HEDIS Measures and the Family Physician Office

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HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
NCQA and payers’ policy changes frequently. Please refer to the source documents for your future reference.
This presentation was prepared as a tool to assist family physicians and other primary care providers.
This presentation is a general summary that explains aspects of the NCQA HEDIS® Program. The official program provisions are contained in the NCQAs relevant laws, regulations, and rulings.
I am not representing Humana with the content of this lecture. These are my views and opinions and not those of Humana.
National Committee of Quality Assurance (NCQA) defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.”

HEDIS is one component of NCQA's accreditation for Patient Centered Medical Home.

HEDIS is the most used performance measure in the managed care industry.

NCQA uses these measures for commercial, Medicare and Medicaid.
The majority of HEDIS are measurements from administrative result (claims), but some are pulled from hybrid results medical record review.

- Administrative data is calculated from a claim or an encounter submitted to a health plan.

- Hybrid reviews are a random sample of a members medical record (may also include administrative data).

- Retroactive reviews of the medical record and data submitted may occur for data submitted in the prior year.
What is HEDIS?

* Results from HEDIS data collection serve as measurements for quality improvement processes and preventive care programs
* HEDIS rates are designed to evaluate the effectiveness of a health plan’s ability to demonstrate an improvement in its preventive care and quality measures to the plan’s members
* **HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service**
* HEDIS consists of 75 measures across 8 **domains** of care that address important health issues
What is HEDIS?

**HEDIS Eight Domains of Care**
1. Effectiveness of Care
2. Access/availability of Care
3. Satisfaction with the Experience of Care Provided
4. Health Plan Stability
5. Use of Service
6. Cost of Care
7. Informed Health Care Choices
8. Health Plan Information is Clear and Descriptive

**RED** = those areas you have the most control over outcome
What is HEDIS?

* Data is reported to NCQA in June of the reporting year. Data reflects events that occurred during the measurement year (calendar year).
* HEDIS 2015 data is reported in June 2015; however, it reflects data from January to December 2014.
* HEDIS 2015 = 2014 data.
What is HEDIS?

Key Terms to Know

– **Denominator** = eligible members of the population

– **Numerator** = members that met the criteria of a measure
  • Example: 100 members of which 20 met criteria
  = \( \frac{20}{100} = 20\% \)

– **Anchor date** = the specific date the member is required to be enrolled to be eligible for the measure

– **Provider specialty** = certain measures must be provided by a specific provider specialty
HEDIS Obstacles

– Members are assigned to the wrong PCP provider or information is not properly transferred to new PCP
– Claims are submitted without the proper ICD-9 or CPT codes that count toward the measure
– The provider specialty does not count for the measure
– The member is not continuously enrolled
– The services are not documented properly in the member’s medical record
– All components of the required measure were not met
– Appointment availability to members and provider’s open hours

What is HEDIS?
HEDIS measures are specified for one or more of three data collection methods:

1. Administrative
2. Hybrid
3. Survey

Clinical measures use the Administrative and/or Hybrid data collection methodology as specified by NCQA
I. Administrative methodology requires that the health plan:
– identify the eligible population for the specific HEDIS measure through use of electronic records of service to include insurance claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs; and,
– determine the number of that population who are found to have received the service required for that measure.
II. Measures that are captured through administrative data include Breast Cancer Screening and Antidepressant Medication Management.

III. It is critical that ICD-9/ICD-10 codes and/or CPT codes approved by NCQA be submitted to ensure the member receives the necessary screening and the provider receives credit for performing the screening.
In order to comply with CMS requirements, providers will be required to switch to ICD-10 Diagnosis and Procedure codes effective October 1, 2015.

NCQA has created a plan to identify a valid and appropriate set of ICD-10 codes for each HEDIS measure in time for inclusion in the HEDIS 2015 publications.
What Are Measures?

The Hybrid method of data collection consists of the selection of a random sample of the population and allows for supplementation of Administrative data with data collected during the medical record reviews.

* Johns Hopkins Health Care (JHHC) uses this method for 14 measures
* A few examples are Prenatal and Postpartum Care, Comprehensive Diabetes Care and Childhood Immunizations
What Are Measures?

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey which measures members' satisfaction with their care in areas such as claims processing, customer service and getting needed care quickly.
- Data collection relating to the CAHPS 4.0 survey must be conducted by an NCQA-approved external survey organization.
Why Is Documentation Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and,
- collection of data that may be useful for research and education.
An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.
Why is HEDIS Important to You?

- Improved Physician Coding
- Higher HEDIS Scores
- Higher PQRS Scores and Bonus
- Priority Partners Higher Risk Scores
- Priority Partners Potentially Receives Increase in Capitation from Medicare / Medicaid
- Provider Compensation Potentially Increases
Physician Quality Reporting System (PQRS)

* Created by CMS
* Reporting program that uses a combination of incentive payments and payment adjustments to promote quality.
  * Program provides an incentive payment to Practices with eligible providers who satisfactorily report data on quality measures covered by the Medicare Physician Fee Schedule for services furnished to Medicare Part B Fee-for-Service beneficiaries.
  * Commencing in 2015, the program also applies a payment reduction adjustment to eligible providers who do not satisfactorily report data on quality measures.
Eligible professionals may choose at least three individual measures or one measures group as an option to report on measures to CMS.

If already participating in PQRS, there is no requirement to select new/different measures for the 2015 PQRS.

**NOTE:** All PQRS measure specifications are annually updated and posted prior to the beginning of each program year; therefore, eligible professionals will need to review them for any revisions or measure retirement for the current program year.
Providers may earn a 0.5% PQRS incentive (paid in 2015) based on 2014 Medicare payments.

If a provider does not participate in the PQRS program, the provider will be subject of a 1.5% payment reduction adjustment AND a value based modifier adjustment of 1.0% in 2015.
HEDIS and PQRS measure different quality factors, but a provider can meet both criteria on the same visit.

For example:

HEDIS Well Child 3-6 Years visit (measure #1) plus whether the child has complete immunizations on or before the child’s second birthday (measure #2) = 2 HEDIS measures for the one visit!

PQRS measures the percentage of patients age 6 months and older seen for a visit between October 1 and March 31 who have received an influenza immunization OR reported previous receipt of an influenza immunization.
The principles of documentation listed below are applicable to all types of medical and surgical services in all settings.

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
  - assessment, clinical impression, or diagnosis;
  - plan for care; and,
  - date and legible identity of the observer.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
* Past and present diagnoses should be accessible to the treating and/or consulting physician.
* Appropriate health risk factors should be identified.
* The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
* The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
HEDIS Documentation/Coding Tips

Analysis of Key Measures Requirements

PCP Practices
Hybrid Review for Adolescent Well Care Visits, Age 12 – 21 years

- One Well Child Visit with a PCP or OB/GYN during the measurement year
- All three components of an Adolescent Well Visit must be included:
  - Health & Development History (physical and mental) e.g. developmental questionnaires regarding school, emotional development, activities, depression, peer relations, etc.
  - Physical Examination e.g., weight, height, vision, heart, lungs, GU (pap smears).
  - Health Educations/Anticipatory Guidance e.g., sex education, ETOH (short for ethanol) avoidance, safety, etc.
Hybrid Review for Adolescent Well Care Visits, Age 12 – 21 years (con’t.)

- Sick visits are opportunities to include this information
- Visits to school-based clinic practitioners whom the organization would consider PCPs may be counted if the documentation that a well exam occurred is available in the medical record or administrative system
Hybrid Review for Adolescent Well Care Visits, Age 12 – 21 years (con’t.)

Billing Tips – Select from:

- CPT codes: 99384–99385 and 99394–99395
- HCPCS Codes: G0438, G0439
- ICD-9: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, and V70.9

Note: The codes do not have to be primary codes. The codes are deemed meeting the measure’s assessment components.

Note: V72.3 is for a GYN Exam. It is not included in the adolescent well visit. Auditors have rejected this code as a bridge to an Adolescent Well Visit.
Hybrid Review for Well Child 3-6 Years

* One Well Child Visit with a PCP during the measurement year.
* All three components of a Well Child Visit must be included:
  * Health & Development History (physical & mental) e.g., communication skills, self-care skills, disposition
  * Physical Examination e.g., height, weight, lungs, abdomen, vision, hearing, abuse/neglect, etc.
  * Health Educations/Anticipatory Guidance e.g., bed time, second hand smoke, friends, proper eating
* Sick visits are opportunities to include this information
* Visits to school based clinic practitioners whom the organization would consider PCPs may be counted if the documentation that a well exam occurred is available in the medical record or administrative system.
The claim must have the proper ICD-9/CPT codes and be submitted by the correct specialty to be counted.

PCP: A physician or non-physician (e.g. nurse practitioner or physician assistant) who offers primary care medical services. Licensed practical nurses, registered nurses, and physician assistants are not considered PCPs because they are not licensed to practice independently.

Primary Care Physician visit includes:
- General or family practice physicians
- General internal medicine physicians
- General pediatricians
- Obstetricians/gynecologists (OB/GYN)
- Certified nurse midwives and Nurse Practitioners/PAs under the direction of an OB/GYN, certified provider, or PCP

The PCP does not have to be assigned to the member.
Hybrid Review Childhood Immunization and Lead Screenings

The health plan is looking for all childhood immunizations and lead screenings to be completed **on or before** the child’s second birthday – **in other words, 12-23 months (plus the number of days in that 23rd month just prior to the date of birth)**

- Complete immunizations on or before the child’s second birthday:
  - 4 – DTaP/DT
  - 3 – IPV
  - 3 – Hep B
  - 3 – Hib
  - 4 – PCV
  - 1 – MMR
  - 1 – VZV

- Document all seropositives and illness history of chicken pox, measles, mumps, and rubella

- Document the 1st Hep B vaccine given at the hospital when applicable or if unavailable name of hospital where child was born

- No provider requirements specified
Diabetic Eye Exam, Members 18 – 75 years of age with diabetes

- Optometrist/Ophthalmologist exam every two years for patients without retinopathy and every year for diabetic retinopathy.
- A chart or photograph of retina indicating date when photography performed with evidence that an eye professional reviewed the results and must specifically state “with” or “without” retinopathy.
- Identify diabetic exclusions requires a note indicating any of the following:
  - Polycystic ovaries
  - Steroid Induced Diabetes
  - Gestational Diabetes
- A referral is not required. This is a self-referred benefit and the PCP can provide a script to the member to see an eye care provider, with clear indication that if diabetic, the question of retinopathy needs to be answered.
Disabled (SSI) Children, 0 – 20 years of age who are enrolled for 320 days or more

* Children that have had at least one ambulatory care visit in an office or other outpatient site.
* All three components of a Well Child Visit must be included if a Well Child Visit is being performed
  * Health and Development History (physical and mental)
  * Physical Examination
  * Health Education/Anticipatory Guidelines

* No provider requirements specified

* **Exclusions:** Measure does not include mental health or chemical dependency services
HEDIS Documentation/Coding Tips

* Disabled (SSI) Adults, Age 21 – 64 years or older

  * Adults that have had at least one ambulatory care visit in an office or other outpatient visit
  * SSI adults should receive all three components of a Well Care Visit
    * Health and Development History (physical and mental)
    * Physical examination
    * Health Education/Anticipatory Guidance
  * No provider requirements specified

  * Exclusions: Measure does not include mental health or chemical dependency services.
Hybrid Review for Cervical Cancer Screening for Women 21-64 Years of Age

- One screening pap test at least every three years (can be done yearly)
- Obtain copy of results or medical record documenting the date of test results
- The following does not qualify:
  - Lab results that indicate inadequate sample or no cervical cells
  - Referral to OB/GYN alone does not meet the measure
  - Biopsies are considered diagnostic and do not meet the measure

Document exclusions:
- Documentation of Total or Partial Hysterectomy can only be used if Absence of Cervix is documented.
Breast Cancer Screening, Women age 40 – 69 years

* One mammogram breast screening every two years
* Obtain a copy of mammogram results or record date of test and result
* The purpose of the breast cancer screening measure is to evaluate primary screening. Biopsies, breast ultrasounds and MRIs do not count because HEDIS® does not consider them to be appropriate primary screening methods

* Exclusions:
  * Women who have had bilateral mastectomy (may occur on the same or separate dates)
We found that the most common reasons for a negative score across all measures are due to:

* lack of documentation in the medical record
* lack of referral to obtain the recommended service
* HEDIS service received but outside of the recommended time frame

Practice improvement action: look at forms and electronic health records and add guidance on requirements
Lack of documentation in medical record

- No immunization flow sheet
- No preventive health documentation sheet
- No diabetes flow sheet

Lack of referral or recommendation for services

- Diabetic retinal exam
- HbA1c testing
- Cholesterol screening
Member non-compliance Failure to follow physician advice
* Lack of knowledge
* Fear of test results
* “No Shows” for scheduled appointments

PROOF is in the DOCUMENTATION!
# Quality Clinical Star Measures Reminder Form

<table>
<thead>
<tr>
<th>Measure code</th>
<th>Measure</th>
<th>Weight</th>
<th>Age</th>
<th>Date range</th>
</tr>
</thead>
<tbody>
<tr>
<td>* ABA</td>
<td>Body mass index (BMI)</td>
<td>1.0</td>
<td>18 to 74</td>
<td>Jan. to Dec. (2 years)</td>
</tr>
<tr>
<td>* ART</td>
<td>Rheumatoid arthritis (diagnosis of RA, with disease modifying antirheumatic drug dispensed)</td>
<td>1.0</td>
<td>≥ 18</td>
<td>Jan. to Dec. (1 year)</td>
</tr>
<tr>
<td>* BCS</td>
<td>Breast cancer screening (mammography or exclusion)</td>
<td>1.0</td>
<td>50 to 74</td>
<td>Oct. to Dec. (2 years and 3 months)</td>
</tr>
<tr>
<td>* CBP</td>
<td>Controlling high blood pressure (varies based on age and diabetes diagnosis)*</td>
<td>3.0</td>
<td>18 to 85</td>
<td>Jan. to Dec. (1 year)</td>
</tr>
</tbody>
</table>
Diabetic members ages 18 to 75 (CDC2)

**Measure code:** CDC2_EYE

**Measure:** Diabetic retinal eye exam (DRE) performed or evidence of negative DRE performed the prior year

**Weight:** 1.0

**Age:** 18 to 75

**Date Range:** Jan. to Dec. (1 year)
Diabetic members ages 18 to 75 (CDC2)

**Measure code:** CDC2_HBAPOOR

**Measure:** HbA1C (test and poor control) less than 9 percent. **Goals is less than 9 percent**

**Weight:** 3.0

**Age:** 18 to 75 yo

**Date range:** Jan. to Dec. (1 year)
### Market: South FL
- **Center Number:** 000100074
- **Center Name:** HERSHMAN MEDICAL CENTER PA
- **Membership:** 473

### Center Membership Size:
- **Medium**

#### Weighted Average Percent:
- **83%**

#### Center Membership Size:
- **Medium**

#### Weighted Avg STAR Score:
- **3.9**

#### Percentile Among Similar Centers:
- **37**

### STAR Measure

<table>
<thead>
<tr>
<th>STAR Measure</th>
<th># GAPS</th>
<th>NUM</th>
<th>RATE</th>
<th>DENOM</th>
<th>STARS</th>
<th>Gaps to 4</th>
<th>Gaps to 5</th>
<th>*AVG %</th>
<th>4 STAR</th>
<th>5 STAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>5</td>
<td>182</td>
<td>97.33%</td>
<td>187</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>97.0%</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td>Anti-rheumatic drug for RA</td>
<td>2</td>
<td>4</td>
<td>66.67%</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>78.2%</td>
<td>78%</td>
<td>88%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>22</td>
<td>69</td>
<td>75.82%</td>
<td>91</td>
<td>4</td>
<td>---</td>
<td>7</td>
<td>85.3%</td>
<td>74%</td>
<td>83%</td>
</tr>
<tr>
<td>COA - Functional Status Assessment</td>
<td>1</td>
<td>27</td>
<td>96.43%</td>
<td>28</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>90.4%</td>
<td>73%</td>
<td>89%</td>
</tr>
<tr>
<td>COA - Medication Review</td>
<td>-</td>
<td>28</td>
<td>100.00%</td>
<td>28</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>88.3%</td>
<td>80%</td>
<td>92%</td>
</tr>
<tr>
<td>COA - Pain Screening</td>
<td>1</td>
<td>27</td>
<td>96.43%</td>
<td>28</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>91.0%</td>
<td>79%</td>
<td>91%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>62</td>
<td>134</td>
<td>68.37%</td>
<td>196</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>75.5%</td>
<td>58%</td>
<td>68%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>63</td>
<td>81</td>
<td>56.25%</td>
<td>144</td>
<td>3</td>
<td>10</td>
<td>30</td>
<td>44.8%</td>
<td>63%</td>
<td>77%</td>
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<tr>
<td>Diabetes Care - Blood Sugar Controlled</td>
<td>19</td>
<td>72</td>
<td>79.12%</td>
<td>91</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>81.6%</td>
<td>80%</td>
<td>89%</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>32</td>
<td>59</td>
<td>64.84%</td>
<td>91</td>
<td>4</td>
<td>---</td>
<td>15</td>
<td>68.4%</td>
<td>64%</td>
<td>81%</td>
</tr>
<tr>
<td>Diabetes Care - Monitoring Diabetic Nephropathy</td>
<td>12</td>
<td>79</td>
<td>86.81%</td>
<td>91</td>
<td>4</td>
<td>---</td>
<td>7</td>
<td>96.5%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Diabetic and Hypertensive Meds</td>
<td>11</td>
<td>71</td>
<td>86.59%</td>
<td>82</td>
<td>4</td>
<td>---</td>
<td>3</td>
<td>91.8%</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>High Risk Meds</td>
<td>16</td>
<td>411</td>
<td>96.25%</td>
<td>427</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>97.2%</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>Medication Adherence - ACE/ARB</td>
<td>27</td>
<td>152</td>
<td>84.92%</td>
<td>179</td>
<td>4</td>
<td>---</td>
<td>1</td>
<td>80.6%</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>Medication Adherence - Diabetes</td>
<td>19</td>
<td>50</td>
<td>72.46%</td>
<td>69</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>78.9%</td>
<td>77%</td>
<td>81%</td>
</tr>
<tr>
<td>Medication Adherence - STATINS</td>
<td>19</td>
<td>113</td>
<td>85.61%</td>
<td>132</td>
<td>5</td>
<td>---</td>
<td>---</td>
<td>74.5%</td>
<td>76%</td>
<td>83%</td>
</tr>
<tr>
<td>Osteoporosis Management</td>
<td>2</td>
<td>1</td>
<td>33.33%</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>68.5%</td>
<td>60%</td>
<td>76%</td>
</tr>
</tbody>
</table>

**Is Ranked:** 242 Out Of 386 Centers with Similar HMO Humana membership in South FL

**Is Ranked:** 325 Out Of 720 Centers with Similar HMO Humana membership in Florida.

* The Average Percent is based upon Centers with Comparable Humana Medicare membership in the ALL Florida HMO markets. (Small = 0-99 Members, Medium = 100-999 Members, Large = 1000+ Members)
Summary Tips To Improve HEDIS Reporting

* ICD-9/ICD-10 Codes—multiple codes with correct decimals
* CPT Codes—check accuracy
* Complete all required fields
* Improve standardization across providers/locations
* Audit encounters submitted
* Talk to your plan about provider tool-kits containing educational required materials, forms, to assist physicians and staff in utilizing best practices to improve care to members, thus improving HEDIS performance.
What You Can Do to Improve Reporting?

* Review and work reports of members with gaps in care to assist with member and provider interventions
* Develop and **USE** forms and tools for “fail safe” process
* Appoint a staff “guru”
* Work with your IT electronic medical records vendor to all conditions and guidance based on the HEDIS measurement standards
HOW IS CARE TRANSFORMED?

* Transform primary care from a series of episodes to a continuum
* Discrete and isolated health data to a fluid and accessible repository
* Lack of meaningful data further blinds clinicians to patient’s health outside of the office and contributes to unnecessary ED visits and hospitalizations, increasing cost of care
* Old models neglect significant data, potentially meaningful to patient’s daily lives and health
* Payment model changing from FFS to MC capitation, with or without financial risk.
Questions?