STARS

BEST PRACTICE GUIDE

2026

Alignment Health™

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FILE SUBMISSION

AS OFTEN AS POSSIBLE

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

PY2026 DATA COLLECTION DEADLINES

- Last day to upload records to AVA: February 19, 2027.
- Last day for Non-Standard Supplemental file submission (NSSD): February 25, 2027.
- Last day for Standard Supplemental file submission (SSD): March 25, 2027.

NAMING CONVENTION

HEDIS file

- IPA_STARs_Suppl_YYYYMMDD (.xlsx format)

Medical Record file

- PatientID#_LastName_FirstName_DOB (DDMMYY)

SUBMISSION PROCESS

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

BREAST CANCER SCREENING (BCS-E)

EVERY 2 YEARS

(Acceptable Date Range: 10/01/2024–12/31/2026)

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

Demographic: Females, 40 – 74 years old

BEST PRACTICES

- Document patient-self-reported history of mammogram – include the month and year that the mammogram was completed.
- Patient's refusal will not make them ineligible for this measure.
- Send/mail referral for mammogram prior to appointment to encourage completion before appointment date; results can be reviewed during visit.
- Set up alerts within your EHR system to notify providers when patients are due for screenings. This helps providers take action during routine visits.

HOW TO CODE

CPT:

77061 – Digital breast tomosynthesis (DBT) for a single breast

77062 – Digital breast tomosynthesis (DBT) for both breasts

77065-77067 – Mammography

EXCLUSION CODES

ICD-10:

Z90.13 – History of Bilateral Mastectomy

Z90.11 – History of Right Mastectomy

Z90.12 – History of Left Mastectomy

Note: Both Right and Left Mastectomy will need to be done for full exclusion

DOCUMENTATION FOR EXCLUSIONS

- Document if patient has history of bilateral or dual unilateral mastectomy.
- Members who received gender-affirming chest surgery with a diagnosis of gender dysphoria.
- Hospice.
- Living in Long Term Care.
- Deceased.
- Palliative Care.
- Frailty and Advanced Illness.

COLORECTAL CANCER SCREENING (COL-E)

FREQUENCY VARIES

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

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

Document in the medical record if the patient has completed one of these tests and include date.

Demographic: 45 – 75 years old

BEST PRACTICES

- Discuss the importance of early detection and encourage screening.
- Set up alerts within your EHR system to notify providers when patients are due for screening. This helps providers take action during routine visits.

- Document the patient's self-reported history data, including the month and year completed, the type of screening, and the results.
- Patient's refusal will not make them ineligible for this measure. Recommend a FIT-DNA or FOBT if the patient refuses a colonoscopy. Send/mail FOBT kit (if applicable) to patient prior to appointment to encourage completion before appointment date; results can be reviewed during visit.

HOW TO CODE

Report Colorectal Cancer Screenings:

CPT:

45378 – Colonoscopy, flexible; diagnostic

82270 – Fecal Occult Blood Test (FOBT)

82274 – Fecal Immunochemical Test (FIT)

81528 – Cologuard

74261, 74262, 74263 – CT Colonography

HCPCS:

G0121 – Colonoscopy on individual not meeting criteria for high risk

G0105 – Colonoscopy on individual at high risk

G0104 – Flexible sigmoidoscopy

DOCUMENTATION FOR EXCLUSIONS

- Members who had colorectal cancer or a total colectomy any time during history.
- Members in hospice or using hospice services anytime during the measurement year.
- Palliative Care.
- Frailty and Advanced Illness.
- Members who had colorectal cancer or a total colectomy any time during history through December 31 of the measurement year.
- Living in Long Term Care.
- Members who died any time during the measurement year.

CONTROLLING BLOOD PRESSURE (CBP)

EVERY VISIT

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

Demographic: 18 – 85 years old

BEST PRACTICES

- Blood pressures can be captured during a telehealth visit, e-visit and virtual check-ins.
- Document the patient's self-reported blood pressure. Any digital device may be used by the patient, but non-digital devices are not acceptable.

- Ensure patient is properly positioned (i.e., sitting, feet flat on the ground, elbow at heart level).
- Encourage office staff to take patient's blood pressure at the beginning and end of the appointment. If multiple blood pressure (BP) readings are documented on the same date of service, the lowest systolic and lowest diastolic BP results will be used.
- Ensure CPT-II codes for BP readings are coded and submitted for every visit.
- Set follow-up appointments for patients with reading above 140/90 to ensure blood pressure is in healthy range before end of the year.

HOW TO CODE

CPT-II:

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

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

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

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

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

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

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services anytime during the measurement year.
- End-stage renal disease (ESRD): dialysis, nephrectomy or kidney transplant.
- Living in Long Term Care.
- Members in hospice or using hospice services anytime during the measurement year.
- Palliative Care.
- Living in Long Term Care.

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

ANNUALLY

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

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

BEST PRACTICES

- Review the full list of patient's medications in the medical record including details such as the medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
- Ensure both CPT codes are reported for compliance.
- Maintain documentation that shows the medication review was conducted. This is essential for compliance with HEDIS measures.

HOW TO CODE

Report that a medication review was completed:

CPT-II:

1159F, 1160F

CPT:

99605, 99606, 90863, 99483

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services any time during the measurement year.
- Member who died any time during the measurement year.

CARE FOR OLDER ADULTS – FUNCTIONAL STATUS (COA-FHS)

ANNUALLY

Conduct annual functional status assessment. Documentation in the medical record should include evidence of a complete functional status assessment and the date it was performed.

DEMOGRAPHIC

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

FUNCTIONAL STATUS ASSESSMENT

- Must include assessment of ADLs and/or IADLs.
  - ADLs: Assess ADLs or at least 5 of the following:
    Bathing, dressing, eating, transferring, toileting, walking.
  - IADLs: Assess IADLs or at least 4 of the following:
    Shopping, transportation, telephone use, meal preparation, housework, laundry, medication management, finances.
- Other functional independence (i.e., exercise, ability to perform job).

BEST PRACTICES

- Document that ADLs/IADLs were assessed.
- Structured questions may be used to collect member information, including patient-reported outcome measures, screening tools, assessment tools or standardized questionnaires.
- Do not include comprehensive functional status assessments performed in an acute inpatient setting.
- Report appropriate code for assessment.
- Consider using telehealth platforms to facilitate functional assessments, particularly for patients who may have difficulty attending in-person visits.

HOW TO CODE

Report that functional status was assessed:

CPT-II:

1170F – Functional status assessed

CPT:

99483 – Cognitive Assessment and Care Plan Services

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services any time during the measurement year.
- Member who died any time during the measurement year.

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

WITHIN 6 MONTHS OF FRACTURE

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

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

BEST PRACTICES

- The post-fracture treatment window is 180 days. Schedule members for an office visit as soon as possible after the event.
- When clinically appropriate, refer/encourage patient suspected or at risk for Osteoporosis to complete DEXA scan every two years during AWV (regardless of having a fracture).

OSTEOPOROSIS MEDICATIONS:

Bisphosphonates	Other agents
Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid	Abaloparatide, Denosumab, Raloxifene, Raloxifene, Teriparatide

HOW TO CODE

Report that functional status was assessed:

CPT:

Bone Mineral Density Tests:
77080, 77081, 77085, 77086

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services anytime during the measurement year.
- Frailty and Advanced Illness, Living in Long Term Care.
- Palliative Care.
- Members who had osteoporosis therapy during the 12 months prior to the fracture.
- Members who were dispensed a medication or had an active prescription for medication to treat osteoporosis during the 12 months prior to the fracture.
- Members who had a BMD test during the 24 months prior to the fracture.

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

ANNUALLY OR EVERY OTHER YEAR, DEPENDING ON DIAGNOSIS

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

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

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

BEST PRACTICES

- Refer diabetic patients to Optometrist/Ophthalmologist to complete an eye exam during Annual Wellness Visit.
- Report appropriate CPT-II code if patient had an exam in the prior year with a negative result.

- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.
- Document patient self-reported history of retinal eye exam, including the date of the exam, provider type and results. This can be used for any chart chase efforts required for care gap closure.
- Documentation can be in the form of a note or letter prepared by an ophthalmologist or optometrist, primary care physician or other health care provider indicating that an exam was completed by an eye care professional, including the date the procedure was performed and the results.
- Documentation must include a chart note or photograph indicating that fundus photography was performed, along with evidence that the results were reviewed by an optometrist or ophthalmologist.
- Consider investing in portable machines for use in the office or home setting.

HOW TO CODE

CPT-II:

Eye Exam without Retinopathy:
CPTII: 2023F, 2025 F, 2033 F

Eye Exam with Retinopathy:
CPTII: 2022F, 2024 F, 2026F

Diabetic Retinal Eye Exam in Prior Year:
3072F

Unilateral eye enucleation:
CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Bilateral modifier:
CPT: 50

DOCUMENTATION FOR EXCLUSION

- Members in hospice or using hospice services.
- Palliative care.
- Frailty and Advanced Illness.
- Living in Long Term Care.
- Members who died any time during the measurement year.
- Bilateral eye enucleation any time during the member's history through Dec. 31 of the measurement year.

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

EACH VISIT AS APPLICABLE

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

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

BEST PRACTICES

- Schedule labs prior to patient appointment to assist with compliance.
- Use CPT II codes (listed below) on claims to eliminate the need for submitting medical records.
- Ensure documentation clearly states the hemoglobin A1c test result and the date the test was performed, and includes a plan for ongoing patient care if results are out of range.
- Evaluate and document HbA1c levels every three months, with proactive outreach to patients with HbA1c >9% to ensure timely repeat testing before year-end for HEDIS reporting.
- Consider point of care A1c testing in the office setting, when applicable. Please add relevant CPT-II codes (3044F, 3051F, 3052F, 3046F) to claims for specific HbA1c result ranges to reduce chart reviews.

HOW TO CODE

CPT-II:

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

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

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

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

83036, 83037 – HbA1c Lab Test

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services anytime during the measurement year.
- Palliative Care.
- Members who died.
- Frailty and Advanced Illness.
- Living in Long Term Care.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

ANNUALLY

Conduct an annual kidney health evaluation by having the patient complete an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) test.

Demographic: 18 – 85 years old diagnosed with diabetes (Type 1 or Type 2)

BEST PRACTICES

- Order labs for patients to complete prior to the appointment so results are available for discussion with providers on the day of the visit.
- Educate patients about the importance of kidney function and the heightened risk of kidney issues associated with diabetes and discuss healthy lifestyles that can support kidney health.
- Screen for kidney disease regularly by measuring urine albumin to creatinine ratio (UACR) and estimated glomerular filtration rate (eGFR) at least annually for all diabetic patients.
- Use EHR tools to remind clinicians about the need for these screenings during annual wellness visits (AWVs) or other routine care visits.
- Ensure collaboration among healthcare providers, including primary care, endocrinology, nephrology and pharmacy teams, to coordinate care and optimize management for patients with diabetes and kidney disease.

***NOTE:**

- When ordering at **Quest**, please use test panel code 39165, which includes eGFR and uACR.
- When ordering at **LabCorp**, please use test panel code 140301, which includes eGFR and uACR.

HOW TO CODE:

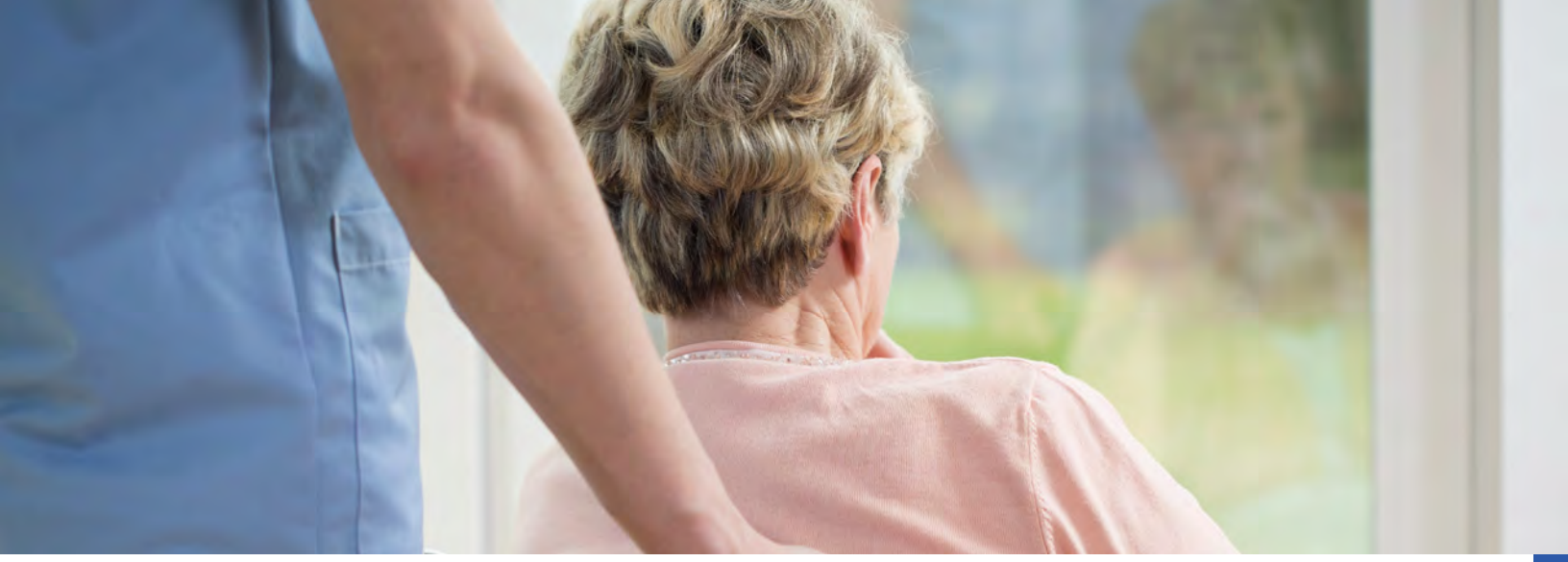
CPT:

Estimated Glomerular Filtration Rate Lab Test:
80047, 80048, 80050, 80053, 80069, 82565

Urine Creatinine Lab Test:
82043, 82570

DOCUMENTATION OF EXCLUSIONS

- End-stage renal disease (ESRD) or dialysis.
- Palliative Care.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died.
- Frailty and Advanced Illness.
- Living in Long Term Care.



TRANSITIONS OF CARE (TRC)

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

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

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

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

BEST PRACTICES

- Notification of Admission.
    - Ensure that when the patient is admitted, the date of when the PCP office is notified of the admission is included in the medical record (needs to be within 2 days of admission).
- Receipt of Discharge Information.
    - Include the discharge summary notes or the summary care notes in the patient's chart.
    - Ensure that the health plan is notified when the patient is discharged from the hospital.
- Patient Engagement After Inpatient Discharge.
    - If patients are uncomfortable with in-person visits, schedule an e-visit or a virtual check-in.
    - Schedule patient for follow-up post-discharge as soon as you are notified of discharge and no later than 7 days post-discharge.

- After discharge, contact the patient and schedule a follow-up appointment with them or their caregiver.
- When conducting a post-discharge follow-up, capture the engagement with the patient as well as the medication reconciliation in one visit.

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

HOW TO CODE

CPT:

98966-98968 – Non-Face-to-Face, Non-Physician Telephone Services

99495 – Transitional Care Management (TCM) services, including communication with the patient or caregiver within two business days of discharge, moderate complexity medical decision-making and a face-to-face visit within 14 days of discharge.

99496 – Transitional Care Management (TCM) services, including communication with the patient or caregiver within two business days of discharge, high complexity medical decision-making and a face-to-face visit within seven days of discharge.

99483 – Assessment of and care planning for a patient with cognitive impairment, including history-taking, exam, standardized assessments and creation of a care plan shared with the patient and/or caregiver.

CPT-II:

1111F – Discharge medications reconciled with the current medication list in outpatient medical records (used for tracking quality measures, not for billing).

DOCUMENTATION OF EXCLUSIONS:

- Members who died.
- Members in hospice or using hospice services any time during the measurement year.

For a complete list of codes, please visit the NCQA website at **ncqa.org** or contact Alignment Star Team at **Stars@ahcusa.com**

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

WITHIN 7 DAYS OF EACH ED VISIT

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

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

BEST PRACTICES

- Schedule a follow-up visit with the patient within 7 days of the discharge.
- Ensure patients notify their primary care provider if they visit the ER for care coordination purposes.
- Schedule telehealth or virtual check-ins for patients with mobility or transportation barrier.
- Flag patients in EHR who have multiple high-risk and chronic conditions.
- Patients must have 2 or more of the following chronic conditions:
  - COPD & Asthma.
  - Unspecified bronchitis.
  - Alzheimer's Disease and Related Disorders.
  - Chronic Kidney Disease (CKD).

- Depression.
- Heart Failure.
- Acute Myocardial Infarction.
- Atrial Fibrillation.
- Stroke and Transient Ischemic Attack (TIA).

- Remove any visit with principal diagnosis for other specified aftercare.
- Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull.

- Address Social Determinants of Health (SDOH).

HOW TO CODE

CPT Codes for Transitional Care Management (TCM):

99495 – Moderate complexity follow-up within 14 days

99496 – High complexity follow-up within 7 days

CPT for Cognitive & Chronic Care Management:

99483 – Cognitive assessment and care planning

CPT for Telephonic Services:

98966-98968 – Non-Face-to-Face, Non-Physician Telephone Services

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice, using hospice services any time during the measurement year.
- Members who died.
- Exclude ED visits that result in an inpatient stay.

For a complete list of codes, please visit the NCQA website at **ncqa.org** or contact Alignment Star Team at **Stars@ahcusa.com**

PLAN ALL CAUSE READMISSION (PCR)

FOLLOW UP AFTER ACUTE INPATIENT AND OBSERVATION STAYS

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

Demographic: 18+ years old

BEST PRACTICES

- Monitor admission, discharge and emergency department visit reports.
- Conduct ongoing, targeted member outreach as appropriate to help prevent potential readmissions.
- Review denominator members with four or more inpatient admissions for potential exclusion opportunities.
- Review denominator members with pre-planned or scheduled surgeries that may qualify for exclusion.
- Review denominator members who entered hospice at any time during the measurement year for exclusions.
- Follow up with provider offices to confirm that patients were seen within the first week post discharge
- Offer telehealth follow-ups for patients with mobility issues
- Ensure accuracy by reconciling medications on discharge instructions with outpatient medication records.
- Address Social Determinants of Health (SDoH)

HOW TO CODE

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

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services any time during the measurement year.
- Member died during the inpatient stay.
- Principal diagnosis of a condition originating in the perinatal period on the discharge claim.
- Planned admissions for:
    - Chemotherapy maintenance.
    - Principal diagnosis of rehabilitation.
    - Organ transplant.
    - Potentially planned procedure without a principal acute diagnosis.
- Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.
- Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

ADVANCED ILLNESS AND FRAILTY

DEFINITIONS

Advanced illness: This is a severe chronic condition that causes general health and function decline.

Frailty: This refers to limited mobility or physical functional impairment that may require the use of durable medical equipment.

BEST PRACTICES

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

DOCUMENTATION

Some measures allow for exclusion based on advanced illness.

Patient must be 66 years of age and older as of December 31 of the measurement year.

Patient must have **two frailty diagnoses** on different dates of service during the measurement year **and an advanced illness diagnosis** within the measurement year or year prior that meet one of the following criteria:

- **At least two** outpatient, observation, ED, telephone, e-visits or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness.
- **A dispensed dementia medication**: donepezil, donepezil-memantine, galantamine, memantine or rivastigmine
- **At least one** acute inpatient encounter with a diagnosis of advanced illness or at least one acute inpatient discharge with a diagnosis of advanced illness on the discharge claim.

Common Advanced Illness Diagnoses

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

Attached table outlines CPT®, HCPCS and ICD-10 codes for each value set. Coding is subject to change and should not be considered official or legal advice. All coding must be supported by medical necessity and appropriate documentation. Please see Frailty and Advanced illness value set table at **https://ava.alignmenthealth.com/patientpriority/guidelines**.
For additional resources, please visit the NCQA website:
http://www.ncqa.org/blog/improving-care-advanced-illness-frailty/

CTM RATE

JANUARY 1 – DECEMBER 31

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

HOW CTM IS CALCULATED

Calculated using the following calculation:

Complaint Rate =

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

HEALTH PLAN MAKES TIMELY DECISIONS ABOUT APPEALS

JANUARY 1 – DECEMBER 31

Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by Independent Review Entity – includes upheld, overturned, and partially overturned appeals (denominator).

A 5-STAR CUT POINT IS NOW 100%

BEST PRACTICES

- Once a notification of a Claims Appeal is sent to your organization, please respond within 3 business days.
- The CMS processing time frame for Claims Appeals is 60 business days.
- Failure to meet this time frame can result in a Corrective Action Plan.

ANNUAL FLU VACCINE

EARLY FALL – EARLY SPRING

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

Demographic: All Patients

BEST PRACTICES

- Remind patients that the flu shot is available at no cost.
- Support patients in finding nearby flu shot locations, including pharmacies and grocery stores.

HOW TO CODE

Submitting correct codes to the health plan can help indicate whether your patients have barriers to getting the flu shot.

CPT:

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

Generic Product Identifier (GPI):

1710002046E620, 1710002023E620, 1710002025E620, 17100020821800, 1710002021E620, 1710002082E620, 17100020251800, 1710002086E520

GETTING APPOINTMENTS AND CARE QUICKLY

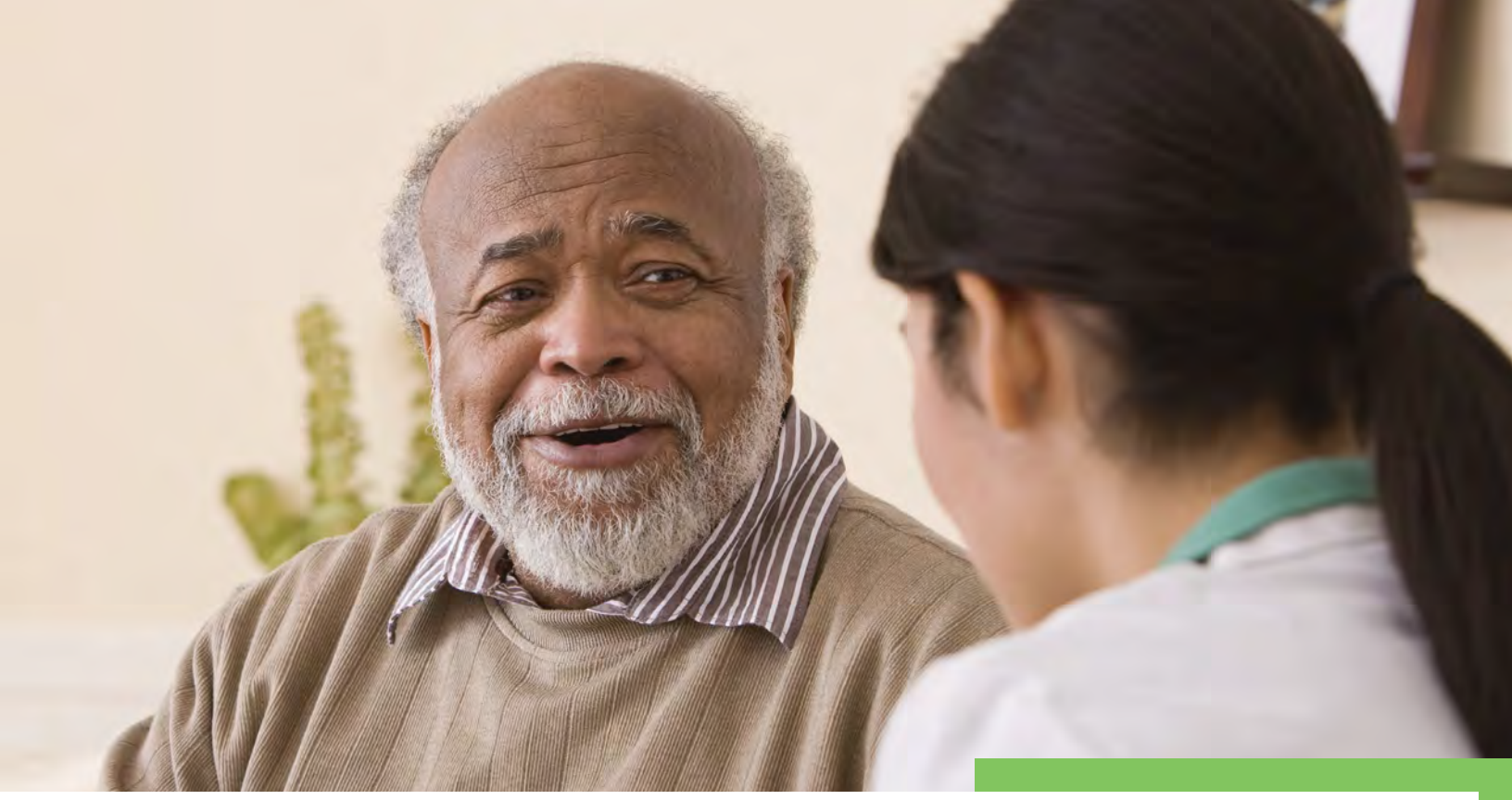
FROM THE PAST 6 MONTHS

Patients rate how often they were able to schedule an appointment and get care as soon as they needed for both urgent and routine care.

Demographic: All Patients

BEST PRACTICES

- Adhere to CMS Standard Access times – for PCP 7 days routine and 48 hours urgent.
- Offer appointments with a nurse practitioner or physician's assistant.
- Encourage patients to make their appointments before they leave your office.



RATING OF HEALTH CARE QUALITY

FROM THE PAST 6 MONTHS

On a scale of 0-10, patients rate the overall quality of their health care.

Demographic: All Patients

BEST PRACTICES

- Ask patients if they received exceptional care today.
- Ask if anything can be improved about their healthcare.
- Reaffirming what the patient says lets the patient know that they were heard, and their perspective was taken into consideration.
- Use knowledge checks to confirm that the patient understands the important aspects of what has been explained.

CARE COORDINATION

FROM THE PAST 6 MONTHS

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

Demographic: All Patients

BEST PRACTICES

- Ensure all medical records and other information about the patient's care is available upon request.
- Follow up and provide test results within a timely matter. If follow-up is not needed, ensure that patient has been explicitly told that there will be no outreach from the office.
- Set realistic expectations for office outreach, test results and any kind of follow-up.
- Review a patient's current medication list with them.
- Help patient set up specialist referrals and other medical appointments.
- Review AVA and confirm with patient other specialist appointments and services.

GETTING NEEDED PRESCRIPTION DRUGS

FROM THE PAST 6 MONTHS

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

Demographic: All Patients

BEST PRACTICES

- Encourage patients to bring in a list of medications at every visit, including over-the-counter medications.
- Review medications with patients at every visit.
- Ask patients about access barriers to obtaining medications.

GETTING NEEDED CARE

FROM THE PAST 6 MONTHS

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

Demographic: All Patients

BEST PRACTICES

- Facilitate referrals and assist with the arrangement of specialist appointments.
- Aim to schedule appointments within CMS standards of 15 days routine and 48 hours urgent.
- Remind patients of the option of telehealth.
- Remind patients of the 24/7 Alignment Concierge line that assists with scheduling an appointment or finding a doctor.

IMPROVING OR MAINTAINING MENTAL HEALTH

EACH VISIT

Providers should assess patient's mental health status.

Demographic: All Patients

BEST PRACTICES

- Screen for depression during every visit and appropriately triage to behavioral health services if needed.
- Encourage self-care practices to improve their mental health such as meditation, regular exercise, healthy eating, and connecting with loved ones.

HOW TO CODE

CPT-II:

Report assessment of mental status:

2014F – Mental Status Assessed

MONITORING PHYSICAL ACTIVITY

There are two HOS measures:

- Improving or Maintaining Physical Health
- Monitoring Physical Activity

EACH VISIT

Providers should assess a patient's level of physical activity and provide education on maintaining physical activity.

Demographic: All Patients

BEST PRACTICES

- Make appropriate recommendations for increasing or maintaining your patient's level of exercise or physical activity.
- Talk to your patients about options for physical activity, such as taking the stairs or walking 20 minutes every day.

HOW TO CODE

CPT-II:

Report patient's activity level was assessed:

1003F – Level of activity assessed

REDUCING THE RISK OF FALLING

EACH VISIT

Providers should discuss falls or problems with balance or walking with patients and suggest fall prevention treatments when applicable.

Demographic: All Patients

BEST PRACTICES

- Patients should have their fall risk assessed. Document any history of falls.
- Talk to your patients about how to mitigate fall risk in their home by removing throw rugs, storing items within easy reach or placing furniture and electrical cords out of walking paths.
- Remind patients to get their vision and hearing checked regularly.

HOW TO CODE

Report patient's risk of falling was assessed:

CPT-II:

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

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

3288F – Falls risk assessment documented

ICD-10:

Z91.81 – History of falling

R29.6 – Repeated falls or tendency to fall

IMPROVING BLADDER CONTROL

EACH VISIT

Providers should discuss whether a patient experiences urine leakage/urinary incontinence.

Demographic: All Patients

BEST PRACTICES

- Patients should be assessed for urine leakage. Document presence or absence of urinary incontinence.
- Discuss various treatment options with a patient experiencing urinary incontinence, such as bladder training exercises, medication or surgery.

HOW TO CODE

CPT-II:

Report patient's incontinence was assessed:

1090F – Presence or absence of urinary incontinence assessed

STATIN THERAPY FOR PATIENTS WITH DIABETES (SUPD)

EACH VISIT

Patients with diabetes should be dispensed at least one statin medication during the calendar year **regardless of LDL levels** to be compliant with the measure.

Demographic: 40 – 75 years old who were dispensed at least two diabetic medication fills.

BEST PRACTICES

- Patient refusal will not make them ineligible for this measure during the measurement year to patients diagnosed with diabetes.
- Diabetic medications used for other conditions, such as GLP1s for weight loss, will still qualify patients into the measure.
- Recommend auto-refill and mail-order services for 90-day maintenance medications, or 100-day prescriptions with up to four refills.
- Respond to refill request same day.
- Identify and address barriers to medication adherence, including understanding benefits, managing side effects, reducing costs and ensuring timely refills.

DOCUMENTATION

- Prediabetes (statin not indicated): R73.03.

EXCLUSIONS INCLUDE:

- Members in hospice or using hospice services at any time during the measurement year.
- Drug-induced myopathy (G72.0).
- Myopathy, unspecified (M60.9).
- Rhabdomyolysis (M62.82).
- Myositis (M60.80).
- Polycystic ovarian syndrome (PCOS) (E28.2).
- Pregnancy, lactation or fertility treatment.
- Cirrhosis of the liver (K74.60).
- End-stage renal disease (ESRD) (N18.6).
- Pre-diabetes (R73.03, R73.09).
- Members who filled a PCSK9 inhibitor or bempedoic acid using Part D benefits during the measurement year without a statin fill or other qualifying exclusion.

For a complete list of codes, please visit the NCQA website at **ncqa.org** or contact the Star Team at **Stars@ahcusa.com**

CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB)

EACH VISIT

Patients using both opioids and benzodiazepines concurrently for 30 cumulative days are noncompliant for the measure and at increased risk of falls, severe respiratory depression, and death. Providers should assess the appropriateness of concurrent use of opioids and benzodiazepines and provide safer alternative therapy as appropriate.

Demographic: Patients aged 18 and older who have been dispensed both opioids and benzodiazepines concurrently.

Exclusion:

- Hospice
- Cancer
- Sickle Cell Disease
- Palliative Care (ICD-10 Z51.5)

BEST PRACTICES:

- Assess the appropriateness of opioid and benzodiazepine use at each visit, ensuring an appropriate indication and duration.
- Educate patients on the risks of concurrent use of opioid and benzodiazepine, including increased fall risk and respiratory depression.
- Offer safer pharmacological and/or non-pharmacological alternatives and taper off benzodiazepine and/or opioid if clinically appropriate.
- If concurrent use of opioid and benzodiazepine is required, limit it to the shortest duration possible (<30 days) and at the lowest effective dose.
- Discontinue non-essential medications when clinically appropriate and ensure pharmacies and members are notified of any discontinued medications.
- If a member is receiving opioids and benzodiazepines from multiple providers, coordinate with other prescribers to optimize therapy and minimize risks.

DOCUMENTATION:

- Document plan for tapering off opioids and/or benzodiazepines when appropriate.
- Document plan for alternative treatments, including safer pharmacological and non-pharmacological options.
- Document patient education on the risks associated with concurrent opioid and benzodiazepine use.
- Document exclusion criteria if applicable, including documentation of hospice care, cancer diagnosis, sickle cell disease or palliative care.

EXCLUSIONS:

Hospice anytime during the measurement year. Members diagnosed with cancer and cancer-related pain treatment. Members diagnosed with palliative care. Members diagnosed with Sickle Cell Disease.

For a complete list of codes, please visit the NCQA website at **ncqa.org** or contact the Star Team at **Stars@ahcusa.com**

POLYPHARMACY USE OF MULTI ANTICHOLINERGICS (ACH)

EACH VISIT

Patients using 2 or more anticholinergic medications concurrently for 30 cumulative days are noncompliant for the measure and at increased risk of cognitive impairment, falls, and functional decline. Providers should assess the appropriateness of poly-ACH medications and provide safer alternative therapy as appropriate.

Demographic: Patients aged 65 and older who have been dispensed two or more anticholinergic medications concurrently.

Exclusion: Hospice

BEST PRACTICES

- Assess the appropriateness of anticholinergic medications at each visit, ensuring an appropriate indication and duration.
- Educate patients on the risks of concurrent anticholinergic therapy, including cognitive impairment and increased fall risk.
- Offer safer pharmacological and/or non-pharmacological alternatives (e.g., cognitive behavioral therapy, physical therapy). Refer to the alternative medication list to anticholinergic medications.
- If concurrent anticholinergic therapy is required, limit it to the shortest duration possible (<30 days) and at the lowest effective dose.
- Discontinue non-essential medications when clinically appropriate and ensure pharmacies and members are notified of any discontinued medications.
- If a member is receiving anticholinergic prescriptions from multiple providers, coordinate with other prescribers to optimize therapy and minimize risks.

DOCUMENTATION:

- Document plan for continuation or discontinuation of concurrent anticholinergic therapies.
- Document plan for alternative treatments, including safer pharmacological and non-pharmacological options.
- Document patient education on the risks associated with concurrent anticholinergic therapy.
- Document exclusion if the patient is in hospice care.

EXCLUSIONS

- Members with at least 1 day of hospice coverage during the measurement year.

For a complete list of codes, please visit the NCQA website at **ncqa.org** or contact the Star Team at **Stars@ahcusa.com**

COMMON ANTICHOLINERGIC MEDICATIONS AND ALTERNATIVES

(This list is for reference and may not include all anticholinergic medications.)

Class	Anticholinergic Drug	Alternative
ANTIEMETIC	PROMETHAZINE, PROCHLORPERAZINE, SCOPOLAMINE	**Allergy**: *cetirizine***, fexofenadine, *loratadine***, desloratadine, levocetirizine, montelukast **Antiemetic**: ondansetron, granisetron
ANTIHISTAMINES	DOXYLAMINE , HYDROXYZINE, MECLIZINE, BROMPHENIRAMINE, CHLORPHENIRAMINE, DIPHENHYDRAMINE, TRIPROLIDINE, CYPROHEPTADINE	**Allergy**: *cetirizine***, fexofenadine, *loratadine***, desloratadine, levocetirizine, montelukast **Antiemetic**: ondansetron, granisetron **Sleep**: Ramelteon, trazodone, *melatonin***
ANTIMUSCARINICS	FESOTERODINE, FLAVOXATE, OXYBUTYNIN, SOLIFENACIN, TOLTERODINE, TROSPIUM, DARIFENACIN	Myrbetriq
ANTIPARKINSON AGENTS	BENZTROPINE, TRIHEXYPHENIDYL	carbidopa & levodopa, carbidopa & levodopa & entacapone, ropinirole, pramipexole, amantadine
ANTISPASMOTICS	DICYCLOMINE, HYOSCYAMINE, CLIDINIUM/ CHLORDIAZEPOXIDE	Linzess

Class	Anticholinergic Drug	Alternative
ANTIDEPRESSANTS	AMOXAPINE, DESIPRAMINE, IMIPRAMINE, NORTRIPTYLINE, PAROXETINE, DOXEPIN	**Depression**: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine er **Sleep**: Ramelteon, trazodone, *melatonin***
SKELETAL MUSCLE RELAXANTS	CYCLOBENZAPRINE, ORPHENADRINE	**Muscle spasm**: Nonsteroidal anti-inflammatory drugs (NSAIDs) **Spasticity**: baclofen tablet or tizanidine tablet/capsule

*American Geriatrics Society. American Geriatrics Society 2023 Updated Beers Criteria for Potential Inappropriate Medication Use in Older Adults. J Am Geriatr Soc 2023.

***Note: The alternative medication list may include over-the-counter (OTC) options, which are not covered under Part D but may be eligible under the Alignment OTC benefits.*

MEDICATION ADHERENCE FOR CHOLESTEROL (STATINS)

EACH VISIT

Patients should remain on a statin medication for at least 80% of calendar year to remain compliant with the measure.

Demographic: 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications.

BEST PRACTICES

- Recommend auto-refill and mail-order services for 90-day maintenance medications, or 100-day prescriptions with up to four refills.
- Respond to refill request same day.
- If change in prescription dosing or directions for use, send a new prescription with updated directions for use to the pharmacy as soon as possible. Have the pharmacy discontinue old prescription.
- Identify and address barriers to medication adherence, including understanding benefits, managing side effects, reducing costs and ensuring timely refills.

EXCLUSIONS

- Members in hospice or using hospice services anytime during the measurement year.
- End-stage renal disease (ESRD) or dialysis coverage dates.

MEDICATION ADHERENCE FOR HYPERTENSION (RASA)

EACH VISIT

Patients should remain on a RASA medication for at least 80% of the calendar year to be compliant with the measure.

Demographic: 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system antagonists (RASA): angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

BEST PRACTICES

- Patients should be prescribed a 90- or **100-day** supply of generic RASA medications **with four (4) refills**. Generic Tier 6 RASA medications are available on our formulary and available at a **$0 copay.**
- Respond to refill request same day.
- If change in prescription dosing or directions for use, send a new prescription with updated directions for use to the pharmacy as soon as possible. Have the pharmacy discontinue old prescription.
- Talk to the patient about their Rx refill barriers.
- Encourage patient to sign up for automatic refills at their pharmacy.
- Encourage patient to have labs performed at least once (1) per year.
- If transportation/mobility is an issue offer mail-order Rx services available.

DOCUMENTATION FOR EXCLUSIONS

- Members in hospice or using hospice services anytime during the measurement year.
- End-Stage Renal Disease (ESRD), including dialysis.
- One or more prescription claims for sacubitril/valsartan (Entresto) under their Part D benefit anytime during the treatment period.

MEDICATION ADHERENCE FOR DIABETES (DIAB)

EACH VISIT

Patients should remain on qualifying diabetes medication for at least 80% of the calendar year to remain compliant with the measure.

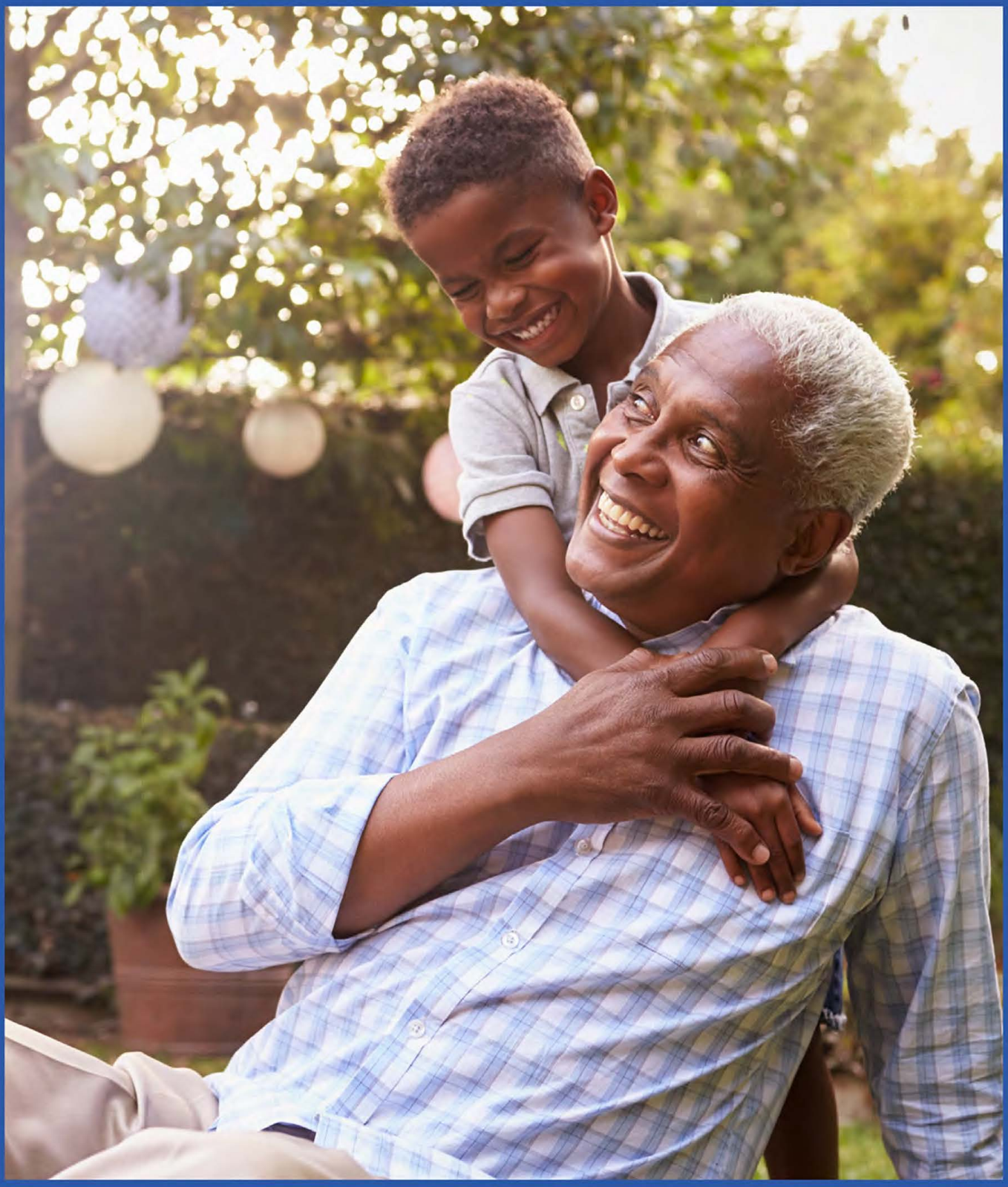
Demographic: 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GIP/GLP-1 receptor agonists, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors. Plan members who take **insulin** are **not included**.

BEST PRACTICES

- Patients should be prescribed a 90- or **100-day** supply of generic diabetes medications with **four (4) refills.**
- Convert diabetic brand medication to lower cost generic alternatives. Generic Tier 6 diabetic medications are available on our formulary and available at a **$0 copay.**
- Respond to refill request same day.
- If change in prescription dosing or directions for use, send a new prescription with updated directions for use to the pharmacy as soon as possible. Have the pharmacy discontinue old prescription.
- Talk to the patient about their Rx refill barriers.
- Encourage patient to sign up for automatic refills at their pharmacy.
- Encourage patient to have labs performed at least once (1) per year.
- If transportation/mobility is an issue offer mail-order Rx services available.
- If A1c is above 8 discuss insulin use with member. Alignment has selected insulin vials at tier 1, available as low as $0 for most plans.

EXCLUSIONS

- Hospice, End-stage renal disease (ESRD) or dialysis.
- One or more prescriptions for insulin.



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