2015 SC Medicaid HEDIS Measures

Putting the Clinical and Billing Pieces Together

OBJECTIVES

- What is HEDIS
  - HEDIS Terms
  - Data Collections Methods
  - HEDIS Obstacles
  - Documentation
- SC Medicaid’s 2015 HEDIS Measures
- Clinical Resources
The 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.”

Why HEDIS?

- Results from HEDIS data collection serve as measurements for quality improvement processes and preventive care programs
- HEDIS rates are used to evaluate the effectiveness of a health plan’s ability to improve the preventive care and quality measures for its members
- HEDIS rates are used by over 90% of US health plans to measure performance on important aspects of care and service
HEDIS Terms

- Denominator - Eligible members of the population
- Numerator - Members that met the criteria of a measure
- 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

Data Collection Methods

- Administrative
  - Obtained from claims database
- Hybrid
  - Obtained from claims database and medical record review
- Surveys
  - Obtained from member and provider surveys

**Clinical measures use administrative and/or hybrid data collection methodology as specified by NCQA**
HEDIS Obstacles

- Members assigned to the wrong PCP
- Claims submitted without proper ICD-9 or CPT codes
- Provider specialty does not count for the measure
- Member is not continuously enrolled
- Services not properly documented in the medical record
- All components of the measure were not met
- Problems with appointment availability at hours convenient to members

Alignment of Measure

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<thead>
<tr>
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<th>HEDIS</th>
<th>PCMH</th>
<th>M/U</th>
<th>UDS</th>
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<tr>
<td>Preventive Care</td>
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<td>Chronic Disease</td>
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<td>Prenatal Care</td>
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<td>Behavioral Health</td>
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Documentation

Appropriate documentation in the medical record can reduce the hassles associated with claims processing and serves as a legal document to verify the care provided.

Documentation

- Documentation for each encounter should include
  - Reason for the encounter, relevant history, findings and diagnostic test results
  - Assessment, clinical impression, or diagnosis
    - Appropriate health risk should be identified
    - Patients progress, response to previous treatment and revision of diagnosis should be documented
  - Plan for care
  - Date and identity of provider
Documentation

- Use your EHR
  - Patient registries list all patients with specific conditions
    - Reminders
    - Track missed appointments
    - Clinical decision support tools such as templates, alerts, and care plans
  - Reports to track outcome measures
    - Compare performance of providers and sites to each other

Display Your Data!
Documentation

The CPT and ICD-9 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

SC Medicaid’s 2015 HEDIS Measures
Diabetes Optimal Care

Eye Exam

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who receive a retinal or dilated eye exam by an eye care professional (Ophthalmologist or Optometrist) in the measurement year, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year.
Eye Exam

- Optometrist/Ophthalmologist exam
  - Every 2 years for patients without retinopathy
  - Every year for patients with retinopathy
  - A note or letter from the eye professional indicating that an ophthalmoscopic exam was completed, the date of the procedure and the results.

- A chart or photograph of the retina
  - Indicates the date the photograph was taken
  - Evidence that an eye professional reviewed the results
  - Specifically states “with” or “without” retinopathy

HbA1c Testing

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had testing for HbA1c performed.
HbA1c Testing

- Patients with Type 1 or Type 2 Diabetes
  - Administrative or documentation from medical record
  - Performed during the measurement year
    - A1c
    - HBA1c
    - Hemoglobin A1c
    - Glycohemoglobin A1c
    - HgbA1c

LDL-C Screening

The percentage of patients with diabetes 8-75 years of age who received an LDL-C screening during the measurement year.
**LDL-C**

- Low density lipoprotein cholesterol
  - Marker for assessing risk for developing heart disease
  - Particles are small and dense and increase risk

**Blood Pressure Control**

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/90 mmHg).
Blood Pressure Control

- Most recent reading in the measurement year
  - Systolic reading $\leq 140$ AND
  - Diastolic reading $\leq 90$
- Not compliant if BP is not done or missing from the medical record

Medical Attention for Nephropathy

The percentage of patients 18-75 years of age with type 1 or type 2 diabetes who received a nephropathy screening test or evidence of nephropathy during the measurement year, as documented through administrative data.
Nephropathy

- Nephropathy screening test or evidence of nephropathy
  - Treatment for nephropathy or ACE/ARB therapy
  - Stage 4 chronic kidney disease
  - ESRD
  - Kidney transplant
  - Visit with nephrologist
  - Positive urine macroalbumin/microalbumin
  - Other

Diabetes Template Example
The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90) during the measurement year.
Use Proper Technique

- Patient should sit comfortably with arm relaxed and supported at level of the heart
- Use a proper size cuff
- Take at least 2 readings
- Wait over 1 hour after exercise, smoking, or consuming caffeine

Asthma Optimal Care
Medication Management for People with Asthma (MMA)

The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2) Remained on an asthma controller medication for at least 75% of their treatment period.

Use of Appropriate Medication for People with Asthma (ASM)

The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.
Asthma

- Quality asthma – 2 pronged approach
  - Initial assessment
  - On-going treatment and follow-up to maintain control

Asthma Management

<table>
<thead>
<tr>
<th>Initial Assessment</th>
<th>On-Going Treatment</th>
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<tr>
<td>Diagnose asthma</td>
<td>Assess &amp; monitor asthma control</td>
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<tr>
<td>Assess asthma severity</td>
<td>Schedule next follow-up appointment</td>
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<tr>
<td>Initiate medication &amp; demonstrate use</td>
<td>Review medication technique &amp; adherence; assess side effects; review environmental control</td>
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<tr>
<td>Develop written asthma action plan</td>
<td>Review asthma action plan, revise as needed</td>
</tr>
<tr>
<td>Schedule follow-up appointment</td>
<td>Maintain, step up, or step down medication</td>
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National Heart Lung and Blood Institute
Preventive Health
Optimal Care

Well-Child Visits in the First 15 Months of Life

The percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care physician during their first 15 months of life (6 visits).
Well Child

- Children ≤15 months old
  - Looking at 7 different rates
  - Children that had 0, 1, 2, 3, 4, 5, 6 or more well-child (EPSDT) visits in their first 15 months
  - Goal – 6 or more visits before 15 months of age

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

The percentage of patients 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year.
Well Child

- Children 3-6 years old
  - Children ages 3-6 years who had one or more well-child visit in the measurement year.

Requirements for Well-Child Visits
Birth – 15 months and 3-6 years

- Documentation in the medical record must include the following:
  - Note indicating a visit with a PCP
  - Health/interval history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health education/anticipatory guidance
Well-Child Visits

- Use templates for documentation
- Don’t miss opportunities – turn sick visits into well-child visits. It takes just a little additional time to complete the history and assessments
- Conduct a well child visit at the time of a child care/school/preschool physical
Adolescent Well-Care Visits

The percentage of patients 12-21 years of age who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN practitioner during the measurement year.

Adolescent Well Visit

- Patients 12-21 years of age who had at least one well-care visit with a PCP or OB/GYN during the year
  - Health history
  - Physical developmental history
  - Mental development history
  - Physical exam
  - Health education/anticipatory guidance
Adolescent Well Visit

- Hybrid review may be used
  - Consider using sick visits to complete missing information
  - May use visit at school-based site
  - Make the most of sports/camp physicals

Adults’ Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventative care visit. The organization reports three separate percentages for each production line. Medicaid and Medicare members who had an ambulatory or preventative care visit during the measurement year.
Preventive/Ambulatory Care

- Provide patient reminders and materials to assist in upcoming visits
- Avoid missed opportunities by taking advantage of office visits (including sick visits, work physicals) to provide preventive care services

Prenatal Care

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and post partum care: Timeliness of Prenatal Care is the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrolling in the organization.
Prenatal Care

- First prenatal visit in the first trimester or within 42 of enrollment in the organization must include the following documentation:
  - The date prenatal care occurred
  - Basic OB physical exam by a provider including auscultation for fetal heart tone or pelvic with OB observations or measurement of fundal height.
  - Evidence that a prenatal procedure was performed.
  - LMP or EDD
  - Prenatal risk assessment, education, counseling, complete OB history

Behavioral Health Measures
Follow-Up Care for Children
Prescribed ADHD Medication (ADD)

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The reported rate, the Initiation Phase, is the percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Follow-Up Care for ADHD

- Children ages 6-12 newly prescribed ADHD medication with 3 visits within a 10-month period
  - Initiation Phase – follow-up visit with the practitioner with prescribing authority during the 30 day initiation phase
  - Continuation and Maintenance - patients with an ADHD medication who remained on the medication for at least 210 days
Follow-Up Care for ADHD

- Children ages 6-12 newly prescribed ADHD medication with 3 visits within a 10-month period
  - Continuation and Maintenance - patients with an ADHD medication who remained on the medication for at least 210 days
  - At least 2 follow-up visits between 4 weeks and 9 months of initiation of prescription

Clinical Resources

- Diabetes
  - Healthy People 2020 – Diabetes
  - American Diabetes Association 2014 Clinical Guidelines
    http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160&loc=rp-slabnav

- Hypertension
  - Healthy People 2020 – Blood Pressure
  - JNC 8
    http://jnc8.jamanetwork.com/

- Asthma Optimal Care
  - National Heart Lung and Blood Institute – Asthma Guidelines
Clinical Resources

- Well Child Care
  - Bright Futures Pocket Guide
    http://brightfutures.aap.org/pdfs/bf3%20pocket%20guide_final.pdf

- Adolescent Well Care Visits
  - Increasing Medicaid Well Visits in Adolescents
    http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf

Clinical Resources

- Adult Access to Preventive/Ambulatory Health Services
  - AAFP Recommendations
  - USPSTF Recommendations
    http://www.uspreventiveservicestaskforce.org/usps/uspabrecs.htm

- Prenatal Care
  - ACOG Consensus Guidelines
    http://www.acog.org/Resources-And-Publications
Clinical Resources

- ADHD
  - AAP – Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
    http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf