Provider Delivered Care Management Quality Webinar July 22, 2015

What is HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS) is a tool set utilized to measure performance on important dimensions of care and services.

Who decides what is a HEDIS measure?

- ***NCQA (National Committee for Quality Assurance is the body that CMS defers to define measures, define criteria for inclusion in measure and compliancy.***

- ***PQA – Pharmacy Quality Alliance is the body that is deferred to for pharmacy part D measures.***

Why Focus on Quality

Quality of care is key imperative to population health.

It is key indicator that providers, hospitals and health plans are being evaluated on and in many instance being reimbursed based on performance to quality indicators>

1. ***Medicare Advantages Stars***
2. ***Quality Rating- Exchange population***
3. ***Accreditation***

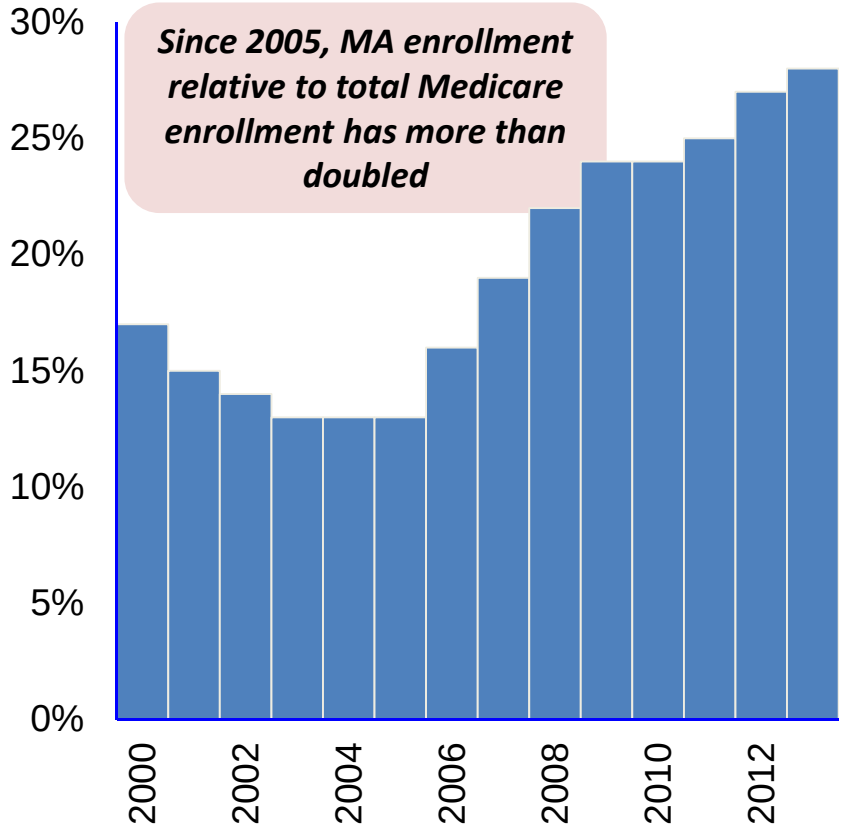
Nationwide, Medicare Advantage is becoming the preferred product for a majority of new Medicare age-ins

Medicare Advantage Market Overview

MA is increasing its presence amongst Medicare beneficiaries for several reasons:

- Rates have become more attractive due to government reform
- Majority of MA plans offer benefits beyond the standard Medicare package

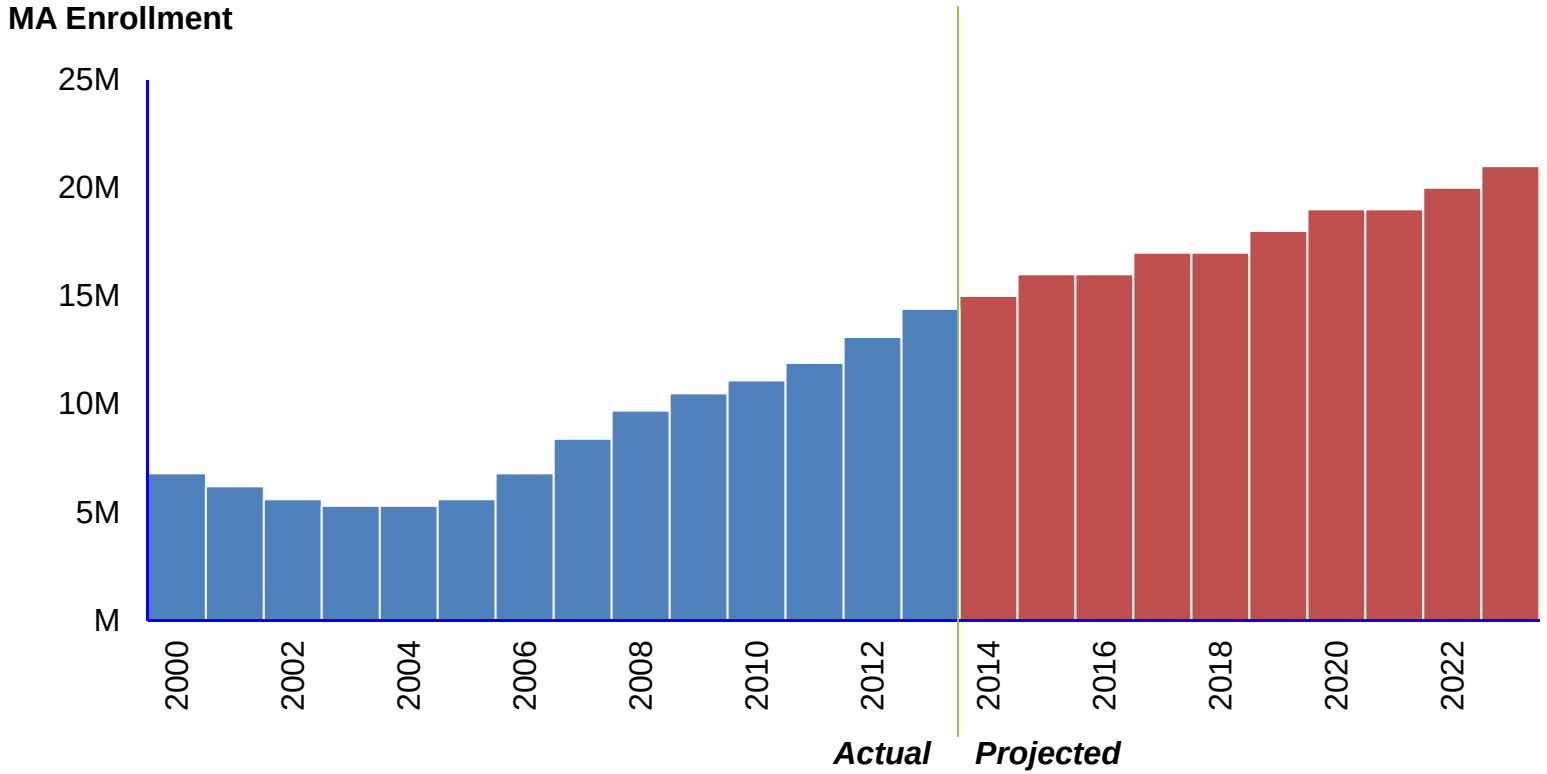
MA as a % of Total Medicare Enrollment (2000-2013)



Source: Kaiser Family Foundation, Medicare Primer 2010

Medicare Advantage enrollment has been rising for more than 10 years due to demographic factors and favorable market dynamics

Medicare Advantage Projected Enrollment
(2000–2023)

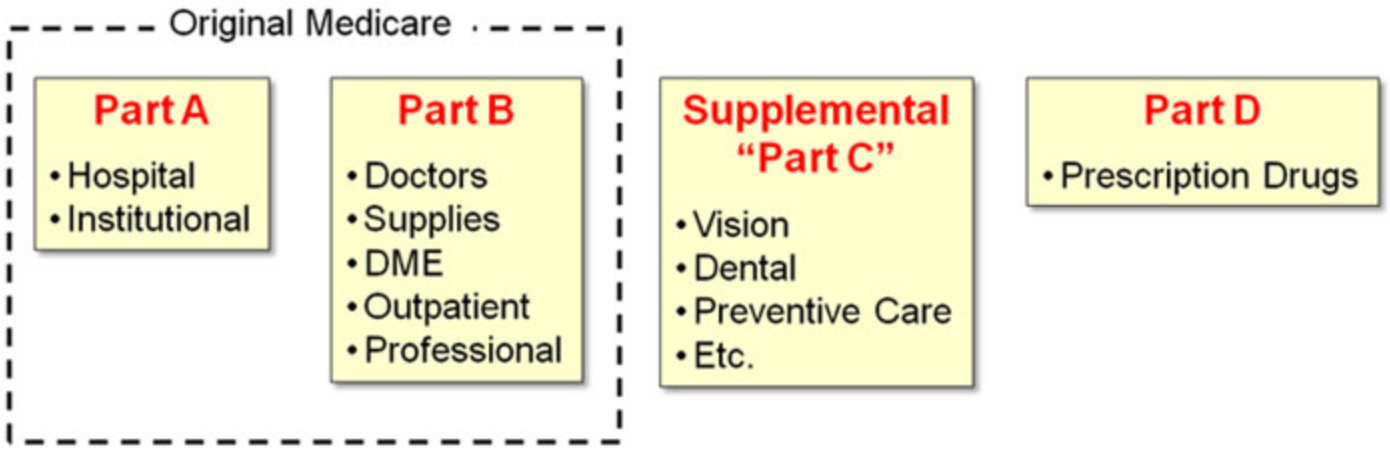


Between 2010–2030, Medicare enrollment is expected to grow by 34%, resulting in 16M additional lives

Source: Kaiser Family Foundation

Medicare Advantage Offering

Medicare Advantage products offer the benefits of Original Medicare Parts A and B with additional Part C supplemental coverage. They may also incorporate the voluntary drug benefit of Medicare Part D, depending on the product selected by the member.



*corporate membership reporting

What is Medicare Star Quality?

The Five Star Quality Rating System for Medicare Advantage Plans, administered by Centers for Medicare & Medicaid (CMS), was put in place as part of an effort to help educate consumers on quality, make quality performance more transparent, and reward high quality Medicare Advantage plans that deliver successful outcomes.

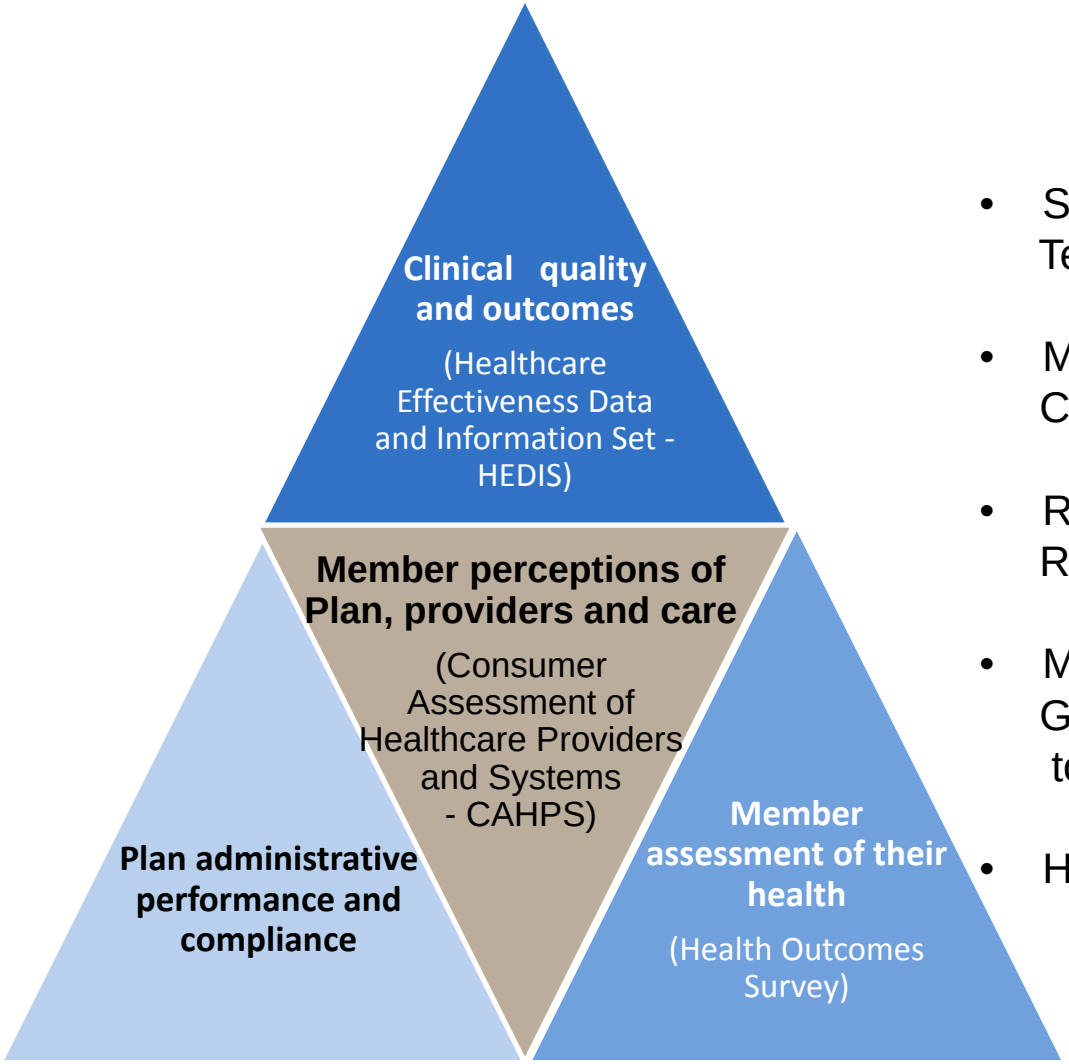
Starting in 2015 the Stars Quality bonus is an "all or nothing" reward; Plans must achieve a 4-Star rating to earn a bonus. There is no building on prior year scores; each new Star measurement year starts at zero.

CMS Star ratings are becoming more important for competitiveness in Medicare Advantage and already exist in Medicaid.

BCBSM MA PPO plan is looking for support of the Physician Organizations to focus on improvement of HEDIS Quality Measures and Pharmacy Clinical measures with Practice Units. Additionally member/provider interaction activities that members are surveyed on.

Star ratings measure a Plan's performance in delivering quality outcomes

Star Ratings are based on 53 key quality measures (36 related to Medicare and 17 related to prescription drug coverage) across the five following domains (subset of HEDIS measures)



What do CMS Star ratings measure?

- Staying Healthy: Screenings, Tests, and Vaccines
- Managing Chronic (Long Term) Conditions
- Ratings of Health Plan Responsiveness and Care
- Member Complaints, Problem Getting Services, and Choosing to Leave the Plan
- Health Plan Customer Service

All measures are relative – a continued focus on improvement will be necessary to maintain ratings

Provider-Facing Star Measures

The following are Star measures that BCBSM Providers either directly or indirectly impact:

CLINICAL MEASURES

Measure	Measure Weight
HEDIS Admin (Claims based Measures)	
Plan All-Cause Readmissions	3
Breast Cancer Screening	1
Osteoporosis Management in Women who had a Fracture	1
Rheumatoid Arthritis Management	1
HEDIS Hybrid (Claims and Medical Record Review based Measures)	
Diabetes Care – Blood Sugar Controlled	3
Controlling Blood Pressure	3
Colorectal Cancer Screening	1
Adult BMI Assessment	1
Diabetes Care – Eye Exam	1
Diabetes Care – Kidney Disease Monitoring	1
Pharmacy (Rx Claims Based Measures)	
High Risk Medication	3
Part D Medication Adherence for Oral Diabetes Medications	3
Part D Medication Adherence for Hypertension	3
Part D Medication Adherence for Cholesterol	3

MEMBER PERCEPTION (SURVEY) MEASURES

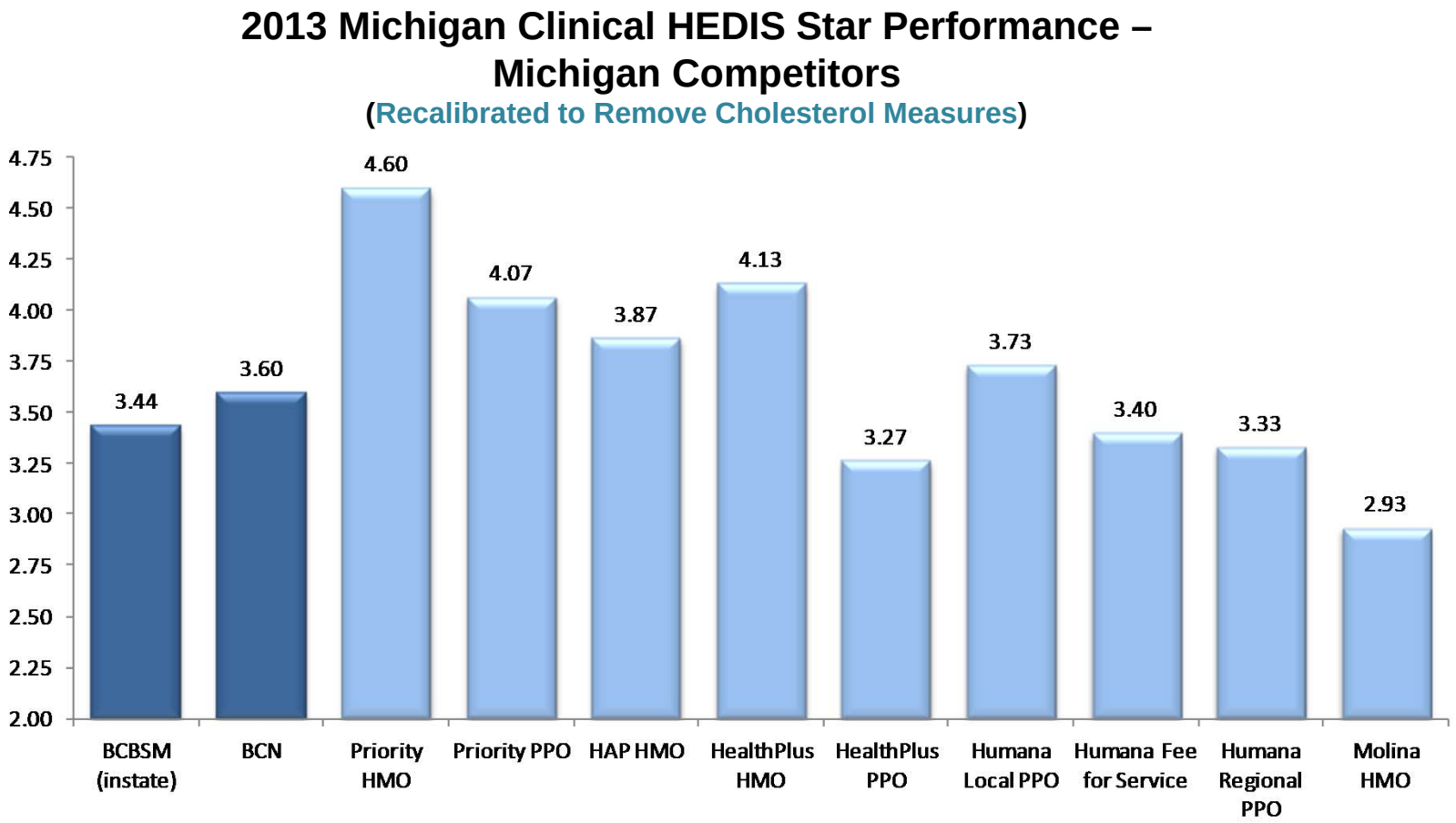
Measure	Measure Weight
Health Outcomes Survey (HOS)	
Improving or Maintaining Physical Health	3
Improving or Maintaining Mental Health	3
Monitoring Physical Activity	1
Improving Bladder Control	1
Reducing the Risk of Falling	1
CAHPS Survey	
Getting Needed Care	1.5
Getting Appointments and Care Quickly	1.5
Customer Service	1.5
Overall Rating of Health Care Quality	1.5
Overall Rating of Plan	1.5
Care Coordination	1.5
Rating of Drug Plan	1.5
Getting Needed Prescription Drugs	1.5
Annual Flu Vaccine	1

Improving Bladder Control :
(Removed for 2014/2015, will return in 2016)

Note: There are other plan-facing operational measures that are part of the Star Rating that are not listed above

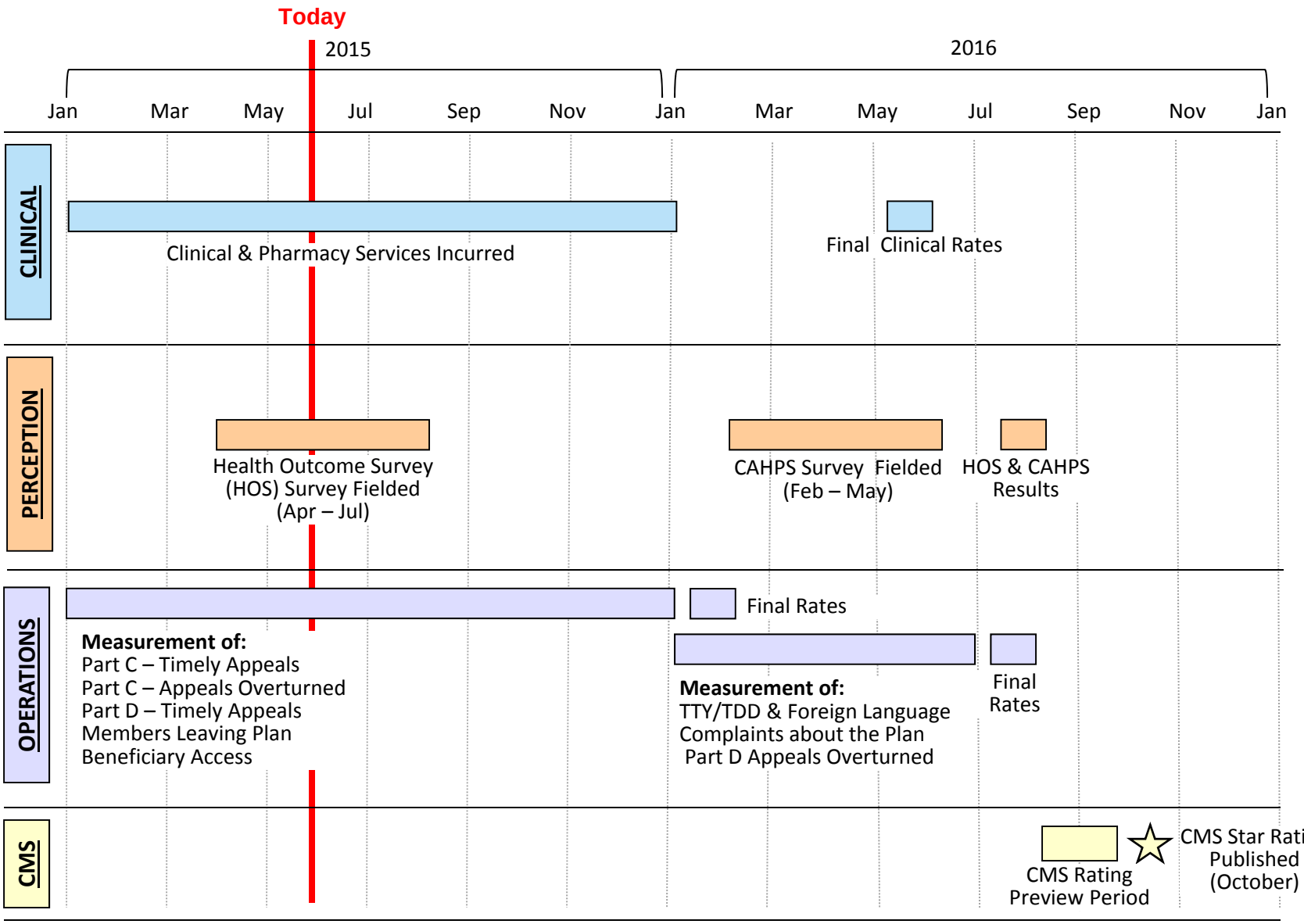
Michigan Physician Network Clinical HEDIS Performance

MA PPO and BCNA performance in Michigan is about average and there are multiple plans that perform much higher across Clinical HEDIS measures.



- BCBSM Michigan physicians performance is below the 4 Star threshold, and also trails many of the top competitors. The clinical performance is the biggest risk to maintaining our PPO and HMO 4 Star ratings.

2015 Measurement Year Projection Update Schedule



Timeline Visual – 2015 Measurement Year View

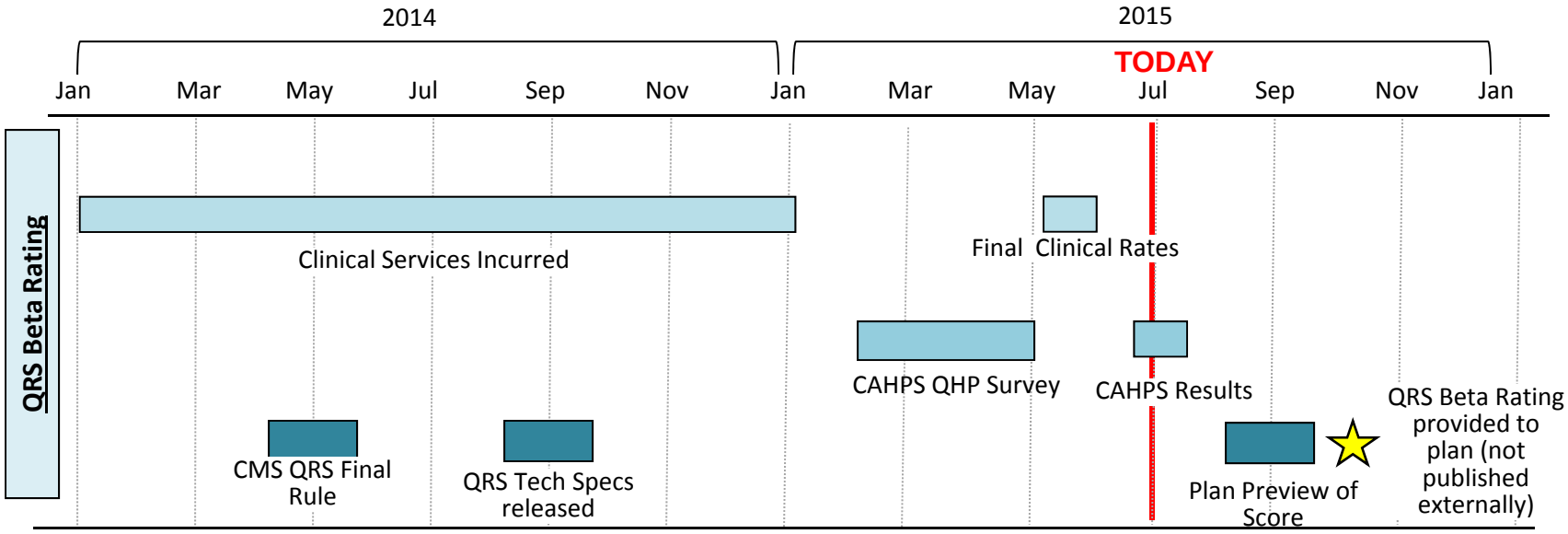
Quality Rating System (QRS) Overview

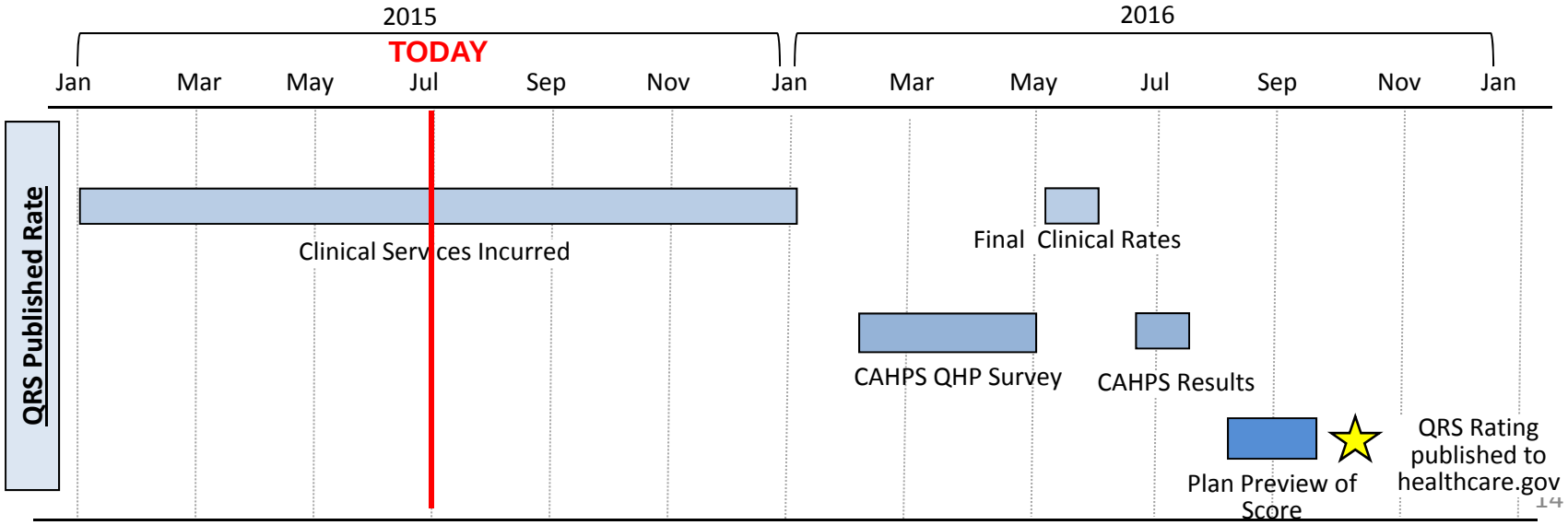
Starting in 2016, based on data collected in 2015, all marketplace products will be assigned a quality rating that will be prominently displayed on state/federal exchanges.

Quality Rating System (QRS) Overview	
What?	• 5-star system for rating Qualified Health Plans (QHPs) sold on and off the exchanges • Includes clinical HEDIS measures and consumer experience measures (QHP Enrollee Satisfaction Survey)
Why?	• Inform consumer and employer choice of a QHP • Monitor QHP performance and facilitate regulatory oversight around compliance with ACA quality standards • Provide actionable information to QHPs for performance improvement
Who?	• Individual and small group QHPs sold on and off the exchanges
When?	• QRS Beta Ratings - based on the 2014 Measurement Year and provided to the plan in October 2015 • QRS Published Ratings – based on the 2015 Measurement Year and posted to healthcare.gov in October 2016
How?	• Mandatory public reporting of QHP quality ratings on marketplace websites beginning Fall 2016 – Ratings assigned by product type (HMO, PPO, EPO, etc.) – Ratings are not tied to reimbursement at this time

QRS Rating Timeline – Beta Rating and Published Rating

The timeline for the QRS Beta rating and the first QRS published rating are below.





2014 Star and Quality Rating System (QRS) Projected Clinical Performance

The QRS performance percentiles will not be available until Fall 2015. As a proxy, the NCQA Commercial PPO benchmarks were used to better understand what the QRS performance may be.

Overlapping Star/QRS Measures

Measure	2014 Projected Star	2014 Projected QRS Performance
Adult BMI Assessment	5	<25%
Breast Cancer Screening	4	50%
Colorectal Cancer Screening	4	50%
Controlling High Blood Pressure	3	<25%
Diabetes Care: Medical Attention for Nephropathy	3	50%
Diabetes Care: Hemoglobin A1c (HbA1c) Control	4	25%
Diabetes Care: Hemoglobin A1c (HbA1c) Testing	n/a	50%
Diabetes Care: Eye Exam (Retinal) Performed	4	<25%
Plan All-Cause Readmissions (PCR)	3	n/a
Proportion of Days Covered (Diabetes All Class)	4	n/a
Proportion of Days Covered (RAS Antagonists)	4	n/a
Proportion of Days Covered (Statins)	4	n/a

QRS Efficient Care Measures

	QRS Measure	2014 Projected QRS Performance
Kids	Appropriate Testing for Children with Pharyngitis	25%
	Appropriate Treatment for Children with URI	50%
Adults	Annual Monitoring for Patients on Persistent Medications	75%
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	25%
	Use of Imaging Studies for Low Back Pain	25%
	Medication Management for People with Asthma (75%)	50%
Behavioral	Antidepressant Medication Management: Acute	75%
	Antidepressant Medication Management: Continuation	75%
	Follow-up After Hospitalization for Mental Illness: 7 days	25%
	Follow-up Care for Children Prescribed ADHD Medication: Con.	<25%
	Follow-up Care for Children Prescribed ADHD Medication: Initiation	75%
	Init. and Engage of Alcohol and Other Drug Treatment: Engagement	<25%
	Init. and Engage of Alcohol and Other Drug Treatment: Initiation	25%

QRS Preventive Care Measures

	Measure	2014 Projected QRS Performance
Kids	Annual Dental Visit	n/a
	Childhood Immunization Status (combination 3)	<25%
	HPV Vaccination for Female Adolescents	25%
	Immunization for Adolescents (combination 1)	75%
	Weight Assess. And Coun. For Nutrition and Physical Activity Children	75%
	Weight Assess. And Coun. For Nutrition and Physical Activity Children	75%
	Weight Assess. And Coun. For Nutrition and Physical Activity Children	50%
	Well-Child Visits in the 3rd-6th Years of Life	50%
	Well-Child Visits in the First 15 Months of Life (6 or more)	50%
Women	Cervical Cancer Screening	<25%
	Chlamydia Screening in Women	50%
	Prenatal & Postpartum Care: Postpartum Care	<25%
	Prenatal & Postpartum Care: Timeliness of Prenatal Care	<25%

STARS/HEDIS -

Best Practice Tips to Success

General Guidelines

- The preferred method of closing gaps is through claims whenever possible as NCQA requirements are not as rigorous as for those collected through supplemental sources.

- All Electronic Medical Record data must be set up through the BCBSM Enterprise process and pass pre-production audit.

- All data submitted via Health e-Blue web is subject to primary source verification (demonstrated medical record documentation)

- **All clinical information used for HEDIS and Stars must be documented in the patient's legal medical record**

- All services must be completed within the timeframes stated in the HEDIS specifications in order to count; service orders are not acceptable documentation.

General Guidelines – Lab and Diagnostic Tests

- To determine numerator compliance for rates that require results to be at a certain level, documentation of a numeric result is required. Documentation that a result is "within normal limits" or "under control" would be considered a "missing" result and would not be compliant for rates that require results to be at a certain level.
- All events (e.g., from claims, EMR, lab report) for the same lab test with dates no more than seven days apart can be considered the *same test* and the result associated with that event meets criteria (even if it is not the most recent date of service).
- Collection or reported date can be used. Undated lab results or other tests in medical records may not be used for HEDIS reporting.

General Guidelines - Dates

- Dates must be specific enough to determine that an event occurred during the time frame established in the measure. Terms such as “recent,” “most recent” or “at a prior visit” are not acceptable.

- There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the “measurement year or the year prior to the measurement year.”

General Guidelines Member Reported/Performed Services

- Member Reported Services: The information must be collected by the end of the measurement year, by a PCP or specialist (if the specialist is providing a primary care service related to the condition being assessed), while taking a patient's history. The information must be recorded, dated and maintained in the member's legal health record.

- Test results from member-collected samples may be used for FOBT, urinalysis testing and blood spots for HbA1c, LDL-C, glucose and total cholesterol. Member-collected samples must be sent to the laboratory or provider's office for analysis.

- Other member-collected biometric values (i.e., blood pressure [BP], body mass index [BMI], height and weight) may not be used for HEDIS reporting.

Diabetes

Does Not Have Disease

- If the member does not have disease, the member cannot be removed from the Diabetes (CDC) denominator per NCQA requirements unless:
  - the medical claims that identified the members are re-billed by the original billing provider or
  - the PCP documents in the legal medical record prior to the end of the measurement year that the member does not have diabetes.
- **Note**: If the member has filled prescriptions for diabetic management that appear in the NCQA list, they must stay in the denominator. (prescriptions for Metformin alone will not identify members for the denominator to avoid false positive identification)

Acceptable Exclusions

Patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year (from claims submitted to the plan) and who meet either of the following criteria:

A diagnosis of polycystic ovaries, in any setting, any time during the member's history through December 31 of the measurement year.

A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

10 Tricky Measures - Documentation Tips

- Diabetes – Eye Exam
- Diabetes – hgbA1c Control
- Blood Pressure Control
- Adult BMI
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Cervical Cancer Screening
- Breast Cancer Screening
- Colorectal Cancer Screening
- Post Partum Care
- Well Child Visits 15 Months

Diabetes – Eye Exam

- On a claim, CPT code 92250 (fundus photography with interpretation and report) if billed by a PCP will count because it indicates the results have been interpreted (by an eye care professional).

- At a minimum, documentation in the medical record must include one of the following:
  - A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
  - A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria).

Blindness is not exclusion for a diabetic eye exam because it is difficulty to distinguish between individuals who are legally blind, but who require a retinal exam, those who are completely blind and therefore do not require an exam.

Diabetes – HgbA1c Control

The most recent test result for the measurement year is used. Re-testing should be repeated prior to the end of the measurement after adjusting medications or diet (usually about 3 months later).

At a minimum, documentation in the medical record must include a note indicating the date when the HgbA1c test was performed and the result or finding. Ordered dates are not acceptable. Acceptable notation of any of the following in the medical record:

- A1c.
- HgbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note: The A1c test report also may include the result expressed in SI units (mmol/mol) and an estimated Average Glucose (eAG), which is a calculated result based on the A1c levels. The purpose of reporting eAG is to help a person relate A1c results to everyday glucose monitoring levels and to laboratory glucose tests. The formula for eAG converts percentage A1c to units of mg/dL or mmol/L.

It should be noted that the eAG is still an evaluation of a person's glucose over the last couple of months. It will not match up exactly to any one daily glucose test result. The ADA has adopted this calculation and provides a calculator and information on the eAG on their website http://professional.diabetes.org/GlucoseCalculator.aspx

Controlling Blood Pressure

The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

- **Note:** One finding during chart reviews was that members often fall out of compliance because the documentation states 140 over 90 for example. It is critical to document the most exact blood pressure reading identified; we also found several providers had records with every member/every visit showing the same BP and vitals; possibly due to carry over in the EMR.

Breast Cancer Screening

This measure evaluates primary screening. Biopsies, breast ultrasounds or MRIs cannot be used to meet this measure criteria because they are not appropriate methods for primary breast cancer screening.

Exclusions: Documentation of bilateral mastectomies or two unilateral mastectomies. If unilateral, they must have service dates 14 or more days apart in order to count.

Colorectal Cancer Screening

Blue Cross Blue Shield of Michigan

GENERAL

A result is not required if the documentation is clearly part of the **"medical history"** section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

Exclusions: Evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

FOBT

Digital rectal exam is not acceptable evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

iFOBT

If the medical record indicates that an iFOBT was done, the member meets the screening criteria, regardless of how many samples were returned/processed.

gFOBT

- If the medical record does not indicate the number of returned samples or the number of samples is documented >= 3, it can be used to meet criteria for this measure.

Method not documented in chart

The member meets the screening criteria only if the number of samples specified is greater than or equal to three samples.

Adult Body Mass Index Assessment (BMI)

Both the weight and the calculated BMI must be documented in the same record; the height documentation can be in a different record but must be available so that the BMI can be calculated and documented in the chart.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Body Mass Index

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. For adolescents 16–17 years of age on the date of service, a BMI value can meet criteria. Height, Weight, BMI must be documented in the record.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Nutrition Counseling

- Current nutrition behaviors documented in notes or checklist

  e.g., eats three meals per day, eats fruits and vegetables; weight or obesity counselling
- Nutrition education documented in notes or checklist

  e.g., educational materials on nutrition and include materials in medical record

Physical Activity Counseling

- Current physical activities documented in notes or checklist

  e.g., Plays 1 hour per day, exercises 30 minutes per day, plays sports or discussion regarding helmet or water safety
- Educational materials given for physical activity documented in notes or checklist e.g., educational materials on physical activity and include materials in medical record

Cervical Cancer Screening

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed and the result of the finding.
- The method must include collection and microscopic analysis of cervical cells. If the report explicitly states the sample was inadequate or that "no cervical cells were present"; it cannot be used.

HPV co-testing requires that service dates for the cytology and HPV testing are four or less days apart during the measurement year or the four years prior to the measurement year for women who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between December 1 and December 5 of the measurement year.

Documentation of biopsies cannot be used to count for this measure as they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Exclusions: Evidence of hysterectomy with no residual cervix. Documentation must include that it is complete – total – radical abdominal or vaginal hysterectomy meets criteria. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone without specificity does not meet the criteria because it does not indicate that the cervix was removed.

Post Partum Care

Postpartum care must be documented between **21 and 56** days after delivery in order to meet criteria.

Well Child Visits 15 Months

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of *all* of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.
- Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.