive Program contract.

Appendix A: MAPCIP Measures, Services, and Member Cost-Share

Measure	Services	Member Cost-Share when Billed as Preventive Service
Breast Cancer Screening (BCS)	Mammogram	No cost share
Colorectal Cancer Screening (COL)	Fecal occult blood test (FOBT)	No cost share
	Flexible sigmoidoscopy	No cost share
	Colonoscopy	No cost share
	CT colonography	Cost-shares apply
	Stool DNA with fecal immunochemical test (FIT)	No cost share
Diabetes Care – HbA1c Controlled (CDC-HbA1c Poor Control)	HbA1c lab test	Cost-shares apply
Controlling High Blood Pressure (CBP)	Blood pressure reading (likely associated with a PCP visit)	No cost share for the reading itself, however cost-share will apply to the visit
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Prescription fill for a high-intensity or moderate-intensity statin medication	Cost-shares apply
Statin Therapy for Patients with Diabetes (SUPD)	At least 2 diabetic medication fills and 1 statin prescription fill	Cost-shares apply
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)	Outpatient visit	Cost-shares apply
	Telephone visit	Cost-shares apply
	Transitional care management services	No cost share for the service itself, however cost-share will apply to the visit
	E-visit or virtual check-in	Cost-shares apply
Access to care incentive payment	Welcome to Medicare Visit	No cost share
	Medicare Annual Wellness Visit	No cost share
	Annual Physical Exam	No cost share

Appendix B: Other Star Measures Impacted by Providers

Measure	Weight	Description and Strategies for Improvement
Annual Flu Vaccine[1]	1	Percent of plan members who got a vaccine (flu shot) CAHPS question: • Have you had a flu shot since July 1, (of previous year)? Strategies for improvement: • Educate patients on the benefits of flu vaccinations and encourage compliance every flu season (Oct. to May) • Recommend annual flu vaccinations • Review vaccination records for all routine vaccines and make recommendations, as appropriate
Monitoring Physical Activity	1	Percent of plan members 65 years of age or older who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the measurement period HOS survey questions: • In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. • In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program. Strategies for improvement:

		• Screen patients about their level of physical activity and if they exercise regularly at every patient encounter • Encourage patient to start, increase, or maintain their level of physical activity with recommendations for activity modification, as appropriate
Osteoporosis Management in Women who had a Fracture (OMW)	1	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months <u>Strategies for improvement:</u> • Use the outreach rosters on the Summit Health provider progress reports to identify patients in need of screening • If your patient is at risk for osteoporosis, a BMD test should be performed every 2 years • Female patients over the age of 67 should receive a BMD test **within 6 months** of a fracture

Diabetes Care – Eye Exam	1	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year
		
		<u>Strategies for improvement:</u>
		
		• Use the outreach rosters on the Summit Health provider progress reports to identify diabetic patients in need of an eye exam
		
		  ○ Perform outreach by mail, telephone, or other method
		
		  ○ Address recommended diabetic retinal eye exam during patient encounter
		
		• If you have a copy of the patient's eye exam in your office chart but the patient has an open care gap, you may file an informational (zero dollar) claim to close the gap
		
		• Ask eye care professionals to fax patients' retinal eye exam reports to your office

		• Refer patients to optometrist or ophthalmologist for dilated retinal eye exam, annually, and explain why this is different than a screening for glasses or contacts • Patients with positive retinopathy results need an annual exam. Those with negative results may be examined every two years.

Diabetes Care – Kidney Disease Monitoring	1	Percent of plan members with diabetes who had a kidney function test during the year
		
		<u>Strategies for improvement:</u>
		
		• Use the outreach rosters on the Summit Health provider progress reports to identify diabetic patients in need of a kidney function test
		
		  ○ Perform outreach by mail, telephone, or other method
		
		  ○ Address recommended diabetic kidney function test during patient encounter

Reducing the Risk of Falling[1]	1	Percent of plan members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner during the measurement period <u>HOS survey questions:</u> • A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months have you had a problem with balance or walking? • Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: Suggest

		that you use a cane or walker; suggest that you do an exercise or physical therapy program; suggest a vision or hearing test. <u>Strategies for improvement:</u> • Conduct medication reviews with patients to identify any adverse side effects, such as dizziness, drowsiness, or others affecting balance or increase risk of falls • Encourage participation in physical activity to promote strength and balance • Refer to health plan resources and programs, such as Summit Health Coaching or Silver & Fit
Improving Bladder Control	1	Percent of plan members 65 years of age and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider <u>HOS survey questions:</u> • Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? • There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? <u>Strategies for improvement:</u> • Screen patients for urinary incontinence • Discuss bladder training exercise, medication, and surgery, as appropriate
Getting Needed Care	4	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including from specialists. <u>CAHPS survey questions:</u>

		• In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? <u>Strategies for improvement:</u> • Create and maintain positive patient experiences as part of the clinic culture • Provide patient education that meets health literacy standards; use teach-back when discussing treatment and prevention plans • Remind patients that if they receive a CAHPS survey to please fill them out and return them • Develop and adhere to standards for appointment scheduling waits and appointment wait times; offer a wait list or cancellation list process, if able
Getting Appointments and Care Quickly	4	Percent of the best possible score the plan earned on how quickly members get appointments and care. <u>CAHPS survey questions:</u> • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? <u>Strategies for improvement:</u> • Create and maintain positive patient experiences as part of the clinic culture • Provide patient education that meets health literacy standards; use teach-back when discussing treatment and prevention plans

		• Remind patients that if they receive a CAHPS survey to please fill them out and return them • Develop and adhere to standards for appointment scheduling waits and appointment wait times; offer a wait list or cancellation list process, if able
Care Coordination	4	Percent of the best possible score the plan earned on how well the plan coordinates members' care. <u>CAHPS survey questions:</u> • In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? <u>Strategies for improvement:</u> • Create and maintain positive patient experiences as part of the clinic culture • Provide patient education that meets health literacy standards; use teach-back when discussing treatment and prevention plans

		• Remind patients that if they receive a CAHPS survey to please fill them out and return them • Develop workflows for care coordination with specialists and other care management team members
Transitions of Care – Medication Reconciliation Post-Discharge	1[2]	Percent of discharges for members 18 years of age and older who had evidence of medication reconciliation on the date of discharge through 30 days after discharge (31 total days) Strategies for improvement: See Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)
Transitions of Care – Notification of Inpatient Admission	1[2]	Percent of discharges for members 18 years of age and older who had documentation of receipt of notification of inpatient admission on the day of admission or the following day. Strategies for improvement: See Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)
Transitions of Care – Receipt of Discharge Information	1[2]	Percent of discharges for members 18 years of age and older who had documentation of receipt of discharge information on the day of discharge or the following day. Strategies for improvement: See Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)
Transitions of Care - Average	1[2]	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information Strategies for improvement: See Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)

Plan All-Cause Readmission	1[2]	Percent of acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge <u>Strategies for improvement:</u> • Update workflows as needed for multidisciplinary communication and shared accountability. Standardize plans, procedures, forms, and training, as appropriate. • In order to get notifications of admissions and discharges, connect to the Collective Medical Platform, talk to your Summit Provider Liaison for more information. • Summit Health has a team of clinicians dedicated to assisting high risk members during the transition from inpatient to their next level of care, which can include completing a medication reconciliation. If you have interest in partnering more closely with this team talk to your Summit Provider Liaison for more information
Medication Adherence for Diabetes Medications	3	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. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator). <u>Strategies for improvement:</u> • Standardize 90-day prescriptions and refills • Reduce the number of daily doses of medications; if possible, prescribe once daily medications • Educate patients on the importance of medication adherence

		• Schedule frequent clinic visits (every 2 months)
Medication Adherence for Hypertension (RAS antagonists)	3	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 This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). <u>Strategies for improvement:</u> • Standardize 90-day prescriptions and refills • Reduce the number of daily doses of medications; if possible, prescribe once daily medications • Educate patients on the importance of medication adherence • Schedule frequent clinic visits (every 2 months)
Medication Adherence for Cholesterol (Statins)	3	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. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). <u>Strategies for improvement:</u> • Standardize 90-day prescriptions and refills

		• Reduce the number of daily doses of medications; if possible, prescribe once daily medications • Educate patients on the importance of medication adherence • Schedule frequent clinic visits (every 2 months)

1. Annual Flu Vaccine and Reducing the Risk of Falling are measures included in Arcadia.
2. Transitions of Care and Plan All-Cause Readmission are new Star Measures for Star Year 2024.