Clinical HEDIS Medicare Stars
Quick Reference Guide

MEASURE	SPECIFICATIONS
Adult BMI Assessment (ABA)	The percentage of members 18 – 74 years of age who had an outpatient visit and whose weight and body mass index was documented during the measurement year or the year prior. Documentation in the medical record must indicate the weight and BMI value, dated in measurement year or year before. For members younger than 19 on the date of service, documentation of BMI percentile also meets criteria: • BMI percentile documentation as a value (e.g., 85th percentile) • BMI percentile plotted on a growth chart Notes: ♦Notation of height & weight only is not compliant! ♦Weight & BMI must be from the same data source but may be from different dates of service ♦Ranges and thresholds do not meet criteria. BMI documentation of >99% or <1% If a distinct BMI percentile is evident, e.g., 100% or 0%, it **DOES** meet criteria.
Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year. **Exclusions:** Women who have had bilateral mastectomy or 2 unilateral mastectomies. Unilateral mastectomies must have service dates 14 or more days apart. Note: Do not count biopsies, ultrasounds or MRIs
Care for Older Adults (COA) **SNP only**	The percentage of adults 66 and older who had each of the following during the measurement year: • **Advance care planning:** a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Evidence of advanced care planning must include: • The presence of an advanced care plan in the record **or** • Documentation of an advance care planning discussion with the provider and a date in the measurement year **or** • Notation that member has previously executed an advance directive Examples of advance care plan include: *Advance directive*- e.g. living will, power of attorney, healthcare proxy *Actionable medical orders*: written instructions regarding initiation, continuation, withholding or withdrawing of life sustaining treatment

Living will : Legal document denoting preferences for life sustaining treatment and end of life care

Surrogate decision maker: A written document designating someone else to make future medical treatment choices

Examples of advance care planning discussion include:

Notation in the medical record of a discussion in the measurement year, **or** oral statements: Conversations with relatives or friends about life sustaining treatment and end of life care, documented in the medical record in the measurement year

- **Medication review:** At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and a medication list in the medical record. Documentation must come from the same medical record and must include :
- A medication list in the medical record ***and*** evidence of a medication review conducted by a prescribing practitioner or clinical pharmacist and the date it was performed
- Notation that the member is not taking any medication and the date it was noted

Note: A review of side effects for a single medication at the time of Rx is not sufficient. An outpatient visit is not required

- **Functional status assessment:** At least one functional status assessment during the measurement year as documented by:

– Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. **OR**

– Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.

OR

– Results of assessment using a standardized functional status assessment tool (SF-36, ALSAR, ADLS, B-ADL, ILS, KELS, etc.) **OR**

– Notation that the following components **(at least three of the four**) were assessed:

1. Notation of functional independence (e.g. exercise, ability to perform job)
2. Sensory ability (hearing, vision, speech) **need all three**
3. Cognitive status (e.g. alert, oriented)
4. Ambulatory status (e.g. walks with cane, gait)

Note: An assessment limited to an acute or single condition, event or body system (e.g. lower back, leg) does not meet criteria for a comprehensive functional status assessment.

	The components of the functional status assessment may take place during separate visits within the measurement year. • **<u>Pain assessment</u>:** At least one pain assessment during the measurement year must include one of the following: • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain) • Result of assessment using a standardized pain assessment tool Notes: • Notation of a pain management plan alone does not meet criteria. • Notation of a pain treatment plan alone does not meet criteria. • Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.
Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had one or more of the following screenings for colorectal cancer: • <u>Fecal occult blood test FOBT</u> during the measurement year. There are two types, guaiac (gFOBT) and immunochemical (iFOBT). • <u>Sigmoidoscopy</u> during the measurement year or four years prior • <u>Colonoscopy</u> during the measurement year or in the nine years prior Notes: -Documentation <u>must include the date the colorectal screening was performed</u> (not just ordered). -Digital rectal exam (DRE) does not count. **<u>Exclusion</u>**: Members with a diagnosis of colorectal cancer or total colectomy (removal most (all) of the large bowel) occurring before December 31of the measurement year.
Comprehensive Diabetes Care (CDC)	**The percentage of members 18 – 75 with diabetes (type 1 and type 2) who had each of the following:** • HbA1c good control <9% (8.9 or lower) • Eye exam (retinal) performed • Medical attention for nephropathy **<u>HbA1c:</u>** Results of the last HbA1c performed in measurement year documented in a lab report or provider's note which includes the date and result of the test **<u>Retinal Eye Exam:</u>** A dilated or retinal eye exam done by an eye care professional in the measurement year or a negative retinal exam (no evidence of retinopathy) done in the year prior **<u>Medical Attention for Nephropathy:</u>** • Look for written documentation of a visit to a nephrologist or a note that

	addresses any of the following in measurement year: o Diabetic nephropathy o Renal Transplant o End stage renal disease (ESRD) o Chronic renal failure (CRF) o Chronic kidney disease (CKD) o Renal insufficiency o Proteinuria o Albuminuria o Renal dysfunction o Acute renal failure (ARF) o Dialysis, hemodialysis or peritoneal dialysis • Macroalbumin – Any of the following tests done in measurement year: o Urinalysis positive (random, spot or timed) for protein o Positive urine dipstick o Positive tablet reagent for urine protein o Positive result for albuminuria o Positive for macroalbuminuria o Positive for proteinuria o Positive for gross proteinuria Note: **"trace"** urine macroalbumin test results are not considered positive. • Microalbuminuria –Any of the following tests in measurement year: o 24-hour urine for microalbumin o Timed urine for microalbumin o Spot urine for microalbumin o Urine for microalbumin/creatine ratio o 24-hour urine for total protein o Random urine for protein/creatinine ratio • Evidence of ACE Inhibitor/ARB therapy during measurement year
Controlling High Blood Pressure (CBP)	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18-59 years of age whose BP was <140/90 • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD). **Exclusions (optional):** • Members with a diagnosis of HIV any time during the member's history through the measurement year. • Members with a diagnosis of pregnancy during the measurement year.
Medication Reconciliation Post-Discharge (MRP)	The percentage of discharges from Jan 1 – Dec 1 of the measurement year for members 66 and older for whom medications were reconciled on or within 30 days of discharge conducted by a prescribing practitioner, clinical pharmacist, or RN. Any of the following evidence meets criteria: • Notation that the medications prescribed upon discharge were reconciled with the current medications in the outpatient record • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications • Notation that no medications were prescribed upon discharge
Osteoporosis Management in Women Who Had a Fracture (OMW)	The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. Intake period: A 12 month (1 year) window that begins on July 1 of the year prior to the measurement year and ends June 30 of the measurement year. The intake period is used to capture the first fracture. **Exclusions *required*:** Members who had a BMD test during the 730 days (24 months) prior to the fracture. Members who had a claim/encounter for osteoporosis therapy or received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the fracture.