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Medicare Advantage HEDIS®, HOS®, and CAHPS®

TOOL KIT FOR PROVIDERS

Table of Contents

Purpose of This Guide

This guide is a resource to assist you with understanding:

- The HEDIS® and Stars measurement process and your rates
- How to access care gap information throughout the year so you can improve your rates
- How you can improve your claims, supplemental data, and medical record documentation to maximize your rates
- Our process for managing clinical exclusions to measures

Because measures and weighting change annually, be sure to access the most current version of this guide at azbluemedicare.com/login "Resources > Provider Guidelines and Training Materials."

Overview of Our Quality Measures

NQF, or National Quality Forum, is a nonprofit organization designed to improve healthcare, with a focus on quality measurement. NQF facilitates a national endorsement procedure for proposed quality measures to ensure measures used are valid, evidence-based, and pass a rigorous consensus process.[i] NQF is a main source of national quality measures used by NCQA and CMS.

NCQA:

- Points the way to healthcare that science says works.
- Studies how well health plans and doctors provide scientifically recommended care.
- Identifies organizations that are run in ways that make care better.

NCQA's Work:

- Saves thousands of lives.
- Helps millions of people stay healthy.
- Saves the country billions of dollars.

Source: NCQA

NCQA, or National Committee for Quality Assurance, is an independent nonprofit organization whose mission is to "use measurement, transparency and accountability to highlight top performers and drive improvement."
HEDIS, or Healthcare Effectiveness Data and Information Set, "consists of 71 measures across 8 domains of care. Because so many plans use HEDIS® and because the measures are so specifically defined, HEDIS® can be used to make comparisons among plans."[ii]

"HEDIS…is the gold standard in health care performance measurement, used by more than 90 percent of the nation's health plans and many leading employers and regulators. HEDIS® is a set of standardized measures that specifies how organizations collect, audit and report performance information across the most pressing clinical areas, as well as important dimensions of customer satisfaction and patient experience."[iii]

HEDIS® measurement methodologies are explained in HEDIS® Technical Specifications, which are copyrighted and may be purchased from NCQA. The technical specifications are highly specific to ensure that all health plans are measuring the same thing in exactly the same way. Health plans are audited annually to ensure we are following the technical specifications and all measurement requirements.

What Are Star Measures?

Star measures are a collection of nationally recognized health plan quality measures that include HEDIS, HOS, CAHPS, and other measures. This guide does not discuss the other measures (Part D, customer service/operations).

"Support CMS's {Centers for Medicare Advantage Services} efforts to transform the health care delivery system by putting a strong focus on person-centered care.

- Provide beneficiaries a true reflection of the plan's quality.
  - "– Measures are relevant and important to beneficiaries.
- Encompass multiple dimensions of high-quality care.
  - "– Focus on aspects of care within the control of the plan.

Data used in the ratings must be complete, accurate, reliable, and valid." [iv]

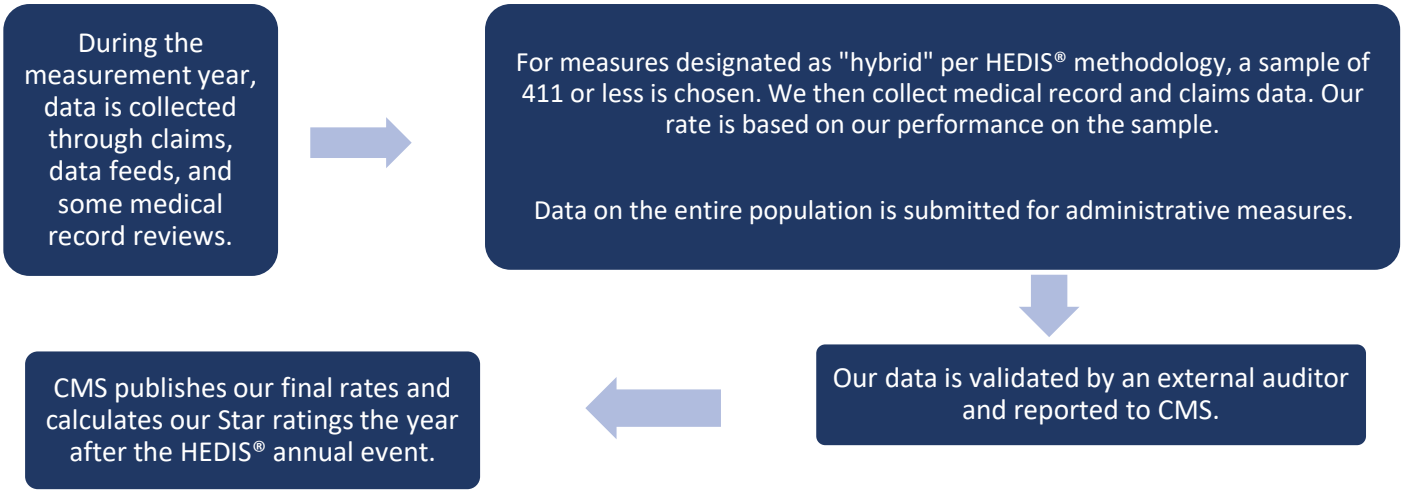
CMS issues a Star rating for each Medicare Advantage plan annually based on retrospective measurement of performance.

Timeline of Reporting for HEDIS® Measures

Here is an example of a timeline.

Services provided	Measured During HEDIS Annual Event	Reported to NCQA/CMS	Draft Star Ratings Given to Plan by CMS	Star Ratings Finalized and Published
2023	First half of 2024	June 2024	Fall 2024	2024

HEDIS® Annual Event



Our HEDIS® Measures

HEDIS® measures all have technical specifications. Our adherence to those specifications is audited annually. Data must remain in compliance with those specifications to be accepted by NCQA/CMS.

Claims

Our goal is to increase the number of numerator events and exclusions captured on claims when appropriate. Coding all possible services on your claims is the most direct route to improving your HEDIS® performance (of course, while

conforming to all coding rules). Claims and pharmacy data are directly submitted to our HEDIS® data vendor each month for inclusion in our rates.

Standard Supplemental Data

Supplemental data is used when data cannot be submitted on a claim. We currently accept automated laboratory feeds, state/national health registries and information exchanges, and provider Electronic Medical Review (EMR) files. Please contact us if you would like to begin submitting either of these files to us.

Nonstandard Supplemental Data

This is done by year-round review of medical records and provider abstraction forms through an auditor-approved process. Our approved provider abstraction form can be located here; it must be signed by either the rendering provider or the provider who took the patient's history reported on the form. Completion of all fields and including the required signature ensures we can accept your data.

Please refer to this section for more information on this process.

Surveys

Some measures are calculated from patient surveys, called the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Additional details on the CMS Stars Program and member perceptions are included on pages 16 & 17.

Other Measures

Some Medicare Stars measures are calculated based on health plan operations, customer service, and Part D. These are not discussed in this tool kit.

Gaps in Care Reports

Blue Cross® Blue Shield® of Arizona (BCBSAZ) instructs the designated quality contact person at our value-based partner organizations how to obtain care gap reports. If you are not in a value-based relationship with us but would like care gaps, please contact us.

The care gap reports provide member-level detail on HEDIS Star measures and measures of importance to CMS. The data reflects members who are currently eligible for the metric according to current HEDIS specifications and indicate their compliance. The members are attributed to their assigned PCP practitioner and/or office, according to the current eligibility and member/PCP assignment maintained by the BCBSAZ Enrollment Department.

BCBSAZ typically distributes the care gap reports at the end of every month (except January), which includes year-to-date data through the preceding month.

Addressing Tobacco Use Can Improve All Performance Measures

As a healthcare provider, your patients listen to your recommendations. In fact, people who receive a recommendation to quit smoking from multiple providers are more likely to make a quit attempt.

Tobacco use not only negatively impacts almost all HEDIS® measures, but it is also the leading cause of preventable death[v] and disability in Arizona, the United States, and the world. We strongly encourage you to utilize evidence-based practices when you address tobacco use.

- ASHLine (Arizona Smokers' Helpline) can help you:
    - Develop tobacco screening and intervention policies
    - Get registered to make patient referrals

    - Track referrals in their database
    - Learn how to bill for intervention services
- CDC's (Centers for Disease Control and Prevention) Clinician Resources
- AHRQ's (Agency for Healthcare Research and Quality) Clinical Guideline: Treating Tobacco Use and Dependence
- American Academy of Family Physicians has a helpful list of best practices and patient handout here.

Measures—Coding and Resources

Advanced Illnesses and Frailties

Coding advanced illness on claims excludes patients from several performance measures. To exclude the patient, the plan must have claim(s) with a code for advanced illnesses and/or frailties, typically on multiple dates of service. NCQA published a blog post with its reasoning here. The list of advanced illnesses is lengthy; it includes, but is not limited to cancers, dementia, Parkinson's, Alzheimer's, heart diseases, kidney diseases, respiratory conditions, complications of alcoholism, and liver diseases. Frailties include use of assistive devices, pressure ulcers, falls, and more.

Prevention and Screening

Breast Cancer Screening (BCS-E)

This measures the percent of women aged 50-74 who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year. It includes women with and without higher risk of breast cancer. All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) are included. Although MRIs, ultrasounds, and biopsies may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are not considered a substitute for a mammogram for this measure.

Patients are excluded if they are using hospice services, under palliative care, have had a bilateral mastectomy, two unilateral mastectomies on different dates of service, or acquired absence of bilateral breasts and nipples. To exclude the patient, the plan must have a claim, medical record, or Provider Abstraction Form that documents all of the required HEDIS criteria. Coding frailties and advanced illnesses on claims may exclude patients from this measure.

Centers for Disease Control and Prevention (CDC) has free downloadable patient education materials here. Have staff follow up with those who refuse mammograms and discuss their underlying concerns, benefits of screening, and risks of refusal.

Colorectal Cancer Screening (COL)

This measures the percent of patients 45-75 who had screening for colorectal cancer. Any of the following qualify:

- Fecal occult blood test (FOBT) during the measurement year
- FIT-DNA test during the measurement year or the two years prior to the measurement year
- Flexible sigmoidoscopy or CT colonography during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year

Providers have had success with distributing FOBT kits directly from their offices. Labs often provide these free of charge for this purpose. Ensure you include an order for the test so the lab will accept it for processing. Educate patients about all of the steps required to complete an FOBT. Follow-up calls to patients increase return rates.

Emphasize that colonoscopies can prevent cancer, not just detect it.

CDC has free downloadable patient education materials here. As with all HEDIS® measures, the best way to succeed is to code services and conditions on a claim. For this measure, we can supplement that with medical record (MR) documentation if:

All these criteria are met	OR	All these criteria are met	OR	All these criteria are met
• The documentation is clearly part of the medical history section of the chart, and • Date of screening is documented and within the required timeframe, and • The type of screening is documented		• You provide us with a copy of the MR from the provider who completed the screening, and • Date of screening is documented, and • The type of screening is documented Note: If the MR is a pathology report that does not indicate the type of screening or an incomplete procedure: ○ Documentation indicates the scope advanced beyond the splenic flexure will be accepted as a completed colonoscopy ○ Documentation that states the scope advanced into the sigmoid colon will be accepted as a completed flexible sigmoidoscopy		• The documentation in your MR is not clearly part of the medical history section, and • The result or finding is documented, and • Date of screening is documented, and • The type of screening is documented

Patients are excluded from the Colorectal Cancer Screening measure if they are using hospice services, under palliative care, have had colorectal cancer, or total colectomy during or prior to the measurement year. To exclude the patient, the plan must have a claim, medical record, or Provider Abstraction Form that documents all of the required HEDIS criteria.

Coding history of colorectal cancer, hospice or palliative care during the measurement year, or frailties and advanced illnesses on claims may exclude patients from this measure.

Diabetes

Hemoglobin A1c Control for Patients with Diabetes (HBD)

This measures the percentage of patients 18–75 years of age with diabetes (type 1 and type 2) whose last HbA1c test in the year had a reported specific numeric result of ≤9%.

Situation	Action to Be Taken
The patient has not completed an HbA1c test.	Reach out to the patient, educate about the importance of annual testing, and schedule an appointment. An alternative is for the member to see if they are eligible to order their own free at-home kit by going to https://kitrequest.sonoraquest.net/BCBSMA/.
Patient has completed an HbA1c test, but the health plan still lists the patient as not compliant.	The plan has not received the specific numeric result, rendering provider, and date of service. You can send the results or medical record to the plan to close the gap. Code the A1c results on your claims or in your standard supplemental data file:
The patient has completed an HbA1c test, but the results are >9%.	Educate the patient and treat as needed; repeat the test before the end of the calendar year. Refer to DSME as appropriate.

A1c result	CPT II Code
<7%	3044F (gap closes unless pt gets another A1c later in the year)
≥7% - <8%	3051F (gap closes unless pt gets another A1c later in the year)
≥8% - ≤9%	3052F (gap closes unless pt gets another A1c later in the year)
>9%	3046F (gap remains open because result is not controlled)

Kidney Health Evaluation for Patients with Diabetes (KED)

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year, which includes:

- ☑ An estimated glomerular filtration rate (eGFR) AND
- ☑ A urine albumin-creatinine ratio (uACR) as defined by one of the following:
  - Both a quantitative urine albumin test and a urine creatinine test with service dates ≤4 days apart
  - A uACR

Eye Exam for Patients with Diabetes (EED)

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam completed by an ophthalmologist or optometrist.

- ☑ Had bilateral eye enucleation any time through December 31 of the measurement year, OR
- ☑ A retinal or dilated eye exam by any provider during the measurement year, OR
- ☑ A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year

Blindness is not an exclusion because it is difficult to distinguish between patients who require a retinal exam (i.e., legally blind) and those who are completely blind.

Exams completed by remote reading of retinal photographs meet this requirement if the reading is done by an ophthalmologist or optometrist.

Blood Pressure Control for Patients with Diabetes (BPD)

This measures the percentage of members 18-75 years of age with type 1 or 2 diabetes whose last BP measurement during the year is <140/90 mm Hg. The patient is not compliant if the BP is ≥140/90 mm Hg, 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). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

An ambulatory visit for the same date of service must accompany the submitted BP results. Patient-reported blood pressure readings taken with a digital device and reported during a telehealth visit are acceptable.

Situation	Action to Be Taken
Patients have no BP documented during the measurement year.	Reach out to the patient, educate about the importance of annual screening, and schedule an appointment.
A patient's final BP reading in the year is controlled, but the health plan still lists the patient as not compliant.	The plan has not received the specific numeric result, rendering provider, and date of service. The submission of compliant BP codes on claims is the best method to improve your rate. Both a systolic and diastolic are needed. • Systolic: CPT CAT II 3074F, 3075F • Diastolic: CPT CAT II 3078F, 3079F You can send the medical record to us to close the gap as an interim step to establishing an automated supplemental data feed with the plan to ensure data is refreshed throughout the year.
Patient's most recent BP reading was out of range.	Ensure the staff are using correct methods and instructing the patient correctly. Repeat the reading. Educate the patient and treat as needed; repeat the test before the end of the calendar year.

Coding frailties and advanced illnesses on claims may exclude patients from this measure.

Centers for Disease Control and Prevention (CDC) has free downloadable patient education materials here and for clinicians here. Department of Health and Human Services has free downloadable materials for providers and patients here.

Cardiovascular

Cardiac Rehabilitation (CRE) —Initiation

This measures the percentage of members 18 years and older who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying cardiac event (myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement).

Controlling Blood Pressure (CBP)

This measures the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose last BP reading during the measurement year showed adequate control (<140/90 mm Hg). Please refer to this section for resources and tips.

Statin Therapy for Patients with Cardiovascular Disease (SPC) – Received Statin Therapy

This measures the percentage of males 21–75 years old and females 40–75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year:

- Atorvastatin 40-80 mg
- Amlodipine-atorvastatin 40-80 mg
- Rosuvastatin 20-40 mg
- Simvastatin 80 mg
- Ezetimibe-simvastatin 80 mg
- Atorvastatin 10-20 mg
- Amlodipine-atorvastatin 10-20 mg
- Rosuvastatin 5-10 mg
- Simvastatin 20-40 mg
- Ezetimibe-simvastatin 20-40 mg
- Pravastatin 40-80 mg
- Lovastatin 40 mg
- Fluvastatin 40-80 mg
- Pitavastatin 1-4 mg

Coding frailties and advanced illnesses may exclude patients from this measure. Other exclusions include muscular disease, ESRD, and cirrhosis coded within the measurement year.

Options to improve your rates on this measure:

Numerator Compliance Options	Exclusion Options
☑ Bone mineral density test within 180 days of the fracture ☑ Dispensed prescription for bisphosphonates, abaloparatide, denosumab, raloxifene, romosozumab, or teriparatide	☑ Bone mineral density test or dispensed prescription for bisphosphonates, abaloparatide, denosumab, raloxifene, romosozumab, or teriparatide within 24 months before the fracture

Target more interventions at patients who appear to be willing to adhere to medications if given education, support, and reminders. Encourage patients to fill all prescriptions at the same pharmacy so they can better track medications and develop a relationship with pharmacists, who are well positioned to influence the patient's behavior. Simplify dosing schedules when possible and encourage the use of pill boxes or other visual reminders, such as apps. When prescribing, inquire about willingness and ability to adhere to the recommendations and assist with removal of barriers, knowledge gaps, and reluctance.[vi] CDC has free downloadable patient education materials here. New York City Department of Health has a free downloadable medication adherence kit here.

Falls, Fractures, and Musculo-Skeletal

Monitoring Physical Activity (PAO)—HOS Survey

Discussing physical activity during visits increases the rate of this measure and can decrease the risk of falls. The survey asks members if they received advice to start, increase, or maintain their level of exercise or physical activity within the measurement year.

Annually, ask about the patient's level of physical activity and give specific advice on improving or maintaining (for example, advise patient to take the stairs or increase the number of minutes walking each day).

Osteoporosis Management in Women Who Had a Fracture (OMW)

This measures the percentage of women 67–85 years of age who had a fracture and either a bone mineral density (BMD) test or prescription fill for a drug to treat osteoporosis in the six months after the fracture; the test or treatment must occur no later than 180 days after the fracture.

Ensure coding accurately distinguishes old fractures vs. new fractures. Coding as a new fracture causes the patient to have a gap in care for osteoporosis screening or treatment.

Options to improve your rates on this measure:

Numerator Compliance Options	Exclusion Options	Process Improvement
☑ Claim for a moderate-high statin ☑ Send us proof of a prescription fill of a moderate-high statin medication with the name, dose, route, and fill date, such as: ○ photo of the prescription bottle ○ receipt with prescription detail ○ medical record note	☑ Claim with a code for ESRD, cirrhosis, or muscular pain or disease ☑ Medical record documenting current ESRD, cirrhosis, muscular pain, or disease	☑ Automate referrals to imaging centers from urgent care, ED, and IP discharge plans for members treated for fractures ☑ Schedule screenings to be completed at the same time as mammograms ☑ Set up EMR prompts to automatically order screenings when female members turn 67, if they have never had one

Coding frailties and advanced illnesses on claims may exclude patients from this measure.

Osteoporosis Screening in Women (OSW)

Bone mineral density (BMD) test between the member's 65th birthday and December 31 of the measurement year. (The measurement starts at age 66, looks back to age 65.)

Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls (DDE)

This measure may provide an opportunity to mitigate fall risk. It includes members who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after an accidental fall or hip fracture (antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, or antidepressants (SSRIs, tricyclic antidepressants, and SNRIs).

Reducing the Risk of Falling (FRM)—HOS Survey

Increasing discussions of falls and fall prevention with providers, along with recommendations to prevent falls and treat problems with balance and walking, improve rates on this survey measure and ultimately reduce falls.

Annually, give patients specific suggestions on how to prevent falls or treat problems related to balance or walking (for example, suggest use of a walker or cane, suggest physical therapy or exercise, suggest vision or hearing tests).

Care Coordination

Care Coordination (CAHPS Survey)

This measures the percent of members responding positively to survey questions on the following topics:

- How often providers shared records, results, or other care-related information
- How often the member got lab or other test results in a timely manner
- How often the member talked with their personal doctor about all of the member's prescription medications
- If the member got needed help from their personal doctor's office to manage care among these different providers and services
- How often their personal doctor seemed informed and up to date about the care the member got from specialists

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

This measures the percentage of Emergency Department (ED) visits for adults who have multiple high-risk chronic conditions who had a claim for a follow-up service within 7 days of the ED visit.

Patients with any of these chronic conditions:	A claim for follow-up services within 7 days of ED visit:
COPD	Outpatient visit or observation
Asthma	Telephone, e-visit, virtual check-in, or telehealth visit
Alzheimer's and related conditions	Transitional care management services (TCM)
Chronic kidney disease	Case management/complex care management services
Depression	Intensive outpatient visit (IOP)
Heart failure	Partial hospitalization
Acute myocardial infarction	Community mental health center visit
Atrial fibrillation	Substance use disorder service
Stroke or TIA	Electroconvulsive therapy

Telephonic engagement or engagement with the member or caregiver through a patient portal meets criteria for this measure. You may code these services on a claim or send us medical record documentation.

Plan All-Cause Readmissions (PCR)

This measures adults with acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

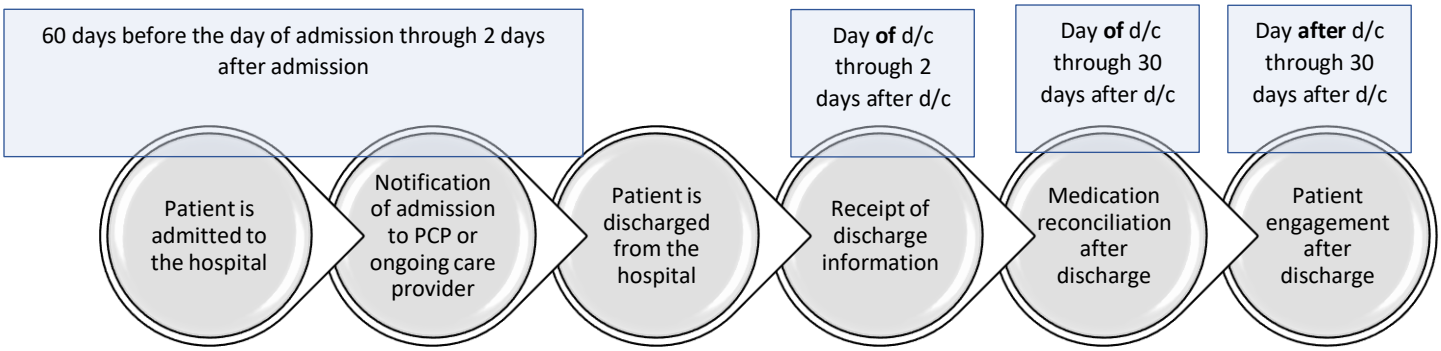
Follow-up ambulatory visits after hospital discharge, preferably within 7 days but no longer than 30 days, may decrease readmissions.[vii] Because the health plan's HEDIS® data does not include patients in this measure until after the 30-day period has passed, providers cannot rely on this data source to give them timely notification of admission or discharge. To automate timely admission notifications, seek participation in data exchanges with hospitals or with Arizona's health information exchange (HIE) to automate timely admissions notifications. Resources, initiatives, and tools to reduce readmissions can be found at:

- Institute of Healthcare Improvement (IHI)
- Health Services Advisory Group

Transitions of Care (TRC)

This measures the percentage of hospital discharges having each of the following: Four rates are reported: Notification of Inpatient Admission, Receipt of Discharge Information, Patient Engagement after Inpatient Discharge, and Medication Reconciliation Post-Discharge. All four metrics can be reported to us through standard supplemental data files; please contact us to walk through this process. A patient can be included in this measure multiple times in the same year if he/she was discharged from a hospital multiple times in the same year.

Below is the sequence of events for this measure.



Notification of Inpatient Admission

This metric can either be reported in standard supplemental data files, using custom code TRC_SM1_ADM_NOTIF_EVDN_PHN, or through medical record review.

Medical record documentation must include evidence of receipt of notification of inpatient admission, including one or more of the following:

- ☑ Communication between hospital or admitting providers/staff and the patient's PCP or ongoing care provider, OR
- ☑ Communication about admission between the ED and the patient's PCP or ongoing care provider, OR
- ☑ Communication about admission to the patient's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system, OR
- ☑ Communication about admission to the patient's PCP or ongoing care provider through a shared electronic medical record (EMR) system. (When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge or the following day meets criteria.), OR
- ☑ Communication about admission to the patient's PCP or ongoing care provider from the health plan, OR
- ☑ Documentation that the patient's PCP or ongoing care provider admitted the patient to the hospital or placed orders for tests and treatments any time during the patient's inpatient stay, OR
- ☑ Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. Documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria.

Note: When an ED visit results in an inpatient admission, notification that a provider sent the patient to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

Receipt of Discharge Information

This metric can either be reported in standard supplemental data files, using custom code TRC_SM1_ADM_NOTIF_EVDN_PRE, or through medical record review.

Documentation must include evidence of receipt of discharge information on the day of discharge or the following day with evidence of the date when the documentation was received. Qualifying documents are, for example: discharge summary, summary of care record or structured fields in an Electronic Health Record (EHR). All of the following must be included:

- ☑ The practitioner responsible for the member's care during the inpatient stay

- ☑ Procedures or treatment provided
- ☑ Diagnoses at discharge
- ☑ Current medication list
- ☑ Testing results, or documentation of pending tests or no tests pending
- ☑ Instructions to the PCP or ongoing care provider for patient care. Discharge instructions provided to the member to follow-up with their PCP does not meet criteria

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge or the following day.

When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission or the following day meets criteria.

Patient Engagement After Inpatient Discharge

This information can be reported in claims and supplemental data files or documented in your medical record. This component must occur on the day after discharge through 30 days after discharge and include at least one of the following:

- ☑ An outpatient visit, including office visits and home visits, OR
- ☑ A telephone visit, OR
- ☑ A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication

If the patient is unable to communicate, this interaction can occur with their caregiver.

Medication Reconciliation Post-Discharge

This information can be reported in claims and supplemental data files or documented in your medical record. This component must occur the day after discharge through 31 days after discharge. This service can be provided by an RN, clinical pharmacist, or prescriber, using any one of the following codes:

- ☑ CPT: 99483, 99483, 99495, 99496 OR
- ☑ CPT CAT II: 1111F OR
- ☑ SNOMED: 430193006, 428701000124107

If you rely on medical record data to comply with this measure, be sure your documentation from an RN, clinical pharmacist, or prescriber includes at least one of the following:

- ☑ Documentation of the current medications with a notation that the provider reconciled the current and discharge medications or documentation of the member's current medications with a notation that the discharge medications were reviewed
- ☑ Documentation of the current medications with a notation that references the discharge medications (for example: "no changes in medications since discharge," "same medications at discharge," "discontinue all discharge medications")

★ Earn an extra $10 per claim (TRC) ★

You can close this gap on your claims, improve your rates, and reduce the volume of medical record requests we send you.

- ☑ Bill for a qualifying patient engagement service on a date of service within 30 days of hospital discharge AND
- ☑ The hospital discharge was between 1/1/23 and 12/1/23 AND
- ☑ The claim includes CPT II 1111F on the claim (medication reconciliation) with a rendering practitioner's NPI indicating they are a prescriber

- ☑ Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service
- ☑ Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
- ☑ Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record
- ☑ Notation that no medications were prescribed or ordered upon discharge

Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. Hospitals' documentation of reconciliation of medications upon admission with medications upon discharge does not meet criteria.

Please refer to the best practices described in the readmissions section of this document here. Use of Contexture or other automated notifications of admission and discharge count towards compliance for this measure.

Immunizations

Yearly Flu Vaccine (CAHPS Survey)

This measures the number of adults surveyed who indicate they had a flu shot since July 1 of the previous year. Encouraging patients to get the flu shot each year, addressing hesitancy, assisting them to obtain the shot easily, and reviewing their vaccine status aloud during visits can increase the rate of utilization and the rate of patients answering this survey question affirmatively.

Adult Immunization Status (AIS-E)—Influenza

This measures the number of members age 19 and up who received an influenza vaccine between July 1 of the previous year through June 30 of the measurement year.

Bladder Control

Improving Bladder Control (HOS Survey)

Annually, ask patients if they experienced leaking of urine. Discuss specific options for reducing incontinence, such as bladder training exercises, medication, or surgery.

Member Experience

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an Agency for Healthcare Research and Quality (AHRQ) program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with healthcare. A sample of patients is selected, and a nationally standardized survey is conducted by an external organization. Each plan has rates for the various sections of the surveys. The results are submitted to NCQA, who submits them to CMS. CMS may adjust scores slightly based on population characteristics, and then the plan's Star ratings are calculated based on scores. The CAHPS survey remains voluntary and anonymous for the MA population.

CAHPS scores represent 35% of the plan's overall Star rating. The official survey submitted to CMS does not provide patient-level data to the plan or provider specific performance Star Ratings. BCBSAZ will be surveying members who have completed a PCP visit. The results of this off-cycle survey will be loaded into Provider Performance CAHPS scorecards and shared with VBP's and PCP Groups. You can view the survey instruments here. AHRQ has free webinars and tools to improve patient experience.

Getting Needed Care (CAHPS Survey)

This measures how often members surveyed indicate they were able to get the care, tests, and treatment they needed easily.

Getting Appointments and Care Quickly (CAHPS Survey)

This measures how often members answered survey questions positively related to obtaining care and appointments as soon as they needed, as well as being able to see the provider within 15 minutes of the appointment time.

About HOS Survey Measures

CMS monitors the quality of care provided by Medicare Advantage Organizations (MAOs). To better evaluate the quality of care provided by Medicare Advantage plans and their contracted providers, CMS and NCQA conduct the Medicare Health Outcomes Survey, implemented in 1998. The HOS survey is worth 3% of the overall Star Ratings for each Medicare Advantage contract. The HOS survey is focused on the following measures: Improving Bladder Control, Reducing the Risk of Falling, and Monitoring Physical Activity.

You can view the survey instruments here.

How to Contact the Medicare Advantage HEDIS Team

For questions:	**EMAIL**	HEDIS@azblue.com
To send us a medical record, abstraction form, or lab result	**FAX**	602-916-8225
	EMAIL	HEDIS@azblue.com
	MAIL	Blue Cross Blue Shield of Arizona Attention: Medicare Advantage HEDIS team Post Office Box 13466 Phoenix, AZ 85002-3466

Our Prospective Medical Record Review Procedure for MY2023

We collect HEDIS data from medical records and Provider Abstraction Forms year-round. This is limited to situations when performance data was missing from claims and standard supplemental data. The expectation of our partners is that they will maximize capture of performance data through claims and supplemental data they provide to us; medical record review is a last resort.

If you choose to participate in this process, please plan to submit records steadily throughout the year to allow our team time to review them. The final deadline to submit records for measurement year 2023 is **January 19, 2024;** however, please submit most of your records year-round, as medical record abstractors' time is limited in January.

HEDIS technical specifications allow us to collect data from medical records year-round through a standardized, audited process. This is collected by the MA HEDIS team and converted into nonstandard supplemental administrative HEDIS data once approved by the auditor.

For traditional HEDIS measures, this data comes *last* in the hierarchy; if the same data point is reported through a claim or standard supplemental administrative data source, the medical record data is "cancelled out." Because of this, it's important we target our efforts on data that will not be received by other measures.

Because this data collection method is extremely labor-intensive and risks data being "cancelled out," it is our last resort. We encourage pursuit of all means to capture this data in claims and standard supplemental data files instead. However, we do appreciate and expect our partners to send us records for this project.

What to Send Us

- Legible documents from the legal health record that close a specific HEDIS gap
- Dates of service within range of the measure
- Only records that contain data that is not or will not be included in claims or standard supplemental data files
- Not sending us records with dates of service in the last 2 months is a good rule of thumb. Assume the gap will close by claims if the service was provided in the last 2 months. If the service was provided more than 2 months ago, we assume it will not be coming across in claims and abstract it. This prevents us abstracting data that will later be overridden by claims data.
- Please avoid sending us A1cs and blood pressures between May and October, as this data generally will get overridden by the last reading taken later in the year. (HEDIS technical specifications require us to report the final reading in the year, regardless of compliance.)

Measure	Date Range	Comments
All can be self-reported by patients if documented in the legal health record (i.e., medical history section):		
A1c results [HBD]	Last one done in 2023	
Blood pressure readings [BPD, CBP]	Last one done in 2023	Include entire visit note so we can confirm the patient had no change in diet or medication that day May be self-reported readings during a tele-visit as long as the specific reading is documented in the legal health record
Bone mineral density screenings [OMW, OSW]	Most recent DEXA on or after member's 65th birthday	
Breast Cancer Screening [BCS-E]	10/1/2021 – 12/31/2023	Completed bilateral mammogram
-BCS exclusion-bilateral mastectomy	Any time up to and including 12/31/2023	
Colorectal Cancer Screening [COL] – Colonoscopy	1/1/2014 – 12/31/2023	
-Flexible sigmoidoscopy or CT colonography	1/1/2019 – 12/31/2023	

Measure	Date Range	Comments
-FIT DNA	1/1/2021 – 12/31/2023	
-Fecal occult blood test (FOBT)	Any time in 2023	Does not include tests performed in an office setting or performed on a sample collected via DRE (digital rectal exams)
-COL exclusions (total colectomy or colorectal cancer)	Any time up to and including 12/31/2023	
Eye Exam for Patients with Diabetes [EED]	1/1/2022-12/31/2023	If the exam found the member has diabetic retinopathy, only 2023 dates of service can be accepted
Kidney Health Evaluation for Patients with Diabetes [KED]	1/1/2023 – 12/31/2023	At least one estimated glomerular filtration rate (eGFR) and one urine albumin-creatinine ratio (uACR)
Statin Use in Cardiovascular Disease (SPC)	1/1/2023-12/31/2023	Exclusions diagnosed or documented to be current during the measurement year: muscular disease, ESRD, cirrhosis

What to Expect from Us

BCBSAZ cannot guarantee we will have the resources to review all records sent to us, though we will strive to. The reviewers' regulatory priorities take precedence over Measurement Year Medical Record Retrieval and Review (MY MRR). The team generally begins to review records received within 2 business days.

If we notice an issue, such as sending us out-of-date records, we may return them to you and ask for further transmission of records to be paused on your end until you are able to triage them/educate the team who is pulling records for us.
The impact of this activity on your final rates will be provided when available from our HEDIS data vendor.

Format of Records

- ☑ We can only accept pdf files. Each patient's medical record should be in a separate pdf.
- ☑ Use the file naming convention required by our FTP automation.
- ☑ The records you send should typically include the entire visit note for the date of service in question. Please avoid sending us entire medical records.

Transmission of Records

We established an automated FTP to receive HEDIS medical records from each Value-Base Care (VBC). Please use only the site created for this exclusive purpose. Providers who are not in value-based agreements with our Medicare Advantage plans can fax us records.

Cadence and Volume

We can generally review 150-250 records per month per organization between the months of May and January. We will review records outside those months as time allows.

HEDIS Provider Abstraction Form

You may use this form to report HEDIS data to us in lieu of sending us existing medical records.

Date Range Needed	Date of Diagnosis or Procedure[viii]	Other
Blood Pressure		
Report last reading in 2023	___/___/____[ix]	Systolic: _____ Diastolic: _____ Please attach the full visit note when the BP was taken.
Statins		
Moderate-High Intensity Statin Date of Prescription Fill	___/___/____	Medication name: Dose: Route:
Or date when condition excluding the pt for statin use were confirmed 1/1/2023-12/31/2023	___/___/____	Indicate type: ☐ Myalgia ☐ Myositis ☐ Myopathy ☐ Rhabdomyolysis ☐ ESRD ☐ Cirrhosis ☐ Estrogen agonist use ☐ Muscle pain
Breast Cancer Screening Mammogram in Women Aged 50-74		
10/1/2021 – 12/31/2023	___/___/____	
Or date of bilateral mastectomy any time up to 12/31/2023	___/___/____	
Colorectal Cancer Screening in Patients Aged 45-75		
Colonoscopy 1/1/2014-12/31/2023	___/___/____	
Or Flexible Sigmoidoscopy 1/1/2019-12/31/2023	___/___/____	
Or FIT-DNA 1/1/2021-12/31/2023	___/___/____	
Or FOBT 1/1/2023-12/31/2023	___/___/____	
Or date when condition excluding the pt for screening were confirmed any time up to 12/31/2023	___/___/____	Indicate type: ☐ Colorectal cancer diagnosed ☐ Total colectomy
Osteoporosis Screening in Women Aged 65-75		
Most recent bone mineral density screening on or after pt's 65th birthday	___/___/____	
Recommended[x]		
Annual Fall Risk Assessment[xi] All pts age 65+		
Annual Influenza Vaccine		
Diabetic A1c		
Hemoglobin A1c Report the latest test from 1/1/2023-12/31/2023	___/___/____	Specific numeric HbA1c result: _____%
Diabetic Retinal Screening		
Retinal Exam by 1/1/2021-12/31/2023	___/___/____	Name of ophthalmologist or optometrist performing exam: _____ Result: ☐ Negative for retinopathy ☐ Positive
Kidney Health Evaluation		
An estimated glomerular filtration rate (eGFR) 1/1/2023-12/31/2023	___/___/____	
Quantitative urine albumin test 1/1/2023-12/31/2023	___/___/____	The quantitative urine albumin test and urine creatinine test must have dates of service ≤4 days apart.
Urine creatinine test	___/___/____	
UACR	___/___/____	

Group Practice Name:			
Phone:		Email:	

By submitting this form, I confirm I have added this form to the patient's legal health record.

My signature indicates I am the MD/DO/NP/PA who reviewed the patient history and referrals as noted above.

Provider Signature with Credentials:	
Date signed:	

CPT II Codes – Quick Reference

Screening	Code	Description
Blood Pressure		
Diastolic Readings	3078F	Most recent diastolic BP < 80 mm Hg
	3079F	Most recent diastolic BP 80-89 mm Hg
	3080F	Most recent diastolic BP ≥ 90 mm
Systolic Readings	3074F	Most recent systolic BP < 130 mm Hg
	3075F	Most recent systolic BP 130-139 mm Hg
	3077F	Most recent systolic BP ≥ 140 mm Hg
Eye Exams		
Diabetic Retinal Exam Negative in Prior Year	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Eye Exam w/ Evidence of Retinopathy in Current Year	2022F	Dilated retinal eye exam w/ interpretation by an ophthalmologist or optometrist documented and reviewed; w/ evidence of retinopathy
	2024F	7 standard field stereoscopic retinal photos w/ interpretation by an ophthalmologist or optometrist documented and reviewed; w/ evidence of retinopathy
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; w/ evidence of retinopathy
Eye Exam w/o Evidence of Retinopathy in Current Year	2023F	Dilated retinal eye exam w/ interpretation by an ophthalmologist or optometrist documented and reviewed; w/o evidence of retinopathy
	2025F	7 standard field stereoscopic retinal photos w/ interpretation by an ophthalmologist or optometrist documented and reviewed; w/o evidence of retinopathy
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; w/o evidence of retinopathy
Hemoglobin A1c Tests		
HbA1c Test with Results	3044F	Most recent hemoglobin A1c (HbA1c) level < 7.0%
	3046F	Most recent hemoglobin A1c (HbA1c) level > 9.0%
	3051F	Most recent hemoglobin A1c (HbA1c) level ≥ 7.0% and < 8.0%
	3052F	Most recent hemoglobin A1c (HbA1c) level ≥ 8.0% and ≥ 9.0%
Medication Reconciliation		
Medication Reconciliation	1111F	Discharge medications reconciled w/ the current medication list in outpatient medical record

[i] National Quality Forum. "How Endorsement Happens". Retrieved from the Internet on 5/6/19: http://www.qualityforum.org/Measuring_Performance/ABCs/How_Endorsement_Happens.aspx

[ii] United States Office of Disease Prevention and Health Promotion. "Healthcare Effectiveness Data and Information Set". Retrieved from the Internet on 3/15/23: Healthcare Effectiveness Data and Information Set (HEDIS) - Healthy People 2030 | health.gov

[iii] National Committee for Quality Assurance (NCQA). "HEDIS® Compliance Audit™: Standards, Policies and Procedures". Retrieved from the Internet on 5/16/19: http://store.ncqa.org/index.php/catalog/product/view/id/3383/s/hedis-2019-volume-5-epub/

[iv] United States Centers for Medicare and Medicaid Services. "Medicare Part C & D Star Ratings: Update for 2019" (August 8, 2018). Retrieved from the Internet on 5/6/19: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2019-Star-Ratings-User-Call-slides.pdf

[v] Health Effects of Tobacco Use. Retrieved from the Internet on 3/1/2023: https://www.fda.gov/tobacco-products/public-health-education/health-effects-tobacco-use

[vi] Maningat, P., Gordon, B. R., & Breslow, J. L. (2013). How do we improve patient compliance and adherence to long-term statin therapy?. *Current atherosclerosis reports*, *15*(1), 291. doi:10.1007/s11883-012-0291-7. Retrieved from the Internet on 6/5/19: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3534845/

[vii] Jackson, C., Shahsahebi, M., Wedlake, T., & DuBard, C. A. (2015). Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge. *Annals of family medicine*, *13*(2), 115–122. doi:10.1370/afm.1753. Retrieved from the Internet on 6/5/19: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4369604/

[viii] Enter dates of most recent completed procedures only in the 2nd column, not ordered/incomplete procedure dates.

[ix] Patient-reported BP readings taken during a tele-visit are acceptable if taken with a digital device.

[x] Recommended but not required for this incentive.

[xi] https://www.cdc.gov/steadi/index.html