Medicare Advantage Measurement Period Handbook for Enhanced Personal Health Care

Measurement Period beginning January 1, 2015

Amerivantage is an HMO plan with a contract with the New Mexico Medicare program. Enrollment in Amerivantage depends on contract renewal.

Version 040115
SSO-PEC-0563-15 1179131

Table of Contents

Introduction

Welcome to the Medicare Advantage Measurement Period Handbook. As explained in the Program Description, the Incentive Program gives you the opportunity to share in savings achieved by your Medical Panel during a given Measurement Period. If you meet both quality and cost performance targets, your provider organization could share in the cost savings.

To determine eligibility or how much of a shared savings payment you are eligible for, we measure your performance against quality and cost targets. In this handbook, you'll learn more about those targets and performance metrics. Below are definitions of important terms used in this handbook and details of the Incentive Program:

- **Medical Loss Ratio Report**. The MLR report shows Total Medical Costs incurred by your Medicare Advantage Attributed Patients divided by the total Premiums received by Amerigroup Community Care over the course of the MA Measurement Period. You are eligible to earn shared savings when the Measurement Period Medical Loss Ratio (MPMLR) is less than the Medical Loss Ratio Target (MLRT) and your measured performance on quality metrics and outcomes meets or exceeds the Program's Quality Gate.
- **Measurement Period Start Date**. The first day of the twelve (12) month period during which we measure MPMLR and quality performance for purposes of calculating shared savings between Amerigroup and the Medical Panel. If your organization starts a Measurement Period after the first day of a given year, the initial MA Measurement Period would be less than a twelve (12) month period. In the subsequent years, the new MA Measurement Period would begin on the first day of the new year for a complete twelve (12) month period.
- **Quality Gate**. The minimum clinical quality scores that your provider organization must deliver in order to earn any shared savings under the Incentive Program. Your Quality Gate is set at an average weighted four Star level. Further information about the Quality Gate is reviewed in the shared savings section, on page 9.
- **Shared Savings Percentage.** The percentage of shared savings under the Program to which Provider is determined to be entitled after all other applicable adjustments have been made to the Shared Savings Potential based on the Quality Target scores as shown in the Program Description and this MA Measurement Period Handbook. The Shared Savings Percentage can be the same percent as the Shared Savings Potential if all Quality Targets are fully achieved by Provider under the Program. The Shared Savings Percentage will be less than the Shared Savings Potential if any Quality Targets are not achieved by Provider under the Program.
- **Shared Savings Potential**. The maximum percentage of shared savings under the Shared Saving Program to which Provider may be entitled, as delineated in this MA Measurement Period Handbook. The Shared Savings Potential percent shown in this MA Measurement Period Handbook is subject to the performance adjustments described in this Program Description and in the MA Measurement Period Handbook.
- **Substantial Financial Risk Limit.** The limit applied to the total incentive-based payments to Provider from Amerigroup, inclusive of payments under the Agreement. The Substantial Financial Risk Limit is no more than 25 percent of the total reimbursement the Provider

and Represented Providers receive from Amerigroup for direct services delivered to Amerigroup Medicare Advantage Attributed Members during the applicable MA Measurement Period year.

- **Performance Scorecard Report**. In addition to the MLR report, you will also be able to access your provider organization's performance scorecard by logging in to Availity at www.Availity.com. The performance scorecard shows your performance on the selected clinical quality measures listed in this handbook. The performance scorecard is a tool to help you assess your quality and utilization performance on a quarterly basis.

The information included in this handbook is designed to help you understand your Medical Cost Target report, your performance scorecard and the scoring methodology.

Section 1: Medical loss ratio

Overview

As part of our Enhanced Personal Health Care Program, we track overall medical costs incurred by Attributed Members, and under the incentive portion of the Program, we reward participating providers who are able to provide appropriate care in a cost-effect manner while maintaining or improving performance against nationally recognized quality measures.

The Medical Loss Ratio Report shows Total Medical Costs incurred by a given Medical Panel's Medicare Advantage Attributed Members divided by the total Premiums received by Amerigroup for the Medicare Advantage Attributed Members associated with the Medical Panel over the course of the Measurement Period.

The Medical Loss Ratio Report is meant to give you a sense of the Medical Panel's MLR at various points throughout the Measurement Period. You will receive a Medical Loss Ratio Report for your Medicare Advantage Medical Panel over the course of the Measurement Period on the Availity secure web portal.

As a reminder, the Measurement Period Medical Loss Ratio used to reconcile your final shared savings payment (should you qualify) uses the following equation:

$$MPMLR = \frac{\sum Total\ Medical\ Expense_{Measurement\ Period}}{\sum Premium_{Measurement\ Period}}$$

- **Total Medical Expenses** means the costs incurred by Amerigroup for payment of all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to each Medicare Advantage Attributed member by all providers (participating and nonparticipating, and including Provider and PCPs) furnishing such services to Medicare Advantage Attributed Members, adjusted by the Stop-Loss Expense and Stop-Loss Credit where appropriate. Total Medical Expenses include:
  - Claims, capitation and PMPM reimbursement, where applicable, incurred during the MA Measurement Period, paid through a three month Claims run-out period.
  - Plus a reasonable amount for IBNR
  - Plus the Stop-Loss Expense (if included)
  - Minus the Stop-Loss Credits (if included)
  - Plus the costs associated with supplemental benefits
  - Plus payment made by Amerigroup and/or an Amerigroup vendor for gap closures and/or health risk assessments.
- **Premium** means the total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Amerigroup for the Member Population under an Amerigroup Health Benefit Plan during a MA Measurement Period less any Part B rebates payable or

credited for any Medicare Advantage Attributed Members within the Member Population, less any taxes levied by the Affordable Care Act, less any cost and reinsurance subsidies, and less any other amount otherwise offset against or deducted from amounts payable by CMS to Amerigroup with respect to the Member Population during such MA Measurement Period, exclusive of any Retroactive Addition Amount or Retroactive Deletion Amount, for such Medicare Advantage Member Population for the same MA Measurement Period.

Section 2: Performance scorecard and your measures

Performance scorecard overview

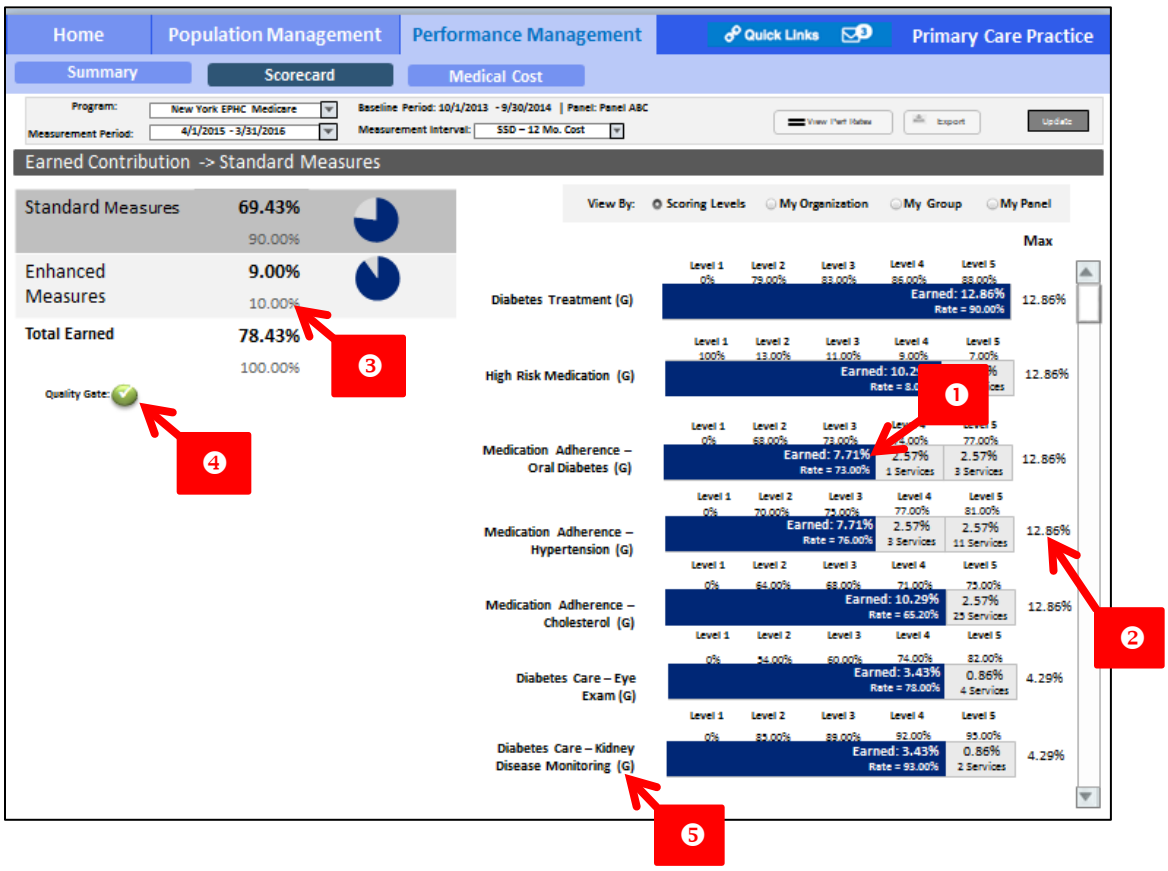
The performance scorecard is comprised of Quality Targets. In addition to serving as a basis for Incentive Program shared savings calculations, these measures are used to establish a minimum level of performance expected of you under the Program and to encourage improvement through sharing of information.

The performance scorecard allows you to monitor your progress in these measures throughout the year. It will identify:

- Current measure rate
- Current measure numerator and denominator
- Benchmarks for your Measurement Period

Scorecard report example

The scorecard below is an example of the information the scorecard will provide and what it will look like. Your scorecard will be provided through the Availity secure web portal once available.



Box 1, Earned Contribution: The proportion of the Shared Savings Potential earned for each measure and for the overall Program. Your earned contribution is shown in each bar that measures your performance.

Boxes 2 and 3, Shared Savings Potential: The maximum percentage of Shared Savings to which a provider is entitled under the Incentive Program. The scorecard shows this at the measure (2) and composite (3) level.

Box 4, Quality Gate: If the Quality Gate has been passed at this point in the Measurement Period.

Box 5, Level of Measurement: If the Measure has been evaluated at the Group or Medical Panel level.

Quality measures for your Measurement Period

Clinical quality measures overview

The Medicare Advantage Program scorecard is comprised of Quality Targets that align with the CMS Stars Program. The applicable Quality Targets are listed below under Standard Measures and Enhanced Measures. In addition to serving as a basis for Medicare Advantage Incentive Program savings calculations, these measures are used to establish a minimum level of performance expected of you under the Medicare Advantage Program, and to encourage improvement through sharing of information. The measures encourage efficient, preventive, high quality and cost-effective health care practices for the Medicare Advantage (MA) Attributed Member population. Eligible providers who meet the Quality Gate can participate in the Medicare Advantage Incentive Program as described in Section 8, Incentive Program-Medicare Advantage Business.

The Quality Targets included in the scorecard for the Medicare Advantage Incentive Program are divided into two categories, referred to as composites, in the Quality Scorecard: (1) Standard Measures and (2) Enhanced Measures. All measures that have at least 20 MA Attributed Members in the denominator will be scored at your provider organizations level. If your provider organization does not have 20 MA Attributed Members in the denominator of a given measure, that measure will be scored at your assigned MA Medical Panel's level. Measures that have been scored at the MA Medical Panel level are marked with a (P) next to the measure name on the scorecard, whereas measures that have been scored at your individual group level will have a (G) next to the measures name.

Composite overview

- **Standard Measures** are measures that are scored using the procedure and diagnosis codes submitted on medical or prescription drug claims that are readily available, widely used by many providers, and that provide conclusive evidence as to whether or not the measure has been achieved. These measures' results are derived solely based on an evaluation of claims submitted to Amerigroup. An example of a Standard Measure is diabetes HbA1C. A review of claims we receive during a Measurement Period for a given Medicare Advantage Attributed Member with diabetes will provide all the information needed to conclusively determine if the test was performed during the Measurement Period. The Standard Measures that will be included on the scorecard for this MA Measurement Period are:
  - Diabetes care – Eye exam
  - Diabetes care – Kidney disease monitoring
  - Diabetes treatment
  - Osteoporosis management in women who had a fracture
  - Rheumatoid arthritis management
  - Breast cancer screening
  - Colorectal cancer screening
  - High risk medication
  - Medication adherence – Oral diabetes

  - Medication adherence – Hypertension
  - Medication adherence – Cholesterol

- **Enhanced Measures** are measures that, for scoring purposes, require additional information to be submitted in addition to the Claim (in addition to standard CPT IV codes), and also require documentation in the Medicare Advantage Attributed Member's medical record. In order to evaluate success with Enhanced Measures, you must submit a CPT II code or V code on the Medicare Advantage Attributed Member's Claim along with a corresponding note in their medical record that supports the use of this code. An example of an Enhanced Measure is diabetes care – blood sugar controlled. A review of claims received for a given Medicare Advantage Attributed Member with diabetes, during the Measurement Period, requires the inclusion of the CPT II code that identifies the member's HbA1c level. The Enhanced Measures serve as a bonus opportunity to increase your overall shared savings potential, and will not reduce your shared savings if not achieved. The use of CPT II codes and V codes are further explained below. The Enhanced Measures that will be included on the scorecard for this MA Measurement Period are:
  - Diabetes care – Blood sugar controlled
  - Controlling blood pressure
  - Adult BMI assessment
  - Medication review
  - Functional status assessment
  - Pain screening

Individual Measure Weighing

CMS assigns weighting to the Stars measures each year. The weighting, as assigned by CMS, is listed below in Table 1. The measures that are triple weighted will carry more weight when calculating your scorecard results. For example, with a five Star rating in Medication Adherence, Oral Diabetes would count as three five Star ratings since it is triple rated, whereas a five Star rating in Breast Cancer Screening will count as one five Star rating. The measure weighting also plays a role in determining the Shared Savings Potential, as shown on the scorecard and described in further details on the following pages.

Table 1: Measure weighting

	Star Metrics	CMS Weighed Values
Standard Measures	Diabetes Care – Eye Exam	1
	Diabetes Care – Kidney Disease Monitoring	1
	Osteoporosis Management in Women Who Had a Fractur	1
	Rheumatoid Arthritis Management	1
	Breast Cancer Screening	1
	Colorectal Cancer Screening	1
	Diabetes Treatment	3
	High Risk Medication	3
	Medication Adherence- Oral Diabetes	3
	Medication Adherence- Hypertension	3
	Medication Adherence- Cholesterol	3
Enhanced Measures	Diabetes Care – Blood Sugar Controlled	3
	Controlling Blood Pressure	3
	Adult BMI Assessment	1
	COA: Medication Review	1
	COA: Functional Status Assessment	1
	COA: Pain Screening	1

The use of CPT II & V codes to evaluate Enhanced Measures

As mentioned above, Enhanced Measures require additional information to be submitted on a claim, in addition standard CPT IV codes, in order to be evaluated and scored as the measure being compliant or controlled. A CPT II code or V code needs to be included on a MA Attributed Member's claim to demonstrate a patient's compliance for the Enhanced Measures. The information reflected by the CPT II and V codes also needs to be documented in their medical record to support the use of this code.

- **What is a Category II Code?**
  CPT Category II codes are tracking codes that facilitate data collection for performance measurement in the Program for the Medicare Advantage Attributed Members. The use of these codes enables us to monitor performance for the Enhanced Measures throughout the MA Measurement Period.
- **How does a CPT Category II code work in capturing quality data for measurement?**
  An example of the process and outcome measurement of Comprehensive Diabetes Care HbA1c testing and control includes the following: The process of caring for a diabetic patient by testing for the HbA1c to monitor the patient's blood sugar control over time. The outcome part of that measure is the result or value of the HbA1c, i.e., result level

<7.0%. The CPT II coding allows for the results data to be captured easily on a claim. See example below:

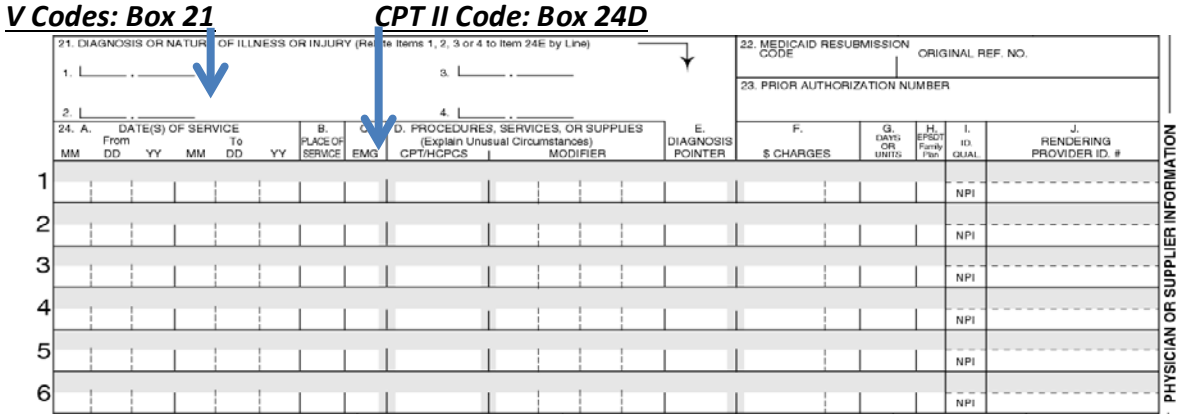
- Process: CPT IV - HbA1c Testing: 83036=Glycosylated (A1C) or 83037=at home glycosylated (A1C). The CPT IV code captures the fact that the test was indeed performed at the point of care.
- Outcome: CPT Category II - HbA1C Result: 3044F=Most recent HbA1c level <7.0%. The CPT Category II code captures the outcome or result of the screening above and completes the measure without performing an onsite chart review or submission of a medical record.

- **What is a V code?**
  V codes identify circumstances when a patient presents with issues other than a disease or injury. V codes are also used to report problems or factors that may influence care. The V code is a supplemental classification of ICD-9-CM. For example, V04.81 indicates an encounter for flu vaccine.
- **Where are CPT II and V codes captured on a standard claim form?**
  - CPT II CODES: Box D on a standard claim form captures CPT codes, since the CPT II code is a category of CPT, it also is placed in Box D (see Diagram 1 below).
  - V CODES: V codes are a supplemental classification of ICD-9-CM; therefore, the V code will appear in box 21 below (see Diagram 1 below).

Diagram 1

Placement of CPT II and V Codes (Note: Please refer to CMS for rules and regulations on coding for payment)

V Codes: Box 21 ***CPT II Code: Box 24D***



Section 3: Calculating Your Shared Savings

Overview

The opportunity to share in savings that are realized for your MA Attributed Members is a key characteristic of the Program. After savings are determined, the proportion of shared savings that you can earn depends on your organization's performance on a scorecard. Your scorecard serves two functions: (1) it will let you know if you met the Quality Gate, and (2) it will show you the overall percentage of the shared savings you earn. Below, we review the four major steps to determine your shared savings:

Step 1: Were Gross Savings Demonstrated?

In order to participate in shared savings, the Gross Savings must be demonstrated. For that to happen, your Medical Panel's MA Attributed Member population must demonstrate savings over the course of your Measurement Period. As described more fully in the Program Description; *Section 8: Incentive Program - Medicare Advantage Business,* Amerigroup will calculate Gross Savings by comparing the Measurement Period Medical Loss Ratio for your MA Attributed Member population for a specified 12 month Measurement Period to the established Medical Loss Ratio Target (MLRT). In the event that the MPMLR is less than the MLRT, the Gross Savings can be calculated. Ultimately, the Gross Savings is multiplied by your Shared Savings Percentage to calculate your shared savings payout.

Step 2: Quality Gate – Did you pass the Quality Gate?

Your provider organization must meet a minimum threshold of performance on the clinical quality measures in order to share a portion of the Gross Savings. That threshold, referred to as the Quality Gate, is based on the Standard Measures. Your provider organization's clinical quality score must meet or exceed an *average weighted* four Star rating for the Standard Measure composite to pass the Quality Gate. As illustrated in Table 4 below, a provider can receive a rating from 1 to 5 Stars for each individual measure; however, the Quality Gate is met when the overall rating averages 4 Stars for all of the Standard Measures combined.

Table 2: Overall Stars rating needed for four and five Stars

OVERALL AVERAGE WEIGHTED STAR RATING	STAR EQUIVALENT
3.75 Stars – 4.74 Stars	4 Stars
>4.75 Stars	5 Stars

This means that a provider must earn the equivalent of reaching 3.75 stars on all of the measures. This equates to 75 percent (3.75/5) earned contribution of the Shared Savings Potential for the standard measures. **Earned contribution** is the percentage of the maximum Shared Savings Potential earned for each measure, and is marked on the scorecard. Shared Savings Potential for each measure varies dependent on two components:

1. The individual measure weight – each measure, as shown in Table 1, is assigned a weight by CMS.
2. The composite weight – the Standard Measure composite carries 90 percent of the overall weight of the Shared Savings Potential; whereas the Enhanced Measure composite carries 10 percent of the overall weight of the Shared Savings Potential.

Table 3: Standard Measures and Weights for Calculating the Quality Gate

The Quality Gate is set at an average weighted four Star rating. As defined above in Table 2, that is defined as reaching a total of 3.75 of the total 5 Stars available. As shown below, the summed total for earned for the Standard Measures must be 67.5 to demonstrate an average of 3.75 for all Standard Measures. Although the table demonstrates this by showing each measure earning exactly 3.75 Stats, in reality an organization could reach 4 Stars on 5 measures, 2 Stars on 3 measures, and 5 Stars on the remainder – as long as they reach an average of 3.75 resulting in a summed total of equal to or greater than 67.5 percent.

	Star Metrics	CMS Weighed Values			Quality Gate	
		CMS Weighted Value	MAX points possible	Max Shared Savings Potential	Star Value Needed to Reach Quality Gate	Earned Contribution Needed to Reach Quality Gate
Standard Measures	Diabetes Care – Eye Exam	1	5	4.29%	3.75	3.21%
	Diabetes Care – Kidney Disease Monitoring	1	5	4.29%	3.75	3.21%
	Osteoporosis Management in Women Who Had a Frac	1	5	4.29%	3.75	3.21%
	Rheumatoid Arthritis Management	1	5	4.29%	3.75	3.21%
	Breast Cancer Screening	1	5	4.29%	3.75	3.21%
	Colorectal Cancer Screening	1	5	4.29%	3.75	3.21%
	Diabetes Treatment	3	15	12.86%	3.75	9.64%
	High Risk Medication	3	15	12.86%	3.75	9.64%
	Medication Adherence- Oral Diabetes	3	15	12.86%	3.75	9.64%
	Medication Adherence- Hypertension	3	15	12.86%	3.75	9.64%
	Medication Adherence- Cholesterol	3	15	12.86%	3.75	9.64%
						67.50%

Table 4: **Example of Quality Gate being passed**

In the example below, the providers earned contribution achieved for the Standard Measures was 69.43 percent. Since this is above the 67.5 percent needed to pass the Quality Gate, this group would pass the Quality Gate.

	Star Metrics	Providers Performance	
		Provider's Star Value By Measure	Earned Contribution Achieved
Standard Measures	Diabetes Care – Eye Exam	4	3.43%
	Diabetes Care – Kidney Disease Monitoring	4	3.43%
	Osteoporosis Management in Women Who Had a Fractur	5	4.29%
	Rheumatoid Arthritis Management	3	2.57%
	Breast Cancer Screening	3	2.57%
	Colorectal Cancer Screening	5	4.29%
	Diabetes Treatment	5	12.86%
	High Risk Medication	4	10.29%
	Medication Adherence- Oral Diabetes	3	7.71%
	Medication Adherence- Hypertension	3	7.71%
	Medication Adherence- Cholesterol	4	10.29%
	Standard Measures		69.43%

Quality Gate met
► score in excess of 67.5%.

Weighting Composites

As mentioned above, the measures that form the two composites contribute differently to the Shared Savings Potential depending on their weighting (Table 1). This same concept applies to the weighting of the two composites that make up the scorecard.

- The Standard Measure Composite is weighted to account for 90 percent of the Shared Savings Potential.
- The Enhanced Measures Composite is weighted for 10 percent of the Shared Savings Potential.

The individual weighting of the measures and the weighting of the composites result in a range of Shared Savings Potential across the measures. Table 5 brings the weighting details together for the measures and the composites and shows the Shared Savings Potential for each measure, and per composite. The Shared Savings Potential for each measure below corresponds to the earned contributions shown on the scorecard.

Table 5: Weighting – Composite and Measure Shared Savings Potentials
This table shows the weighting of the measures, and how that measure translates to the total Shared Savings Potential.

	Star Metrics	CMS Weighed Values	
		CMS Weighted Value	Max Shared Savings Potential
Standard Measures	Diabetes Care – Eye Exam	1	4.29%
	Diabetes Care – Kidney Disease Monitoring	1	4.29%
	Osteoporosis Management in Women Who Had a Fractur	1	4.29%
	Rheumatoid Arthritis Management	1	4.29%
	Breast Cancer Screening	1	4.29%
	Colorectal Cancer Screening	1	4.29%
	Diabetes Treatment	3	12.86%
	High Risk Medication	3	12.86%
	Medication Adherence- Oral Diabetes	3	12.86%
	Medication Adherence- Hypertension	3	12.86%
	Medication Adherence- Cholesterol	3	12.86%
	Standard Measures Potential		**90.00%**
Enhanced Measures	Diabetes Care – Blood Sugar Controlled	3	3.00%
	Controlling Blood Pressure	3	3.00%
	Adult BMI Assessment	1	1.00%
	COA: Medication Review	1	1.00%
	COA: Functional Status Assessment	1	1.00%
	COA: Pain Screening	1	1.00%
	Enhanced Measures Potential		**10.00%**
			100.00%

Step 3: Earned Contribution Calculated > Calculating Composite Scores

As mentioned above, there are two composites that are calculated for the scorecard, and the Standard Measures Composite is used to determine if the Quality Gate has been met.

Composite 1 – Standard Measures:

1. Calculate compliance rate for each measure.
Each measure is calculated by identifying the compliance rate for providers Medicare Advantage Attributed Members eligible for that measure. The compliance rate is the numerator (the number compliant with measure) for each of the measures divided by the denominators (eligible population).

2. Compare compliance rate to measure benchmark to assign Star rating achieved.
The compliance rate is compared to the benchmarks to assign a Star rating achieved for each measure.

3. Calculate earned contribution for each measure.
Based on the Star level achieved and the weight of the measure as shown in Table 6 below, the earned contribution for each measure is calculated. For example, a one Star would earn you

20 percent of the Shared Savings Potential for that measure, two Stars 40 percent all the way up to 5 Stars earning 100 percent of the Shared Savings Potential for that measure.

4. Calculate shared savings earned for the composite.
After the percentage of earned contribution for each measure is determined, the shared savings earned is calculated by summing the earned contribution across all measures within the composite.

5. Determine if the Quality Gate has been passed (As shown in Table 3).
The sum of the Standard Measures earned contribution is compared to the Quality Gate of 67.5 percent to determine if it has been passed. In our example, the Quality Gate has been passed because the earned contribution of 69.43 percent (4) is above the 67.5 percent Quality Gate (5).

Table 6: Standard Measure scoring
Steps above captured in the table below.

	Star Metrics	CMS Weighed Values		Providers Performance					Quality Gate	
		CMS Weighted Value	Max Shared Savings Potential	Den.	Num.	Compliance Rate ①	Provider's Star Value By Measure ②	Earned Contribution Achieved ③	Star Value Needed to Reach Quality Gate	Earned Contribution Needed to Reach Quality Gate
Standard Measures	Diabetes Care – Eye Exam	1	4.29%	100	78	78%	4	3.43%	3.75	3.21%
	Diabetes Care – Kidney Disease Monitoring	1	4.29%	100	93	93%	4	3.43%	3.75	3.21%
	Osteoporosis Management in Women Who Had a Frac	1	4.29%	200	150	75%	5	4.29%	3.75	3.21%
	Rheumatoid Arthritis Management	1	4.29%	60	41	68%	3	2.57%	3.75	3.21%
	Breast Cancer Screening	1	4.29%	125	83	66%	3	2.57%	3.75	3.21%
	Colorectal Cancer Screening	1	4.29%	80	58	73%	5	4.29%	3.75	3.21%
	Diabetes Treatment	3	12.86%	100	90	90%	5	12.86%	3.75	9.64%
	High Risk Medication	3	12.86%	325	26	8%	4	10.29%	3.75	9.64%
	Medication Adherence- Oral Diabetes	3	12.86%	100	73	73%	3	7.71%	3.75	9.64%
	Medication Adherence- Hypertension	3	12.86%	275	209	76%	3	7.71%	3.75	9.64%
	Medication Adherence- Cholesterol	3	12.86%	250	163	65%	4	10.29%	3.75	9.64%
	Standard Measures		**90.00%**				④▷	**69.43%**	**Quality Gate ⑤**	**67.50%**

<u>Composite 2 – Enhanced Measures:</u>

1. Calculate compliance rate for each measure.
Each measure is calculated by identifying the compliance rate for the measure for the providers Medicare Advantage Attributed Members. The compliance rate is the numerator (the number compliant with measure) for each of the measures divided by the denominators (eligible population).

2. Compare compliance rate to measure benchmark to assign Star rating achieved.
The compliance rate is compared to the benchmarks set for each Star level ranking to assign a Star rating achieved for each measure.

3. Calculate earned contribution for each measure.
Based on the Star level achieved, as shown in Table 7, the earned contribution for each measure is calculated by determining the portion of the Shared Savings Potential that the

provider has earned. For example, a one Star would earn you 20 percent of the Shared Savings Potential for that measure, two Stars 40 percent all the way up to 5 Stars earning 100 percent of the Shared Savings Potential for that measure.

4. Calculate shared savings earned for the composite.
After the percentage contribution for each measure is determined, the total for all measures in the Enhanced Measures composite are totaled.

Table 7: Enhanced Measure scoring – Steps above captured in the table below

	Star Metrics	CMS Weighed Values		Providers Performance				
		CMS Weighted Value	Max Shared Savings Potential	Den.	Num.	Compliance Rate ①	Provider's Star Value By Measure ②	Earned Contribution Achieved ③
Enhanced Measures	Diabetes Care – Blood Sugar Controlled	3	3.00%	100	82	82%	5	3.00%
	Controlling Blood Pressure	3	3.00%	250	180	72%	4	2.40%
	Adult BMI Assessment	1	1.00%	300	294	98%	5	1.00%
	COA: Medication Review	1	1.00%	80	75	94%	4	0.80%
	COA: Functional Status Assessment	1	1.00%	80	62	78%	4	0.80%
	COA: Pain Screening	1	1.00%	80	74	93%	5	1.00%
	Enhanced Measures		**10.00%**				④▷	**9.00%**

Step 4: Overall Shared Savings Percentage Calculated

Below, table 8 pulls together the various scoring segments described in this Measurement Period Handbook to demonstrate how the total Shared Savings Percentage earned by your provider organization is calculated.

In Table 8, the following steps take place:

- Confirm that the Quality Gate is passed and shared savings have been demonstrated (As shown in Table 3 and 4).
- Calculate the Earned Contributions for the Standard Measures (As shown in Table 6).
- Calculate the Earned Contributions for the Enhanced Measures (As shown in Table 7).
- Apply the maximum Shared Savings Potential of 50 percent (As identified on page 2 of this Medicare Advantage Measurement Period Handbook) to calculate your provider organizations overall Shared Savings Percentage earned.

Table 8: Summary of Scoring

In this example, the provider organization would earn 39.21 percent of the Gross Savings Achieved. For demonstration purposes, we are assuming that shared savings has been earned. The total shared savings earned is 79.43 percent of the Shared Savings Potential of 50 percent. Therefore, the Shared Savings Percentage earned is 78.43 percent earned contribution time the 50 percent Shared Savings Potential, which in this example is equal to 39.22 percent.

Composite	Savings Potential	Category % Earned	Savings Earned
Passed Quality Gate (>67.5%) ------>			**YES**
(1) Standard Measures	90.00%	69.43%	
(2) Enhanced Measures	10.00%	9.00%	
Total for composites		**78.43%**	
OVERALL SHARED SAVINGS POTENTIAL	**50%**		
EARNED SHARED SAVINGS PERCENTAGE			**39.22%**

Index – Scorecard measure specifications

Standard Measures				
Measure	Description	Numerator/Denominator	Technical Specifications	Measure Citation
Diabetes Care – Eye Exam	This measure identifies patients between 18 and 75 years old who have diabetes and who had a retinal eye exam from an eye care professional in the last 2 years.	**Numerator** Patients in the denominator who received a retinal eye from an eye care professional in the last 730 days. **Denominator** Patients identified as having diabetes during the measurement year or the year prior to the measurement year.	**Numerator** • ≥1 claim for a visit from an eye care professional in the last 730 days *Note: HEDIS specifications only count retinal eye exams from the previous year if the results were negative, but due to data limitations this measure was loosened to accept all eye exams from the previous year regardless of result.* **Denominator** • Age of 18–75 years as of the end of the measurement year • AND meet NCQA/HEDIS criteria for diabetes diagnosis, identified during the measurement year or the year prior • AND have service eligibility during the measurement year AND exclude members who meet NCQA/HEDIS criteria for diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes during the measure year or year prior	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.
Diabetes Care – Kidney Disease Monitoring	This measure identifies diabetic patients with a nephropathy screening test or evidence of nephropathy during the measurement year	Numerator Members with diabetes who have received nephropathy screening during the measurement year. Denominator Members between 18–75 years as of the end of the measurement year who meet NCQA/HEDIS criteria for diabetes diagnosis, identified during the measurement year or the year prior and who have service eligibility during the measurement year.	Numerator ANY of the following during the measurement year: ≥1 procedure in any position for "Nephropathy Screening Tests" OR ≥1 lab LOINC claim for "Nephropathy Screening Tests" OR ≥1 procedure in any position for "Treatment for Nephropathy" OR ≥1 diagnosis in any position for "Treatment for Nephropathy" OR ≥1 procedure in any position for "ESRD" OR ≥1 diagnosis in any position for "ESRD" OR ≥1 diagnosis in any position for "CKD Stage 4" OR ≥1 procedure in any position for "Kidney Transplant" OR ≥1 diagnosis in any position for "Kidney Transplant" OR≥1 procedure in any position for "Positive Urine Macroalbumin Tests" OR ≥1 procedure in any position for "Urine Macroalbumin Tests_P" OR ≥1 lab LOINC claim for "Urine Macroalbumin Tests" OR ≥1 Rx claim for "CDC-L: ACE Inhibitors/ARBs" OR ≥1 outpatient visit defined by "Outpatient" with a nephrologist specialist Denominator Age of 18–75 years as of the end of the measurement	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.

			year AND meet NCQA/HEDIS criteria for diabetes diagnosis, identified during the measurement year or the year prior AND have service eligibility during the measurement year.	
Osteoporosis Management in Women Who Had a Fracture	This measure identifies women age 67 or older who suffered a bone fracture and had either a bone mineral density (BMD) test or a prescription for a drug to treat or prevent osteoporosis during the six months after the date of fracture.	**Numerator** Patients in the denominator who had either a bone mineral density test or a prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture **Denominator** Women who are 67 years or older who suffered a bone fracture during the 6 months prior to the measurement year or during the first 6 months of the measurement year	**Numerator** • ≥1 claim for osteoporosis drugs from within 180 days following the index episode of bone fracture • OR at least 1 claim for a BMD test within180 days of the index episode of bone fracture **Denominator** • At least 67 years old as of the end of the measurement year • AND Female • AND had a claim for bone fracture during the six months prior to the measurement year through the first six months of the measurement year, with the earliest date of bone fracture diagnosis being the index episode • AND no claims for bone fracture 60 days prior to the index episode • AND had service and Rx eligibility between 12 months prior and six months after the index episode AND have no claims for a BMD test or a prescription for a drug to treat or prevent osteoporosis during the 365 days prior to the index episode	This measure identifies women age 67 or older who suffered a bone fracture and had either a bone mineral density (BMD) test or a prescription for a drug to treat or prevent osteoporosis during the six months after the date of fracture.
Rheumatoid Arthritis Management	This measure identifies patients with a diagnosis of RA and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year.	**Numerator** Patients in the denominator who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year **Denominator** Patients ≥18 years old with two face-to-face physician encounters with different dates of service in an outpatient or non-acute inpatient setting during the first 11 months of the measurement year with any diagnosis of rheumatoid arthritis (RA). Excludes patients diagnosed with HIV or who were pregnant during the measurement year	**Numerator** • ≥1 Rx claim for "DMARD" during the measurement year **Denominator** • Age ≥18 years old as of the end of the measurement year • AND ≥2 medical claims for face-to-face physician encounters with different dates of service in an outpatient or non-acute inpatient setting, with a diagnosis of rheumatoid arthritis based on HEDIS criteria, during the first 11 months of the measurement year • AND no medical claims for HIV or pregnancy during the measurement year AND has continuous medical and Rx eligibility (as defined by NCQA/HEDIS) during the measurement year	National Committee for Quality Assurance. HEDIS 2012. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol. 2, 2011.
Breast Cancer Screening	This measure identifies women age 52 to 74 as of	**Numerator** Patients in the denominator who	**Numerator** • ≥1 claim for mammogram	National Committee for Quality Assurance.

	the last day of the measurement year who had a mammogram during the measurement year or during the 15 months prior to the measurement year.	had a mammogram during the measurement year or during the 15 months prior to the measurement year **Denominator** Women who are 52-74 years of age as of the last day of the measurement year without evidence of history of breast cancer or a bilateral mastectomy	during the 820 days prior to the end of the measurement year **Denominator** • Female • AND between 52 and 74 years old as of the end of the measurement year • AND have service eligibility during both the measurement year and the year prior to the measurement year • AND exclude members with a history of breast cancer in the past • AND exclude members with claims for "bilateral mastectomy" in the past AND exclude members with ≥2 claims for mastectomy on 2 separate days anytime in the past	HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications, Vol.2, 2013.
Colorectal Cancer Screening	This rule identifies members 50-75 years of age who had appropriate screening for colorectal cancer.	**Numerator** Members who have received at least one screening for colorectal cancer. Screenings include fecal occult blood test during the measurement year, flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year, colonoscopy during the measurement year or the 9 years prior to the measurement year. **Denominator** Members between the age of 51 and 75. Excluding members who have had a diagnosis for colorectal cancer or a total colectomy procedure anytime in the past.	**Numerator** ANY of the following: ≥1 claims for colonoscopy during 3,650 days prior to the end of the measurement year; OR ≥1 claims for flexible sigmoidoscopy during 1,825 days prior to the end of the measurement year; OR ≥1 claims for fecal occult blood test during the measurement year. **Denominator** Age >=51 and <=75 yrs as of the end of the measurement year; AND No claims for colorectal cancer screening anytime in the past; AND No claims for colorectal cancer anytime in the past; AND No claims for total colectomy anytime in the past; AND has member eligibility during the measurement year.	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.
Diabetes Treatment	The rule identifies patients who were dispensed a medication for diabetes and hypertension that are receiving an ACEI or ARB or direct renin inhibitor medication.	**Numerator** Patients who receive an ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor combination during the measurement year. **Denominator** Patients who were dispensed at least one prescription for an oral hypoglycemic agent, insulin, incretin mimetics (Table APP-A: Oral Hypoglycemic, Insulin, and Incretin Mimetics) and at least one prescription for an antihypertensive agent (Table APP-B: Antihypertensive Agents) during the measurement year.	**Numerator** ≥1 Rx claim for an "RAS" Agent during the measurement year **Denominator** Age >= 18 years old as of the end of the measurement year; AND ≥1 Rx claim for an "DM Med for HTN Tx" with dispense date during the measurement year; AND ≥1 Rx claim for an "HTN Med" with dispense date during the measurement year.	Pharmacy Quality Alliance.
High Risk Medication	The rule identifies patients 65 years of age and older who did not received two or more prescription fills for a high-risk medication during the measurement period.	**Numerator** Patients who did not received at least two prescription fills for the same high-risk medication (Table HRM-A: High-Risk Medications) during the measurement period. **Denominator** Patients who are at least 65 years old.	**Numerator** NOT Any of the following during the measurement year: ≥2 Rx prescriptions for 'Elderly High Risk Meds' for the same medication at GPI10 level; OR ≥ Rx prescriptions for Digoxin medication AND average daily dose* > 0.125 mg for each of the earliest two claims; OR ≥2 Rx	Pharmacy Quality Alliance.

			prescriptions for Reserpine medication AND average daily dose* > 0.1 mg for each of the earliest two claims; OR ≥2 Rx prescriptions for Doxepin medication AND average daily dose* >6 mg for each of the earliest two claims; OR ≥2 Rx prescriptions for 'Nitrofurantoin' medication AND a total supply >90 days; OR ≥2 Rx prescriptions for 'Nonbenzodiazepine Hypnotics' medication AND a total supply >90 days. *NOTE: Average daily dose is calculated using the earliest two Rx claims during the measurement year. **Denominator** Age >= 65 years old at the end of the measurement year; AND sustained Rx eligibility during the measurement year.	
Medication Adherence-Cholesterol	This measure identifies patients with at least two prescriptions for a Statin in the measurement year who have at least 80% days covered (PDC) since the first prescription of a Statin during the year.	**Numerator** Patients in the denominator with at least 80% days covered for a Statin since the first prescription for the drug during the last 365 days **Denominator** Patients who have at least two prescriptions for a Statin during the last 365 days	**Numerator** • >=80% days covered (PDC) for Statins (removing overlapping days) from index event to end of measurement year **Denominator** • >=2 Rx claims for Statins from end of measurement year-365 to end of measurement year, saving earliest instance as index event (IE); • Rx eligibility from index event to end of measurement year using HEDIS gap method, <=1 gap <=45 days max; >=18yo	CMS Part D Specifications 2012
Medication Adherence-Oral Diabetes	This measure identifies patients with at least two prescriptions for diabetic oral agents in the measurement year who have at least 80% days covered (PDC) since the first prescription of an oral diabetic agent during the year.	**Numerator** Patients in the denominator with at least 80% days covered for an oral diabetic Rx since the first prescription for the drug during the last 365 days **Denominator** Patients who have at least two prescriptions for an oral diabetic drug during the last 365 days	**Numerator** >=80% days covered (PDC) for Diabetic Oral Agents (removing overlapping days for Rx) from index event to end of measurement year **Denominator** • >=2 Rx claims for diabetic oral agents from end of measurement year-365 to end of measurement year, saving earliest instance as index event (IE); • Rx eligibility from index event to end of measurement year using HEDIS gap method, <=1 gap <=45 days max; • >=18yo No Rx claims for 'Insulin' from index event to end of measurement year	CMS Part D Specifications 2012
Medication Adherence-Hypertension	This measure identifies patients with at least two prescriptions for an ACE/ARB in the measurement year who have at least 80% days	**Numerator** Patients in the denominator with at least 80% days covered for an ACE/ARB since the first prescription for the drug during the last 365 days	**Numerator** • >=80 days covered (PDC) for ACE/ ARB (removing overlapping days) from index event to end of measurement year	CMS Part D Specifications 2012

	covered (PDC) since the first prescription of an ACE/ARB during the year.	**Denominator** Patients who have at least two prescriptions for an ACE/ARB during the last 365 days	**Denominator** • >=2 Rx claims for ACE/ ARB from end of measurement year-365 to end of measurement year, saving earliest instance as index event (IE); • Rx eligibility from index event to end of measurement year , using HEDIS gap method, <=1 gap <=45 days max; >=18yo	
Enhanced Measures				
Measure	**Description**	**Numerator/Denominator**	**Technical Specifications**	**Measure Citation**
Diabetes Care – Blood Sugar Controlled	This rule identifies diabetic members age 18-75 years with a most recent HbA1c < 8% during the measurement year.	Numerator: Patients in the denominator with a most recent HbA1c level <8.0% during the measurement year. Denominator: Patients with diabetes diagnosed during the measurement year or the year prior to the measurement year.	**Numerator:** Most recent lab result for HbA1c Tests' < 8 from during the measurement year; OR Most recent CPT CatII A1c Test result < 7 defined by 'HbA1c Level Less Than 7.0' during the measurement year * A1c Test CPT CatII codes defined by the following tracers 'HbA1c Level Greater Than 9.0' and 'HbA1c Level 7.0-9.0' and 'HbA1c Level Less Than 7.0'. ** HEDIS SPEC: 7.0-9.0 **Denominator:** Age >= 18 and <= 75 years-old on aaod; AND history of diabetes; AND has <1 gap of 45 days member eligibility during the measurement year. The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%-9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed.	
Controlling Blood Pressure	This rule identify members age >= 18 and <= 85 years old who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.	**Numerator**: Members identified in the denominator who whose Blood pressure was adequately controlled (<140/90) during the measurement year. **Denominator:** Members between the age of 18 and 85 who have received at least one diagnosis for hypertension in an outpatient setting during the first 6 months of the measurement year. Exclude members with evidence of end-stage renal disease or kidney transplant anytime in the past; exclude members with a	**Numerator:** - Both of the following on the same and most recent claim from onset date to 365 days after onset date: Claims for 'Systolic Blood Pressure < 140 CAT II'; AND - Claims for 'Diastolic Blood Pressure < 90 CAT II'. **From HEDIS spec: The member is not compliant if the BP reading is >=140/90 or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). **Denominator**: Age >= 18 and <= 85 years-old on AAOD; AND	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.

		pregnancy diagnosis or members who had a nonacute inpatient encounter during the measurement year.	continuous member eligibility from AAOD-365 to AAOD, max 1 gap <= 45 days; AND - >= 2 Claims for '=Hypertension=' concurrent with 'Outpatient CPT' separated by 30 days from AAOD-365 to AAOD-181, save start Date as OD; AND No Claims for 'Pregnancy' from AAOD-365 to AAOD; AND No Claims for 'Nonacute Care' from AAOD-365 to AAOD; AND None of the following from AAOD-9999 to AAOD: Claims for 'ESRD'; OR Claims for 'ESRD Obsolete'; OR Claims for 'Kidney Transplant'.	
Adult BMI Assessment	This rule identifies members 19-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	**Numerator:** Members identified in the denominator who had a CPT4 CATII claim for BMI during the measurement year or the year prior to the measurement year. **Denominator:** Members age 19-74 who had an outpatient visit during the measurement year or the year prior to the measurement year.	**Numerator:** Claims for 'BMI' from during the measurement year or the year prior to the measurement year. **Denominator:** Age >= 19 Years 12 months old and <= 74 years old; AND member eligibility from AAOD-364 to AAOD, max 1 gap of <= 45 days; AND member eligibility from AAOD-730 to AAOD-365, max 1 gap of <= 45 days; AND Claims for 'Outpatient' from AAOD-730 to AAOD; AND NO claims for 'Pregnancy' from AAOD-730 to AAOD.	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.
COA: Medication Review	This rule identifies members age >= 66 years old who have received an annual Medication Review during the measurement year.	**Numerator:** Members identified in the denominator who had a Medication review during the measurement year. **Denominator:** Members 66 years and older.	**Numerator:** Both of the following on the same date of service during the measurement year: Claim for 'Medication Review'; AND Claim for 'Medication List'. **Denominator:** Age >= 66 years old; AND member eligibility from during the measurement year, max 1 gap of 45 days.	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.
COA: Functional Status Assessment	This rule identifies members age >= 66 years old who have received the annual Functional Status Assessment during the measurement year.	**Numerator:** Members identified in the denominator who had a Functional status assessment during the measurement year. **Denominator:** Members 66 years and older.	**Numerator:** Claims for 'Functional Status Assessment' during the measurement year. **Denominator:** Age >= 66 years old; AND member eligibility during the measurement year, max 1 gap of 45 days.	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.
COA: Pain Screening	The percentage of adults 66 years and older who had a Pain assessment during the measurement year.	**Numerator:** Members identified in the denominator who had a Pain assessment during the measurement year. **Denominator:** Members 66 years and older.	**Numerator:** Claims for 'Pain Assessment' during the measurement year. **Denominator:** Age >= 66 years old; AND member eligibility during the measurement year, max 1 gap of 45 days.	National Committee for Quality Assurance. HEDIS 2014. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2013.