STARS BEST PRACTICE GUIDE 2025

Alignment Health™

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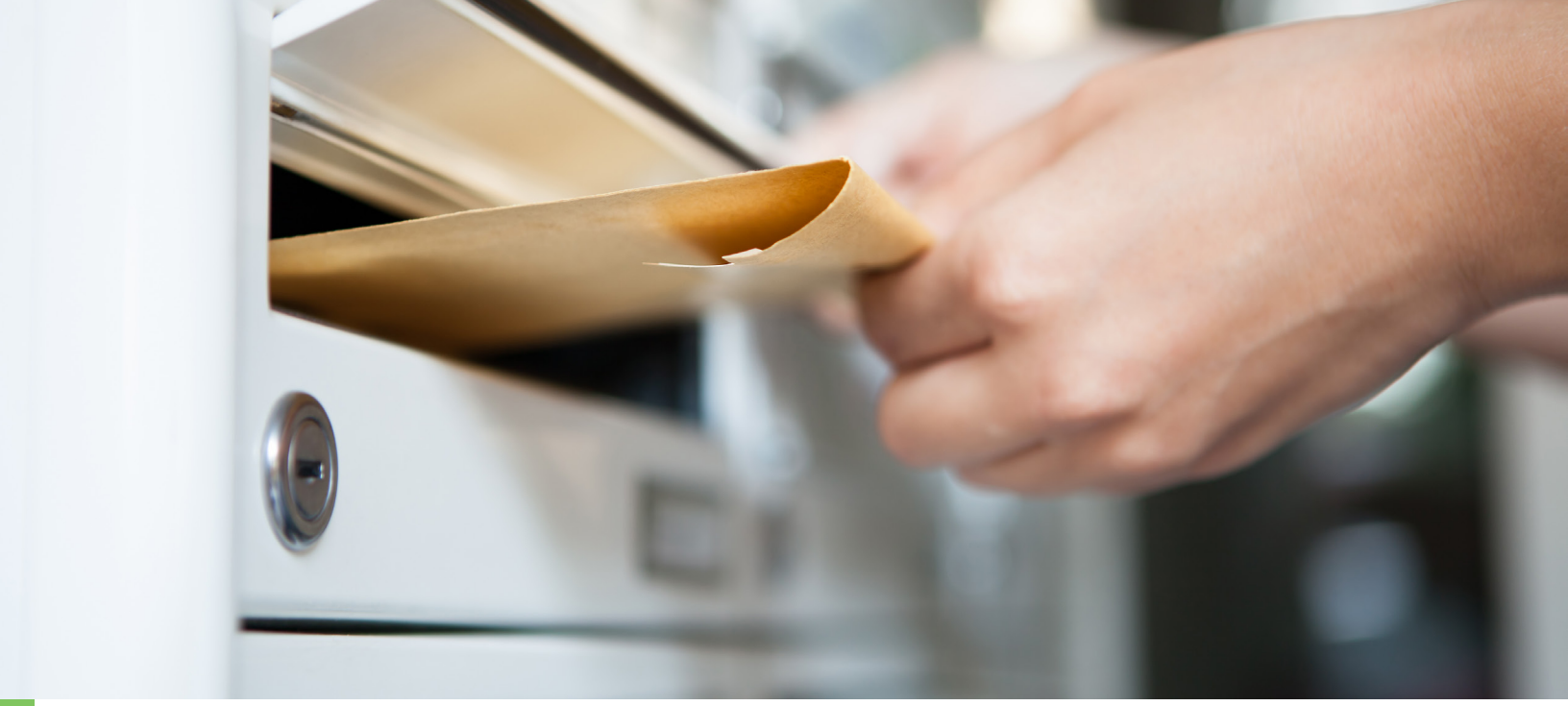


FILE SUBMISSION

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.

TIMEFRAME

Supplemental Data Files

- Accepted through the first week of February for the previous Performance Year for all gaps
- Files are processed on a weekly basis unless otherwise noted (i.e., during a system update)
- Please request a copy of the preferred supplemental file format from your Alignment Health Star team contact

Medical Records

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

NAMING CONVENTION

HEDIS file

- IPA_STARs_Suppl_YYYYMMDD (.xlsx format)

Medical Record file

- PatientID#_LastName_FirstName_DOB (DDMMYY)

SUBMISSION PROCESS

1. Use Alignment's required file layout
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

ANNUAL WELLNESS VISIT (AWV)

ANNUALLY

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

Demographic: All Patients

BEST PRACTICES

- Review open gaps in care to see what preventative screenings the patient is due for in current year and discuss importance of completion with patient
- Send patient lab requisition for standing orders and FOBT kit (if applicable) prior to appointment to encourage completion before appointment date; results can be reviewed during visit
- Schedule annual wellness visits (AWV) preferably within the first 6 months of the year.
- During an AWV, address various factors that influence a patient's health, like behavioral risks, cognitive ability, depression, nutrition, and Social Determinants of Health (SDOH) as these factors can impact a patient's health outcomes and adherence to treatment
- Document all chronic conditions that are current at the time of the encounter. It is important to document and code each current chronic condition at least once every year

HOW TO CODE

Report the Annual Wellness Visit for all Medicare Patients:

HCPCS:

G0438 – Initial Visit
G0439 – Subsequent Visit

ICD-10:

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

DOCUMENTATION

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

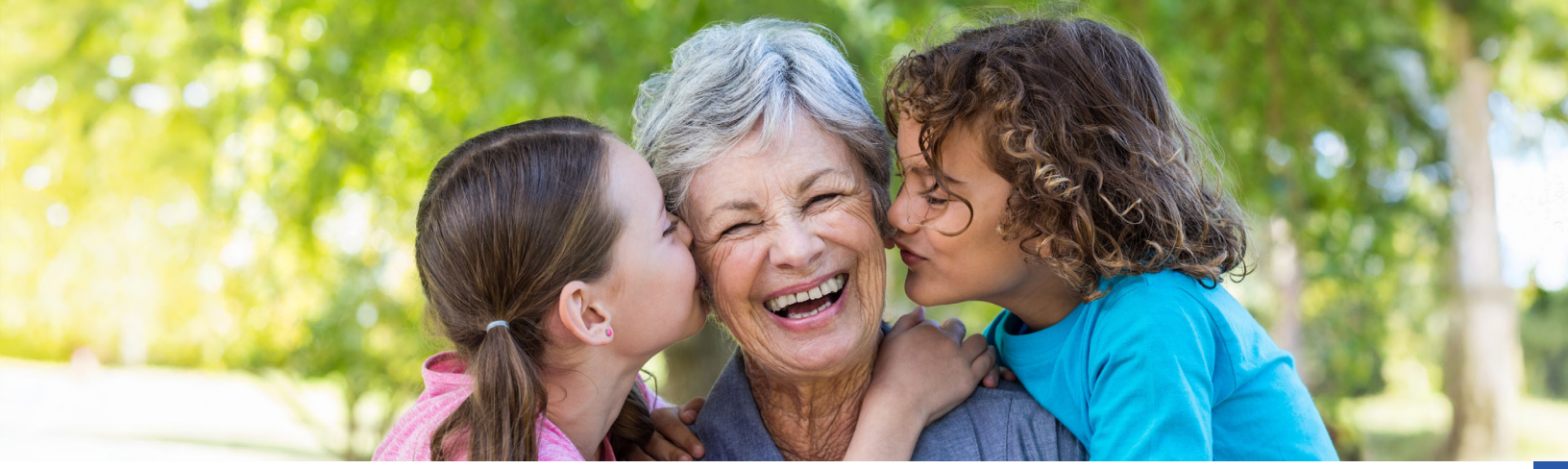
SPECIAL NEEDS PLAN (SNP) CARE MANAGEMENT

ANNUALLY

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

BEST PRACTICES

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



BREAST CANCER SCREENING (BCS-E)

EVERY 2 YEARS

(Acceptable Date Range: 10/01/2023 - 12/31/2025)

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

- Patients who received a mammogram in another country during the acceptable time frame can be documented. Documentation must include the screening name, the screening date, and the result
- Patient's refusal will not make them ineligible for this measure
- Send/mail referral for mammogram prior to appointment to encourage completion before appointment date; results can be reviewed during visit
- Provide referral/authorization for a mammogram during Annual Wellness Visit (if applicable, i.e., not completed prior)
- Understand and address cultural, language, and financial barriers that may prevent women from undergoing mammograms

- Set up alerts within your EHR system to notify providers when patients are due for screenings. This helps providers take action during routine visits
- Follow-up with patient via mailing/phone call to ensure they complete their mammogram
- Promote importance of completing screening during Breast Cancer Awareness Month (October)
- Address individual patient concerns and barriers (i.e., fear of positive results, cultural customs)

HOW TO CODE

HCPCS:

G0202 – Screening Mammography

CPT:

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

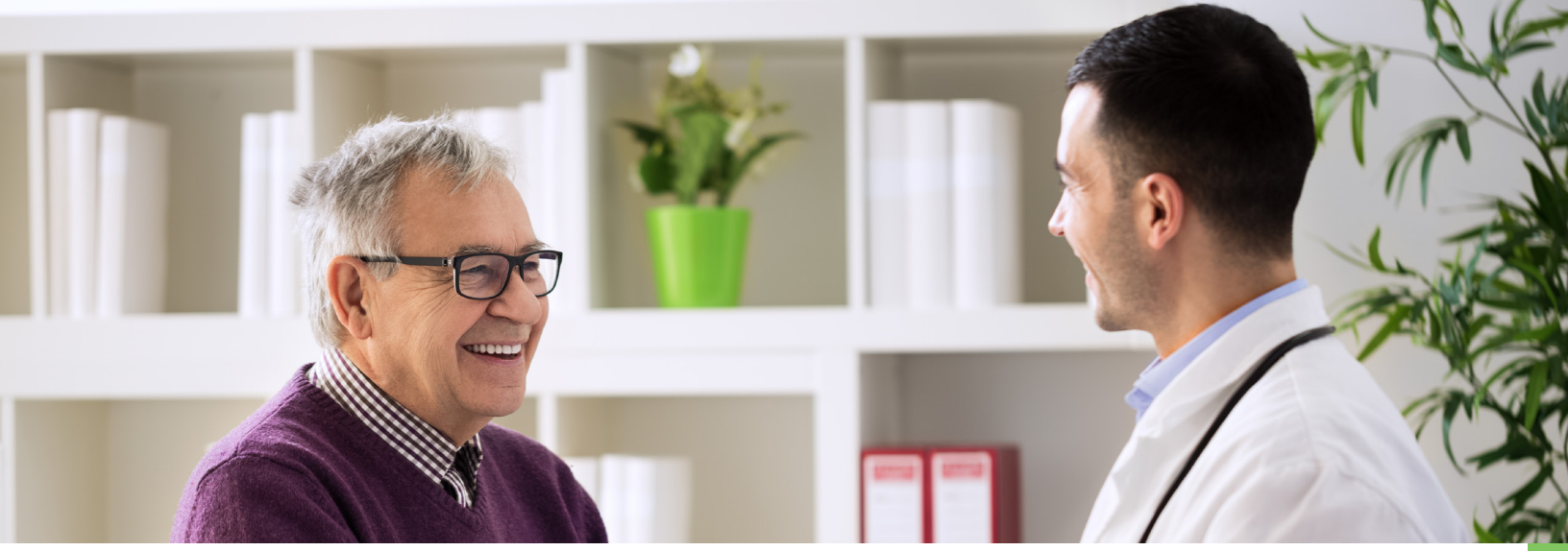
Z90.11 – History of Right Mastectomy

Z90.12 – History of Left Mastectomy

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

DOCUMENTATION

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



COLORECTAL CANCER SCREENING (COL-E)

FREQUENCY VARIES

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

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

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

Demographic: 45 - 75 years old

BEST PRACTICES

- Patients who received a colonoscopy in another country during the acceptable time frame can be documented. Documentation must include the screening name, the screening date, and the result
- Set up alerts within your EHR system to notify providers when patients are due for screening. This helps providers take action during routine visits

- 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
- Stock FOBT kits in offices to provide to the patient at the point of visit
- Encourage colonoscopy when appropriate and provide referral/authorization during Annual Wellness Visit
- Document patient-self-reported history data (must include month and year completed) and send supplemental file
- Address individual patient concerns and barriers (i.e., fear of positive results, cultural customs)
- Call patient to remind them of the importance of completing colon cancer screening

HOW TO CODE

Report Colorectal Cancer Screenings:

CPT:

45378 – Colonoscopy, flexible; diagnostic

82270 – Fecal Occult Blood Test (FOBT)

82274 – Fecal Immunochemical Test (FIT)

81528 – Cologuard

74263 – CT Colonography

HCPCS:

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

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

G0104 – Colorectal cancer screening; flexible sigmoidoscopy

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

DOCUMENTATION

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

CONTROLLING BLOOD PRESSURE (CBP)

EVERY VISIT

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

Demographic: 18-85 years old

BEST PRACTICES

- Patients can self-report blood pressure during telehealth and e-visit
- Blood pressures can be captured during a telehealth visit, e-visit, and virtual check-ins
- Document the patient's self-reported blood pressure. Any digital device may be used by the patient, but non-digital devices are not acceptable
- Telephonic disease management can be conducted for hypertensive patients although any blood pressure results taken in a provider office during same date of service will overrule patient reported

- 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
- Speak to patients about the health risk of hypertension (if applicable) and develop treatment plan
- Ensure CPT-II codes for BP readings are coded and submitted for every visit
- Submit supplemental files on a routine basis; ideally a monthly reconciliation
- Set follow-up appointments for patients with reading above 140/90 to ensure blood pressure is in healthy range before end of the year
- Regularly audit BP control rates and identify patients who are at risk of uncontrolled BP and implement targeted outreach to bring them back into care
- If BP remains uncontrolled despite appropriate management, consider a referral to a cardiologist or hypertension specialist for further evaluation and treatment options

HOW TO CODE

CPT-II:

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

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

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

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

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

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

DOCUMENTATION

- Include all blood pressure readings taken during the visit in progress notes
- Document frailty and advanced illness where applicable; see "Frailty" and "Advanced Illness" sections for additional information

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

ANNUALLY

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

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

BEST PRACTICES

- Review 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

- Educate patients and caregivers about the importance of medication adherence, potential side effects, and the purpose of each medication
- Maintain documentation that shows the medication review was conducted. This is essential for compliance with HEDIS measures
- Utilize EHR systems to track and document medication reviews, ensuring they're completed on time and are accessible to all team members

HOW TO CODE

Report that a medication review was completed:

CPT-II:

1159F – Medication list documented in medical record

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

CPT:

90863 – Pharmacological management, including medication review and prescription, when performed with psychotherapy services

99483 – Assessment of and care planning for patients with cognitive impairment and can be performed in an office, home, or other outpatient setting

99605 – First-time medication therapy management (MTM) consultation with a pharmacist and lasts up to 15 minutes

99606 – Follow-up MTM consultation with a pharmacist and lasts up to 15 minutes

HCPCS:

G8427 – Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

DOCUMENTATION

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

CARE FOR OLDER ADULTS – 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. Standardized functional status assessment tools include, but are not limited to:

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

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

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

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

BEST PRACTICES

- Document that ADLs/IADLs were assessed. For ADL at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking. For IADL at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances
- Consider implementing standardized functional status assessments (i.e., Barthel index)
- Report appropriate code for assessment
- Consider using telehealth platforms to facilitate functional assessments, particularly for patients who may have difficulty attending in-person visits
- Use Electronic Health Records (EHR) systems to integrate functional status data and flag patients who may require a functional status assessment. Decision support tools can also help identify patients at higher risk of functional decline

HOW TO CODE

Report that functional status was assessed:

CPT-II:

1170F – Functional status assessed

CPT:

99483 – Cognitive Assessment and Care Plan Services

DOCUMENTATION

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

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

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

OSTEOPOROSIS MEDICATIONS:

Bisphosphonates

Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid

Other agents

Abaloparatide, Denosumab, Raloxifene, Raloxifene, Teriparatide

HOW TO CODE

Report that functional status was assessed:

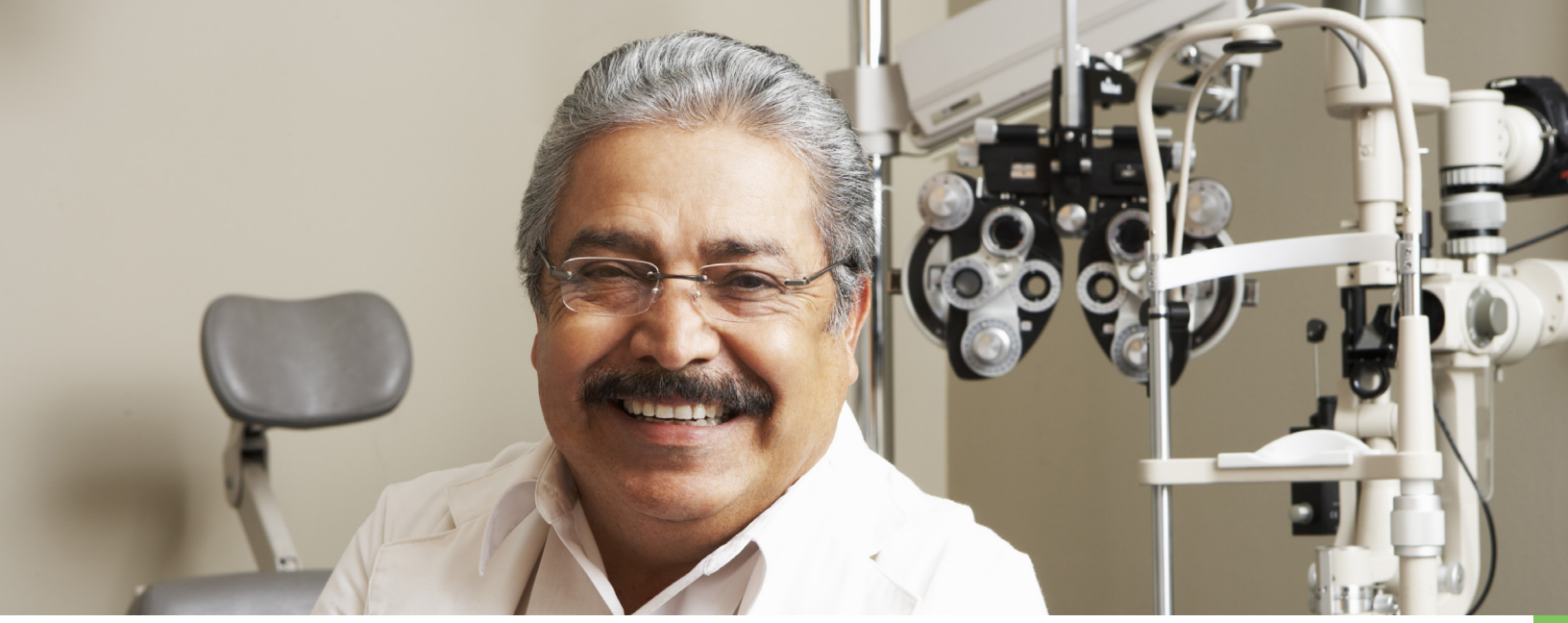
CPT:

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

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

DOCUMENTATION

- Ensure complete documentation of medication list or BMD test report. A BMD test completed within 24 months of fracture date can be documented with month and year of service
- Document frailty and advanced illness where applicable; see “Frailty” and “Advanced Illness” sections for additional information



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

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

HOW TO CODE

CPT-II:

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

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

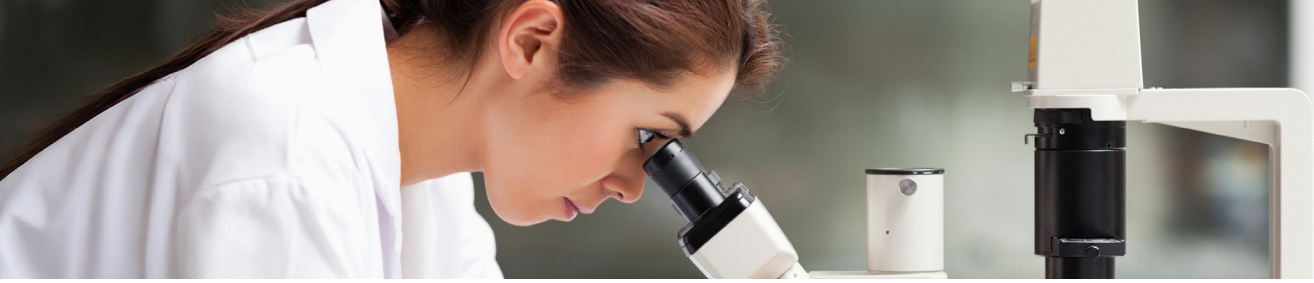
2023F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy

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

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

DOCUMENTATION

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



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

- Telephonic disease management can be provided to out-of-control diabetics
- Ensure AWV includes appropriate lab work
- Provide lab requisition to patient to complete labs prior to Annual Wellness Visit or routine appointment. Physician can discuss results with patient on appointment date
- For patients with results >9, a retest is needed before end of the calendar year
- Follow-up with patient to discuss results
- Enroll patient in any available chronic disease management programs if uncontrolled
- Identify and address social determinants of health (SDoH) that may prevent effective diabetes care, such as food insecurity, transportation issues, or lack of access to healthcare
- Provide resources like diabetes education programs, medication assistance, and community resources to improve patient access to care

HOW TO CODE

Report the results of the hemoglobin A1c test:

CPT-II:

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

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

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

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

83037 – HbA1c Lab Test

DOCUMENTATION

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

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 either [1] a urine albumin-creatinine ratio (uACR) test, or [2] a quantitative urine albumin test and urine creatinine test with service dates no more than four days apart.

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

BEST PRACTICES

- Telephonic disease management can be provided to out-of-control diabetics
- Ensure AWV includes appropriate lab work
- Provide a lab requisition to patients to complete labs prior to Annual Wellness Visit or routine appointment. Physician can discuss results with patient on appointment date
- Educate patients about the importance of kidney function and the heightened risk of kidney issues associated with diabetes
- Discuss healthy lifestyles that can support kidney health
- Call or send letters to patients that are overdue for lab tests

- 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
- Use data tracking tools to monitor kidney function indicators, such as UACR, eGFR, and blood pressure, and follow-up with patients who are at risk for kidney disease

HOW TO CODE:

CPT:

Estimated Glomerular Filtration Rate Lab Test:

80047 – Basic Metabolic Panel (Calcium, Ionized)

80048 – Basic Metabolic Panel (Calcium, Total)

80050 – General Health Panel (AMA)

80053 – Comprehensive Metabolic Panel, or chemical screen.

80069 – Renal Function Panel

82565 – Creatinine

Urine Creatinine Lab Test:

82043 – Quantitative urine albumin lab test.*

82570 – Urine creatinine lab test.*

*Required to satisfy uACR component in the KED measure

DOCUMENTATION

- Ensure documentation states results for eGFR and uACR and include service dates on which these tests were completed
- Document frailty and advanced illness where applicable; see “Frailty” and “Advanced Illness” sections for additional information

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

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

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).

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
- 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
- Ensure that the health plan is notified when a patient is both admitted and discharged from the emergency department
- Flag patients in EHR who have multiple high-risk and chronic conditions
- Patients must have 2 or more of the following chronic conditions:
    - COPD & Asthma
    - 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)
- Identify and address barriers to follow-up care, such as transportation, financial limitations, or lack of caregiver support
- Leverage community health workers or case managers to assist with social support needs
- Provide transportation assistance or home visit options for high-risk patients

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

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

PLAN ALL CAUSE READMISSION (PCR)

FOLLOW UP AFTER ACUTE INPATIENT AND 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

- Explain discharge instructions and ask patients to repeat them back
- Share outpatient care options and locations with patients (e.g., urgent care and post-operative care)
- Have conversations with patients about transportation and home safety
- Follow up with provider offices to confirm that patients were seen within the first week post discharge
- Offer telehealth follow-ups for patients with mobility issues
- Address Social Determinants of Health (SDoH) including;
  - Screen for transportation, food insecurity, and housing stability that may impact recovery
  - Connect patients with community resources and case management services to support their needs
  - Implement home health services or remote monitoring for high-risk populations

HOW TO CODE

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

ADVANCED ILLNESS

EACH VISIT AS APPLICABLE

Some measures allow for exclusions based on Advanced Illness.

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

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

FRAILTY

EACH VISIT APPLICABLE

Some measures allow for exclusions based on Frailty.

BEST PRACTICES

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

DOCUMENTATION

- Some measures allow for exclusion based on frailty

Must meet one of the following criteria:

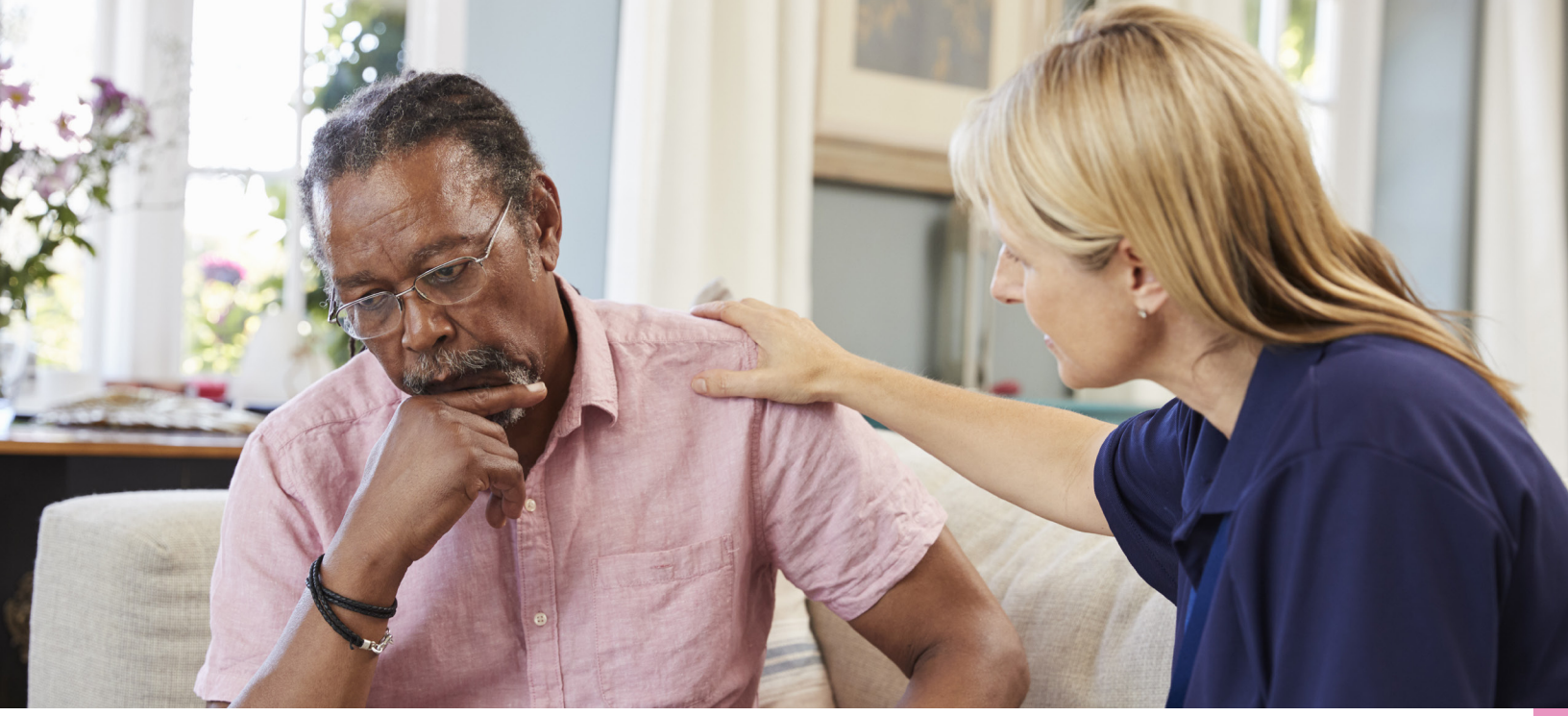
- Patient must be 81 years of age during the measurement year
- Patient must be 66 years of age and older as of December 31 of the measurement year with a specified “advanced illness” diagnosis during the measurement year or the year prior

There are no visit type requirements other than it may not be from a lab claim.

MOST COMMON FRAILTY DIAGNOSES

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

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



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
- Help patients find a flu shot location
- Address any barriers to getting the flu shot

HOW TO CODE

While this measure is a survey measure, submitting correct codes to the health plan can help indicate whether your patients have barriers to getting the flu 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):
17100020046E620, 17100020023E620, 17100020025E620, 17100020821800, 17100020021E620, 17100020082E620, 17100020251800, 17100020086E520

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

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

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

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
- If follow-up is needed, 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
- Ensure patient received help managing care
- Practice reviewing and discussing care received from other health care providers

GETTING NEEDED PRESCRIPTION DRUGS

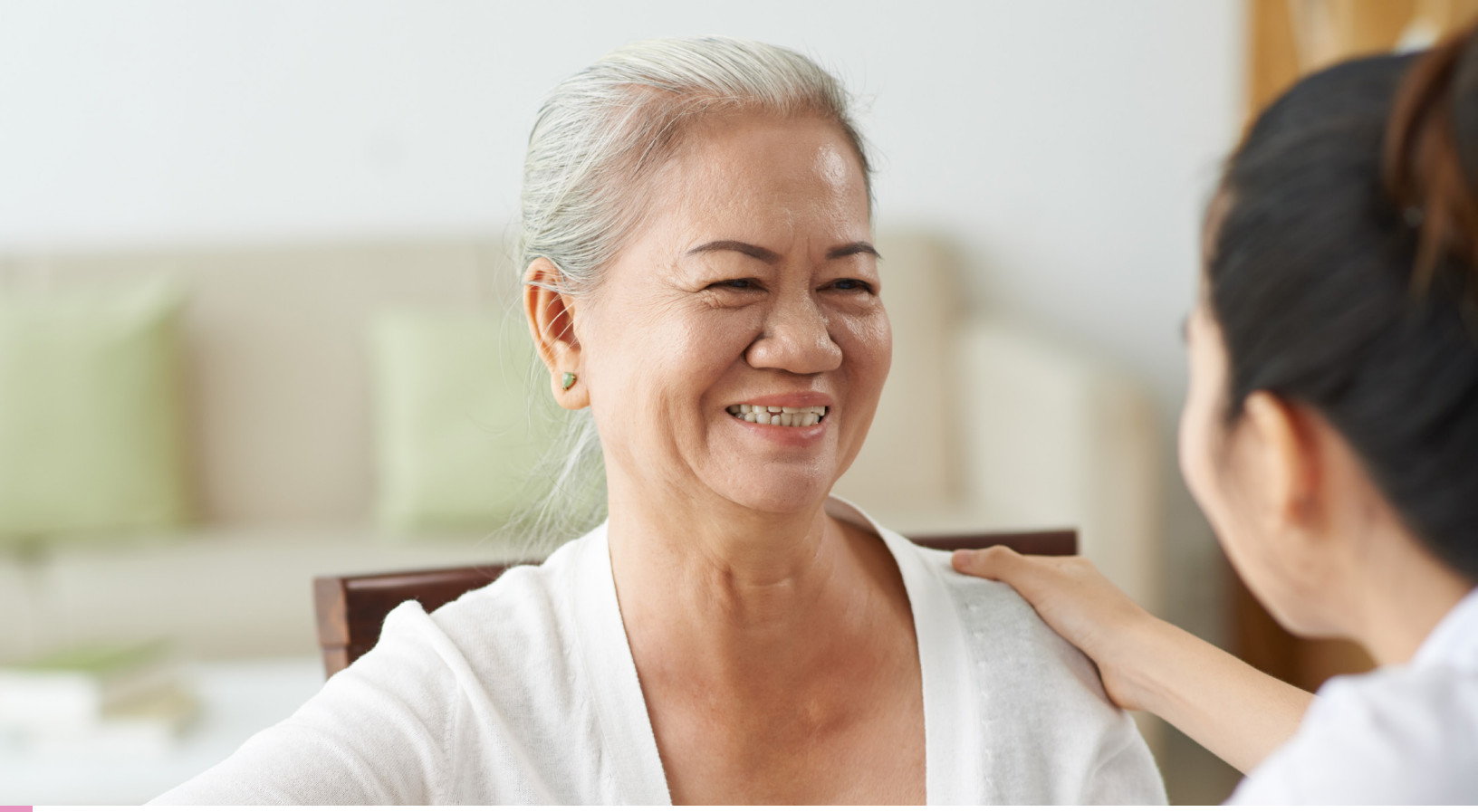
FROM THE PAST 6 MONTHS

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 referral issuance and assist with the arrangement of specialist appointments
- 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

- Be sure to screen for depression during every visit and appropriately triage to behavioral health services if needed
- Encourage patients to incorporate 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

Question 4: During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

a. Accomplished less than you would like **as a result of any emotional problems**

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Question 6: How much of the time during the **past 4 weeks**:

a. Have you felt calm or peaceful?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

b. Did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

c. Have you felt downhearted and blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

Question 7: During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

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.

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

IMPROVING OR MAINTAINING PHYSICAL HEALTH

Sample Question 1: In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

Sample Question 2: The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

b. Climbing **several** flights of stairs

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

Sample Question 3: During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

a. **Accomplished less** than you would like **as a result of your physical health**?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Were you limited in the **kind** of work or other activities **as a result of your physical health**?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Sample Question 5: During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not all
- A little bit
- Moderately
- Quite a bit
- Extremely

MONITORING PHYSICAL ACTIVITY

Sample Question 1: 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.

- Yes -> **Go to Question 47**
- No -> **Go to Question 47**
- I had no visits in the past 12 months -> **Go to Question 48**

Sample Question 2: In the **past 12 months**, did a doctor or other health 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.

- Yes
- No

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

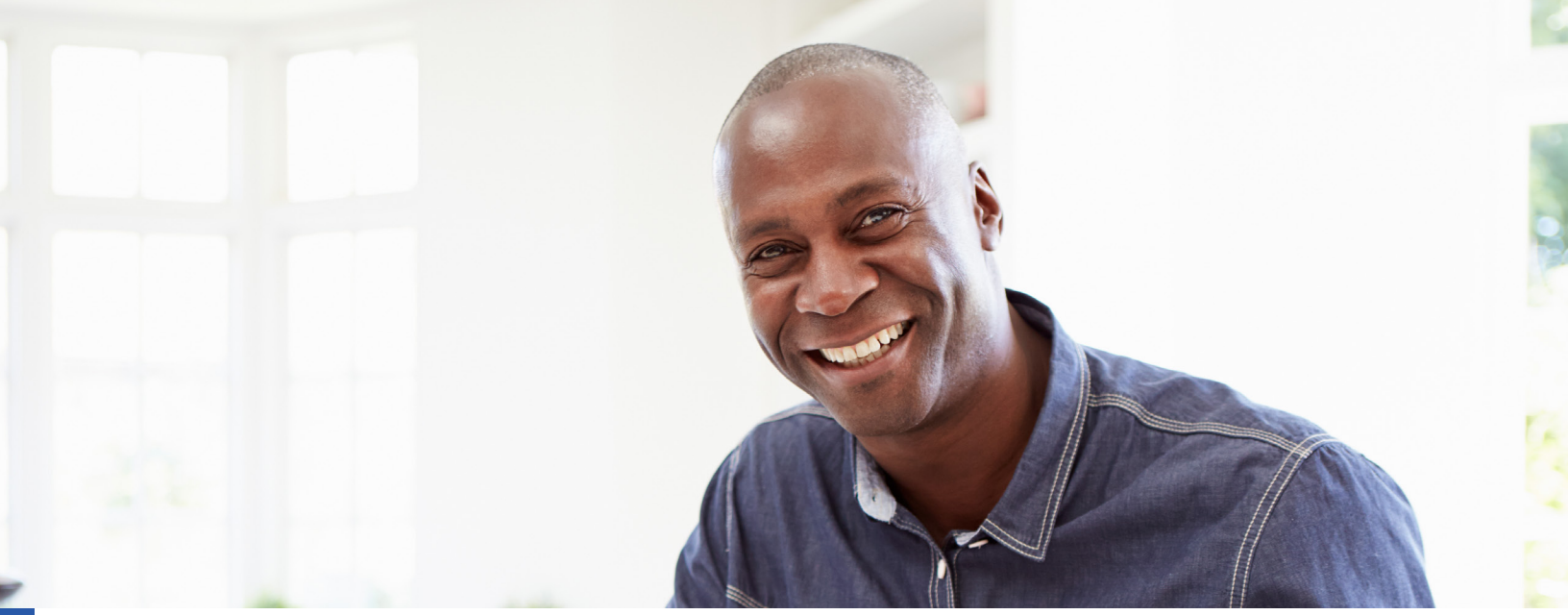
1101F – Documentation of no falls in the past year or only 1 fall without injury in the past year

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 CARDIOVASCULAR DISEASE (SPC)

EACH VISIT

Patients with a diagnosis of atherosclerotic cardiovascular disease should be dispensed at least one high-intensity or moderate-intensity statin medication, **regardless of LDL levels**, during the calendar year to be compliant with the measure.

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

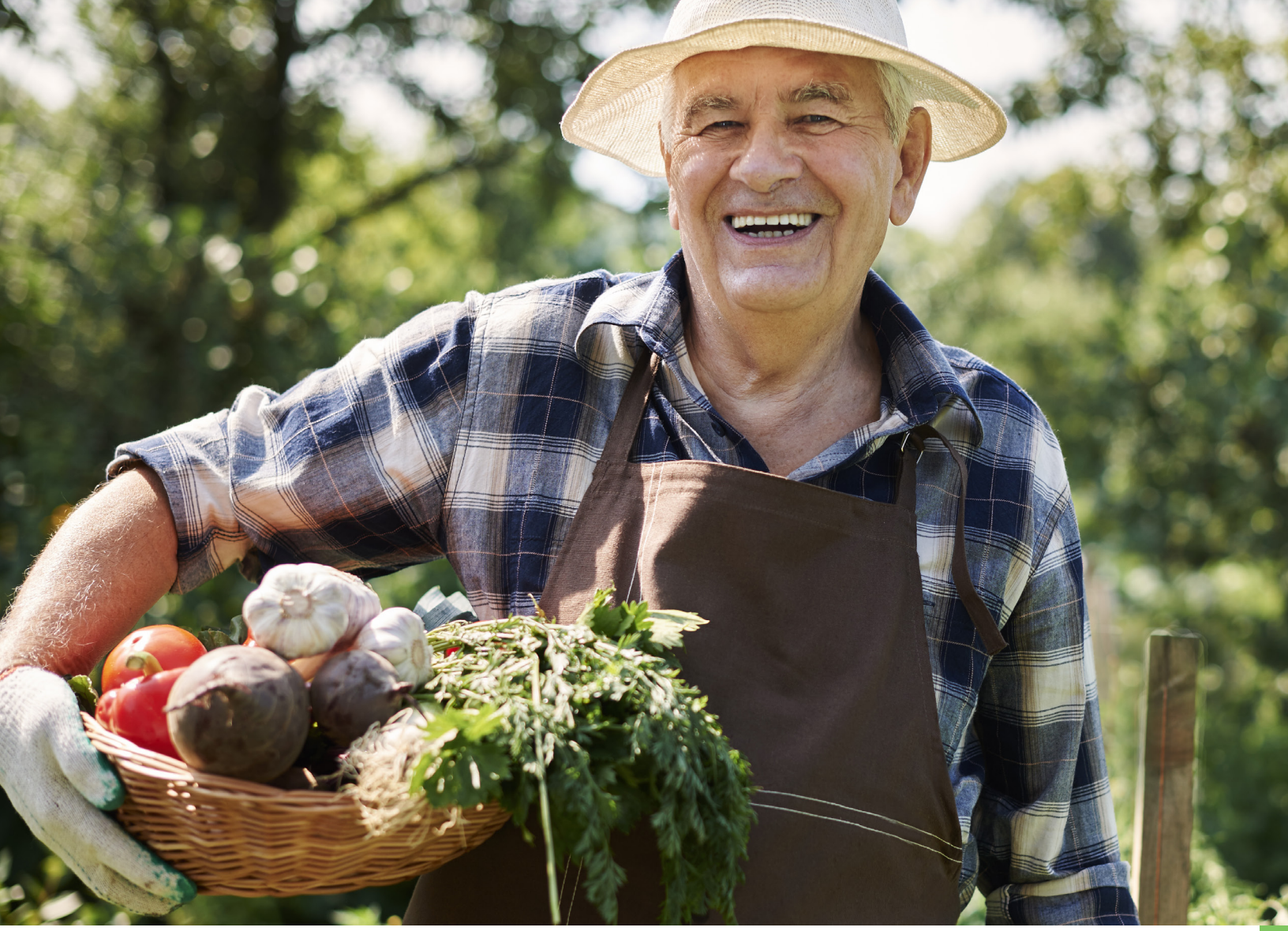
BEST PRACTICES

- Patient refusal will not make them ineligible for this measure
- Patients should be prescribed a 90- or **100-day** supply of generic statin medications with **four (4) refills**. Statins on Tier 6 of our formulary and available at a **$0 copay**
- Respond to refill request same day.
- Talk to the patient about their Rx refill barriers
- Address individual patient concerns and misconceptions related to statins

DOCUMENTATION

- Document medication and dosage in patient medication list
- If member on statin, document last fill date and next fill date
- Document frailty and advanced illness where applicable; see "Frailty" and "Advanced Illness" sections for additional information
- Document diagnosis for most common exclusion if applicable
    - Drug induced myopathy (G72.0)
    - Myopathy unspecified (M60.9)
    - Myalgias (M79.1)
    - Cirrhosis of liver (K74.60)
    - ESRD (N18.6)

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



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
- Diabetic Medications used for other conditions, such as GLP1's for weight loss, will still qualify patients into the measure
- Patients should be prescribed a 90- or **100-day** supply of generic statin medications with **four (4) refills**. Statins on Tier 6 of our formulary and available at a **$0 copay**
- Respond to refill request same day
- Talk to the patient about their Rx refill barriers
- Address individual patient concerns and misconceptions related to statins

DOCUMENTATION

- Document medication and dosage in patient medication list
- If member on statin, document last fill date and next fill date
- Document frailty and advanced illness where applicable; see "Frailty" and "Advanced Illness" sections for additional information
- Document diagnosis for most common exclusion if applicable:
    - Prediabetes (statin not indicated): R73.03
    - Drug induced myopathy (G72.0)
    - Myopathy unspecified (M60.9)
    - Patient on metformin for polycystic ovarian syndrome (E28.2)
    - Cirrhosis of liver (K74.60)
    - ESRD (N18.6)

For a full list of codes, please 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)

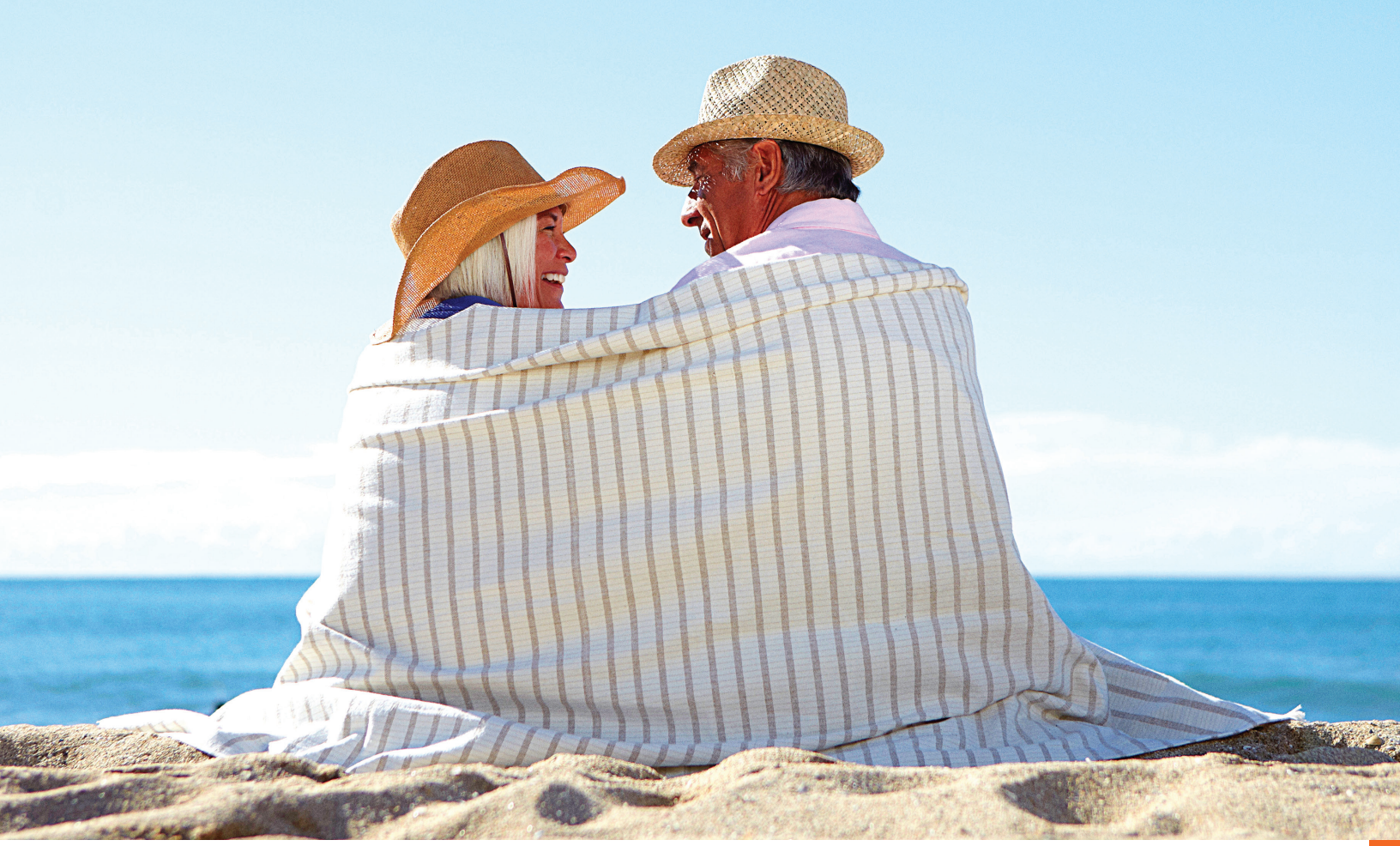
BEST PRACTICES:

- 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

*For a complete coding list, please email **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

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

COMMON ANTICHOLINERGIC MEDICATIONS AND ALTERNATIVES

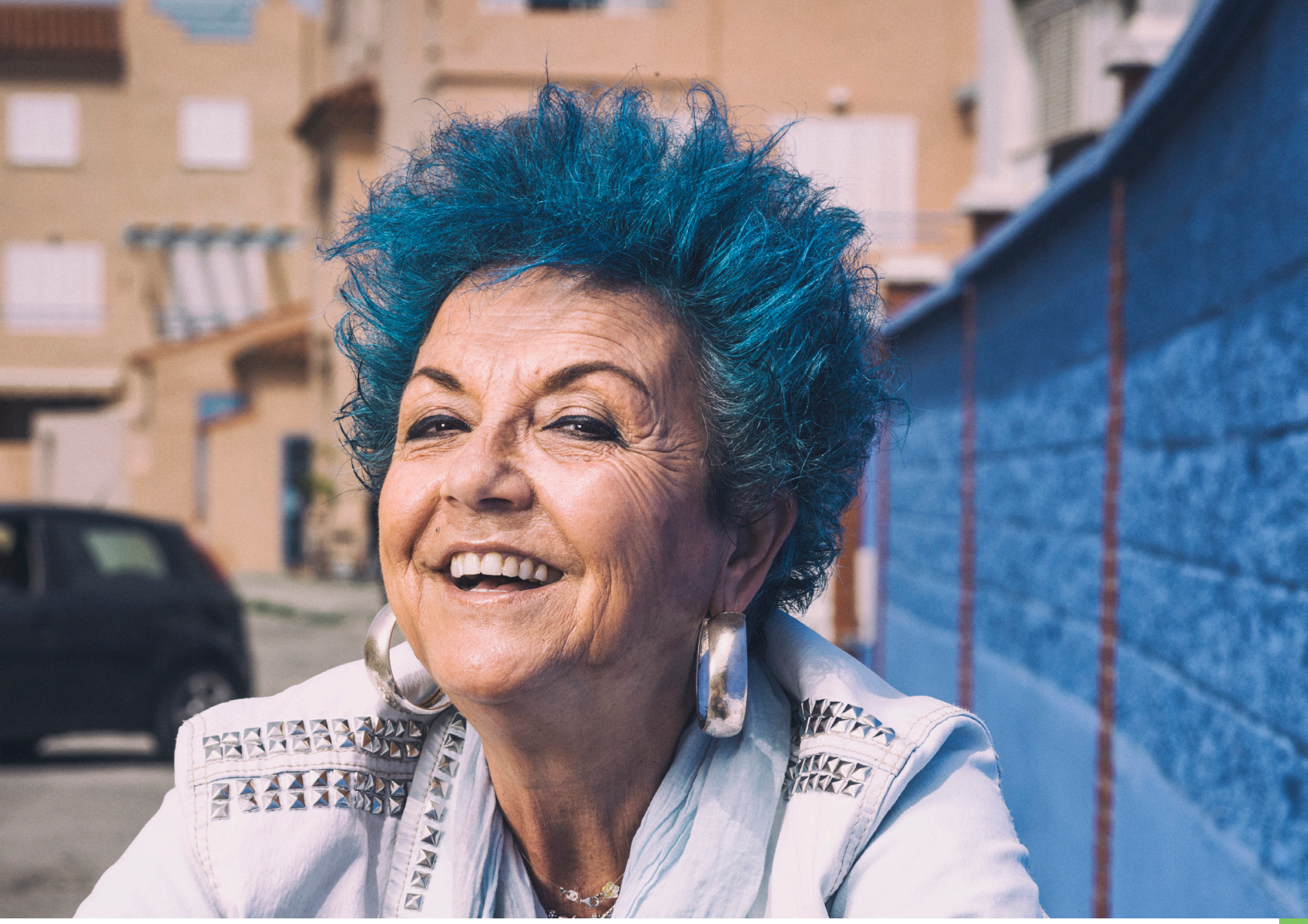
(This list is for reference and may not include all anticholinergic medications.)

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

- Patients should be prescribed a 90- or **100-day** supply of generic statin medications with **four (4) refills**. Statins on Tier 6 of 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:

- Document medication and dosage in patient medication list
- Document lab results in patient chart
- Document if member enters hospice
- Document if member has ESRD or dialysis (including coverage dates) yearly

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.

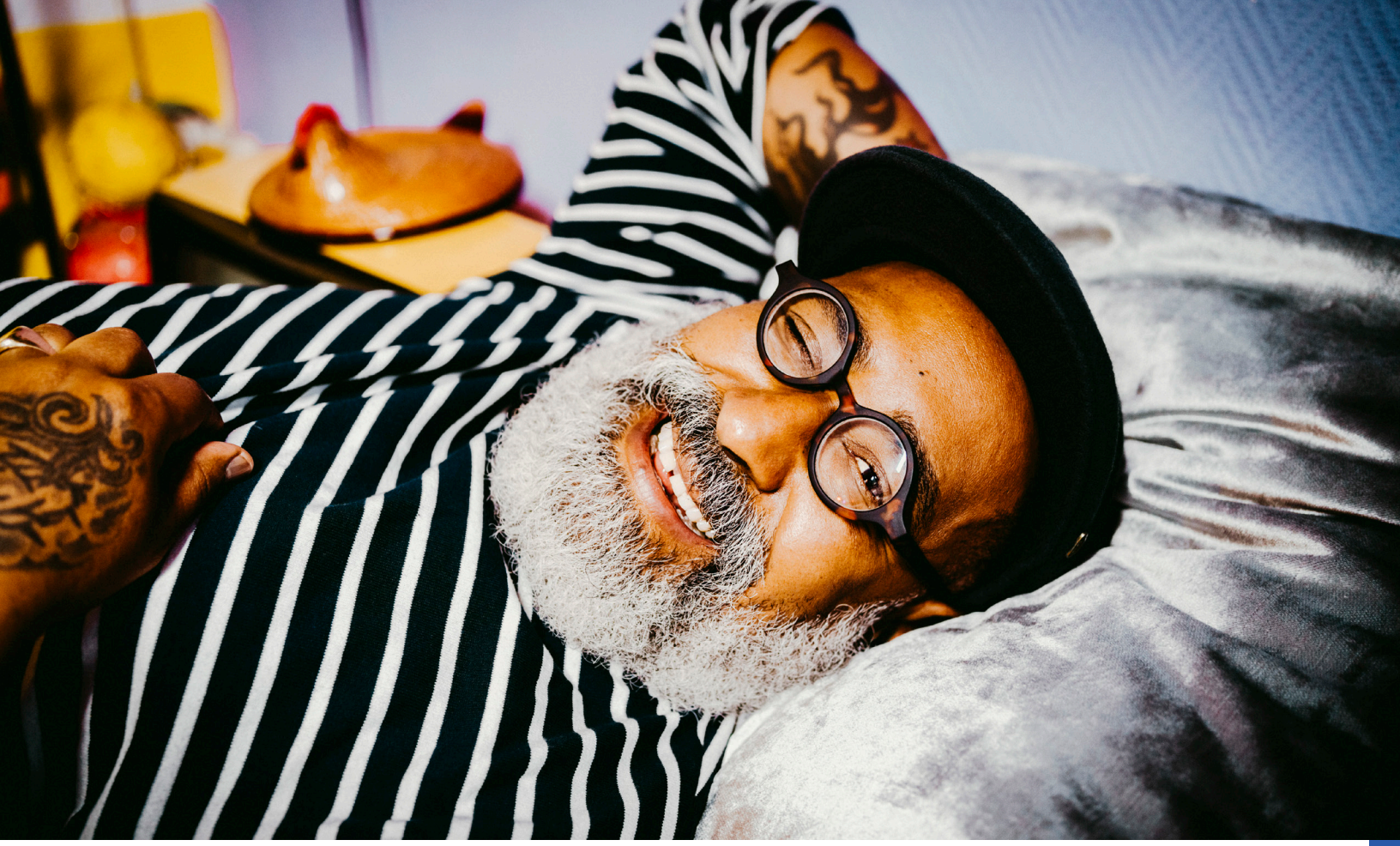
Demographic: 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system antagonists (RASA): angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.

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:

- Document medication and dosage in patient medication list
- Document lab results in patient chart
- Document if member enters hospice
- Document if member has ESRD or dialysis (including coverage dates) yearly
- Document if member is prescribed sacubitril/valsartan



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

DOCUMENTATION:

- Document medication and dosage in patient medication list
- Document lab results in patient chart
- Document if member enters hospice
- Document if member has ESRD or dialysis (including coverage dates) yearly

Alignment Health™