HEDIS QUALITY UPDATES AND DATA COLLECTION STRATEGIES

Applying HEDIS Best Practices to Solve for Quality

Lynn Kafer, LVN, Quality Improvement Project Manager
Gerred B. Smith, Quality Improvement Project Manager
Joan Savage, RN, Manager of Quality Improvement Analytics
August 2020

Coverage for every stage of life™

Objectives

Goal of this presentation is for the listener to:

- Gain knowledge and understanding
- Understand data collection methods and improvements
- Apply understanding for improvement and changes to business practices

The goals are to be applied to the following:

Measure Changes

Telehealth

HEDIS Data Collection and Timeline

Improving Data

2020 MEASURE CHANGES

Noteworthy Changes

- New administrative measures
- Converted measures from hybrid to administrative
- Retired measures
- Added advanced illness and palliative to multiple measures
- Telehealth added to multiple measures

New Admin Measures

Health Net

Cardiac Rehabilitation (CRE)

Measures: 18 years of age and older who attended cardiac rehab following a qualifying cardiac event

- 4 indicators
  - Initiation: 2 or more sessions within 30 days after a qualifying event
  - Engagement 1: 12 or more sessions within 90 days after qualifying event
  - Engagement 2: 24 or more sessions within 180 days after qualifying event
  - Achievement: attended 36 or more session with 180 days after qualifying event

Occurs: After a qualifying annual event

Requirements of PCP: Follow up ensuring member is in cardiac rehab program and following through with treatment program.

Barriers: Members who don't follow through or understand how to navigate the healthcare system post discharge from hospital and are not directly discharged to rehabilitation program.

Best Practice Tip: Recommend Case Management to follow member post event and follow up with member on ongoing basis to ensure member is following through with treatment regimen.

Product Impact: All lines of business

New Admin Measures Cont'd

Health Net

Kidney Health Evaluation for Patient with Diabetes (KED)

Measures: 18-85 years of age with diagnosis of Diabetes who had all of the following in the measurement year:

- Estimated glomerular infiltration rate (eGFR)
- Quantitative urine albumin
- Urine creatinine test

Note: *urine tests should be on the same date of service in order to impact for HEDIS*

❖ *Member with Poly Cystic Ovarian syndrome, gestational diabetes, or steroid induced diabetes are* ***optional*** *for health plan to exclude. The clinical medical record documentation needs to clearly state the member current diagnosis as determined by assessment, plan and intervention. The appropriate diagnosis should be billed at the time of visit.*

Occurs: Annual basis (measurement year)

Requirements of PCP: Order labs yearly

Barrier: Access to care, lack of follow up, lack of coordination with specialist that manage diabetes, not ordering services, capitation to lab - PPG may be invoiced and services do not get billed.

Best Practice Tip: Standing orders for all diabetics that include labs that monitor kidney function on an yearly basis. Engage the member on importance of tests and follow through.

Note: Measure is replacing the CDC Nephropathy measure for Commercial/Medi-CAL lines of business. Medicare will report the CDC_Neph measure for two more years (2020-2021), then measure will likely replace.

Products Impact: All lines of business

New Admin Measures Cont'd

Osteoporosis Screening in Older Women (OSW)

Measures: Women 66-75 years of age who received osteoporosis screening starting on or between the members 65th birthday.

Occurs: Once between ages 65-75

- ❖ Members on palliative care or taking osteoporosis therapy/long acting osteoporosis medications are excluded from the measure

Requirements of PCP: Order Bone Mineral Density Tests for any member that has not received at least one screening for members in age span noted (CPT: 76977, 77078, 77080, 77081, 77085)

Best Practice Tip: Query enrolled members in your system for the age span noted to evaluate if the member had a Bone Mineral Density Test. Create a standing order for members that meet the criteria and refer member to the appropriate testing facility. Members may have already completed the Bone Mineral Density Test prior to becoming a member to the health plan. Health plans should have a supplemental data process for the providers to submit the data.

Note: According to the US Preventative Services Task Force, DEXA screening is recommended for all women over the age of 65.

Note: Measure will likely become a STARS measure, therefore, providers want to get ahead of this measure in the beginning stages to ensure the impact with be at a high rate once it does become available for STARS.

Product Impact: Medicare

Measure Conversion

Health Net

Well Care Measures

- Three measures were combined into two measures and changed from hybrid to administrative only
  - Well Care in First 15 months of life (W15) is now converted to an administrative measure Well Care Visits in First 30 months of life (W30)
  - Two rates are reported:
    - Rate: 0-15 months (6 or more visits)
    - Rate: 15-30 months (2 or more visits)
    - Admin only measure (no longer hybrid)
    - PCP/OB GYN practitioner requirement
    - Note: Measures will be heavily impacted by encounters

  - Well Child visits in 3rd, 4th, 5th and 6th (W34) years of life and Adolescent Well Care Visits (AWC) are a combined measure called Child and Adolescent Well Care Visits (WCV)
    - Admin only
    - Yearly visit
    - PCP/OB GYN practitioner requirement
    - Includes all members from 3-21 years of age
      - Rate: 3-11 years (1 visit yearly)
      - Rate: 12-17 years (1 visit yearly)
      - Rate: 18-21 years (1 visit yearly)
    - Note: Measures will be heavily impacted by encounters

Products Impacted: Commercial and Medi-CAL

Note: Measures that change usually become a baseline measure for the year it changed. However, for Medi-CAL product line the measures requirements also have to align with the state mandates for MCAS requirements.

Retired Measures/Sub-Measures

- Adult BMI Assessment (**ABA**)
- Medication Management for People With Asthma (**MMA**)
  - ***Note**: Asthma Med Ratio (AMR) replaces this measure)*
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (**ART**)
  - ***Note:** This measure is **retired for MY 2021 but is reported for MY 2020***
- Osteoporosis Testing in Older Women (**OTO**)
- Children and Adolescents' Access to Primary Care Practitioners (**CAP**)
- CDC- Nephropathy (**CDC**)
  - ***Note: Retired** the "Medical Attention for Nephropathy" sub-measure **for the Commercial and Medicaid product lines**. (Still **reported for Medicare for next two years 2020-2021**.)*

Additional Exclusions

Billing diagnosis codes that support advance care illness or member enrolled in palliative care can remove the member from the denominator.

Examples of Advance Care Illnesses are as follows, but not limited to:

- Malignant neoplasm (C25.0-C25.9, C70.0-C71.9, C77.0-C77.9)
- Dementia/Alzheimer Disease (G30.0, G30.8, G30.9, G31.83, G31.09)
- ALS (G12.21, F01.51, F02.80)
- Parkinson's Disease (G20.0)
- Creuztfeldt-Jakob Disease (A81.00, A81.01, A81.09)
- Leukemia (C91.00, C91.02, C92.00, C93.00)
- Rheumatic Heart Failure (I09.81)

Examples of Palliative Care:

- Encounter for palliative care (Z51.5)

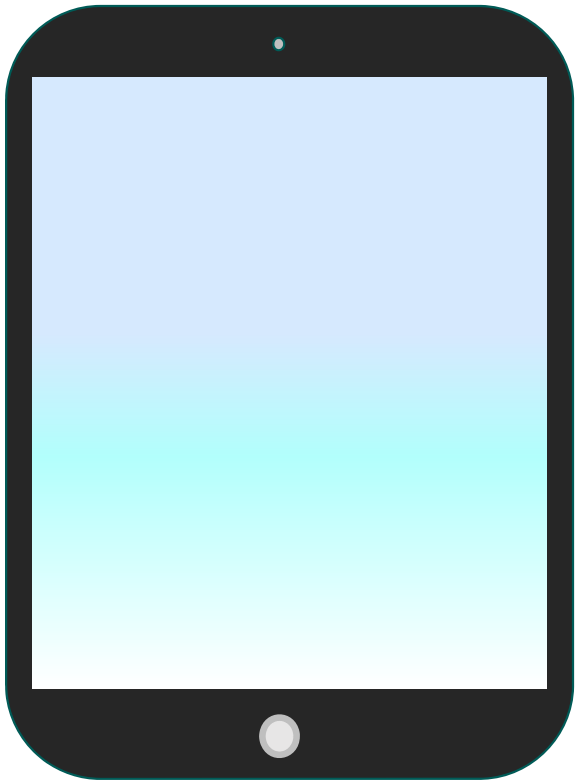
Advance Care Illness

- Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)
- Statin Therapy for Patients with Diabetes (SPD)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Colorectal Cancer Screening (COL/COL-E)
- Breast Cancer Screening (BCS/BCS-E)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA)

Palliative Care

- Colorectal Cancer Screening (COL/COL-E)
- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Therapy for Patients with Diabetes (SPD)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Potentially Harmful Drug-Disease Interactions in Older Adults (ODE)
- Comprehensive Diabetes Care (CDC)
- Use of High Risk Medications in Older Adults (DAE)
- Use of Opioids at High Dosage (HDO)
- Risk of Continued Opioid Use (COU)

Telehealth



Centers for Medicare and Medicaid Services (CMS) and California Department of Health Care Services (DHCS) as of March 6 provided guidance for Telehealth Services.

DHCS defines “Telehealth” services as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self management of a patient’s health care. Provider must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Guidelines are subject to change at the discretion of the governing agencies and may have line of business restrictions to the type of services completed. Guidelines can be reviewed through the following links:

Medicare
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
Medi-Cal
https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx

Examples of systems used by providers: Doximy and Zoom

Types of Telehealth

Health Net

Synchronous

Synchronous telehealth requires real-time interactive audio and video telecommunications.. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.

- Covered by all Lines of Business

Note: A measure specification that is silent about telehealth includes synchronous telehealth

Asynchronous

"Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, store and forward is not "real-time" but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging or email. A measure will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set." (Value Sets are available with purchase of the NCQA specifications)

- Covered by Commercial and Medicare, but may not be covered by Medi-Cal for payment even though the specifications allow for the measure.

Telehealth Guidelines

Providers who can furnish virtual services (subject to State Law) are physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, occupational therapists, speech language pathologists and registered dieticians/nutrition professionals.

Guidelines for billing telehealth services:

- Service must occur using audio and video telecommunication
- Member must be established with the provider
- Medi-Cal providers must be licensed in California, enrolled as a Medi-Cal rendering provider and affiliated with an enrolled Medi-Cal provider group.
- Providers to bill with POS 02 (telehealth),
  - POS requirement is not applicable for Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RH), Indian Health Services (IHS)
- Commercial and Medicare will bill the normal POS code (11, 23 etc.)
- Append the appropriate modifier: 95 (telemedicine service rendered via audio and video telecommunications system) or GQ (store and forward telecommunications)
- Obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services. The consent shall be documented in the patient's medical file
- Guidelines may change post current state of pandemic

Note: *Communication sent anytime between providers and patients (time lag) via email, text messaging, etc (store and forward) are not covered for Medicaid (Medi-Cal in CA)*

Other Changes

Member Reported Services (Biometric Values: BMI, BMI percentiles, Height, Weight, and Blood Pressures) reported at telehealth visits can be utilized for HEDIS providing the following criteria is met.

NCQA noted: Member-reported services using digital devices are acceptable only if the information is collected by a primary care practitioner or specialist, if specialist is providing primary care service related to condition being assessed while taking the patient's history. The following must occur:

- Information is documented, dated and maintained in the member's legal health record

Note: Documentation does not need to state that the BP was taken with a digital device or that the BP was **NOT** taken with a manual device. However, a BP is **NOT** eligible for use if the medical record documentation specifically states the BP was taken by the member using a manual blood pressure cuff and a stethoscope.

- Telehealth added to multiple measures
  - Two types
    - Synchronous telehealth visits
    - Asynchronous telehealth (e-visits, virtual check-ins)

Measures Impacted by Telehealth

Health Net

Examples of measures that can be impacted by use of telehealth (not limited to)

Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)	BMI percentile, nutrition counseling, physical activity counseling
Care of Older Adults (COA)	Advance Care Planning, Functional Status Assessment, Pain assessment, Medication Review
Controlling Blood Pressure (CBP)	Diagnosis in first 6 months of the year and blood pressure readings with any digital device
Comprehensive Diabetes Care (CDC)	Dx of diabetes, BP readings, Order labs
Metabolic Monitoring for Children and Adolescents (APM)	Order Labs
Transitions of Care (TRC)	E- visits and virtual check-ins for patient engagement, receipt of discharge information indicator
Prenatal and Postpartum Care (PPC)	Prenatal Visits
Well Child Visits in the First 30 months of Life (W30)	Visits
Child and Adolescent Well Care Visits (WCV)	Visits
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescent and Adults (DSM-E)	Screening
Depression Screening (DSF)	Screening
Breast Cancer Screening (BCS)	Order/Referral
Asthma Medication Ration (AMR)	Confirm Dx of Asthma, order medication and follow up on RX being filled

HEDIS® DATA

HEDIS® Data

Health Net

- Collecting Data for HEDIS is a Complex Undertaking

The lack of interoperability and updated processes and systems can impact the ways HEDIS measures meet the specification requirements.

- Implications
  - » Inefficiencies can have financial consequences (incentives, contracts, member retention)
  - » Increasing in demand of standardization – more measures are being changed to administrative or ECDS
    - Reliance on encounter/claims
  - » Moving towards value based care models

- Barriers
  - » Outdated EHRs (codes: LOINC, SNOMED, CPT, ICD_10, HCPCS, CVX)
  - » Archaic processes (paper charting)
  - » Lack of interoperability (connections to other health systems: hospital, labs, radiology)
  - » Difficulty with extracting data due to cost, resources, provider not on an EHR, or EHR is not updated
  - » Lack of resources

Collecting HEDIS® Data

Health Net

Health plans collect data in two ways.

- Standardized administrative method
- Non-standardized administrative method

A standardized administrative method does not require a medical record review audit with the HEDIS auditor. The auditor at any time can choose to audit, but it is not a requirement. The process is called primary source verification.

Data that is considered standard data are as follows:

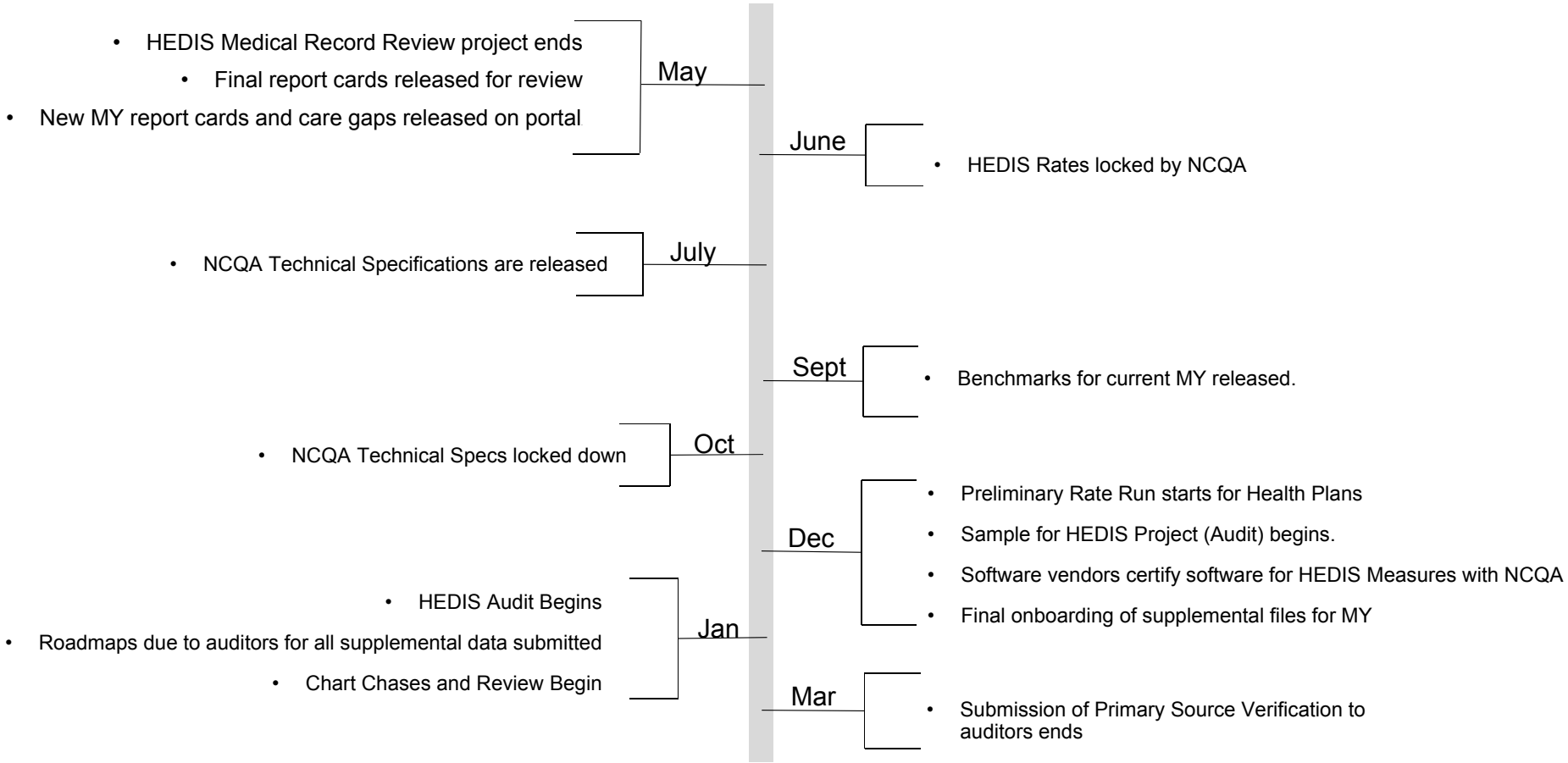
- Claims and Encounter
- Extraction of EHR data from the back end
- Extractions from immunization registry
- Lab vendor data extraction
- Pharmacy Claims

A non-standard administrative method does require medical record review. The burden is on the entity to back up data with the medical record documentation (proof of service).

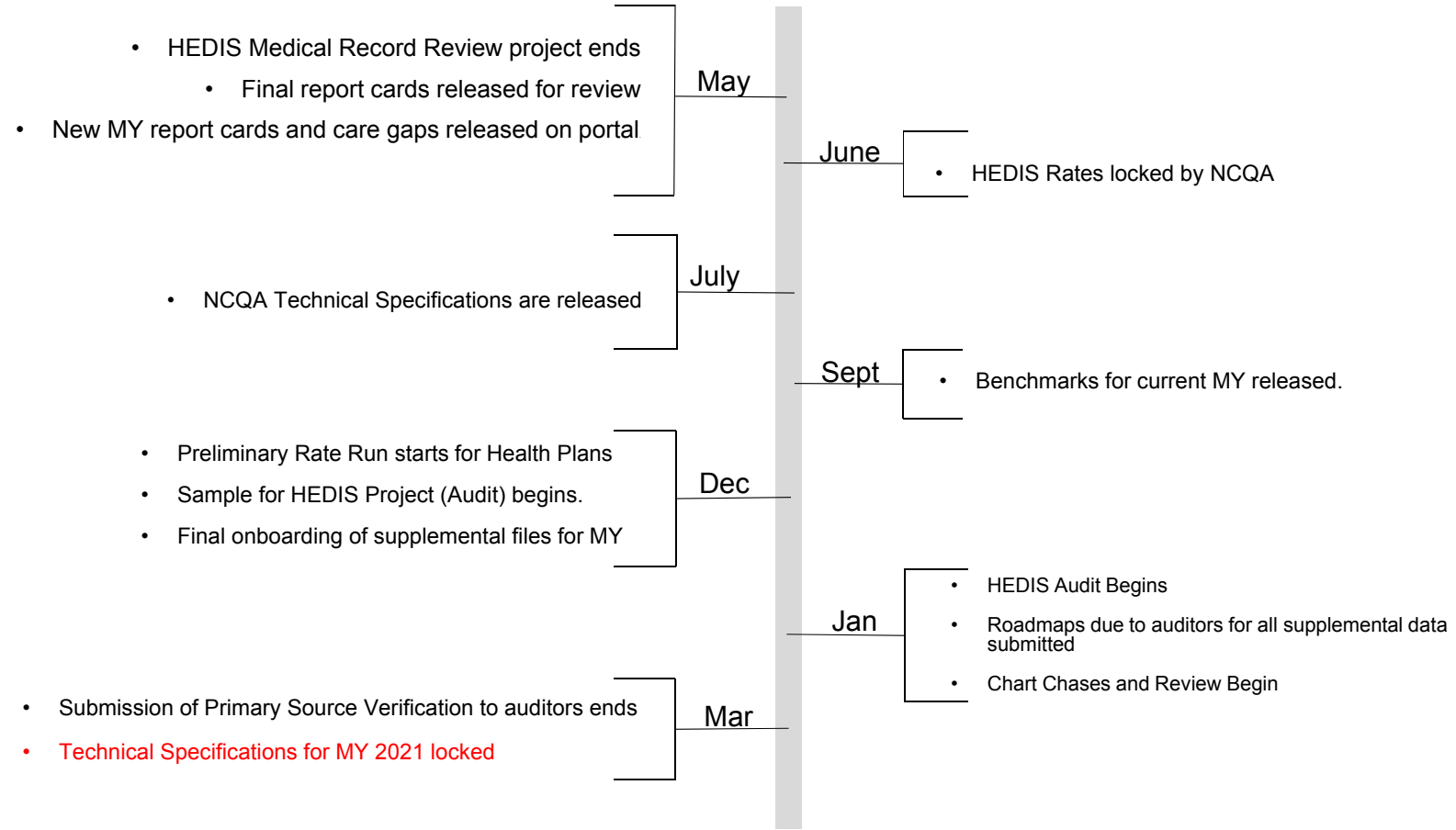
Data that is considered non-standard data are as follows:

- Medical Record Review
- Non-standard data extraction
- C-CDA data
- Health Information Exchange (HIE)

HEDIS® Timeline 2020



HEDIS® Timeline Change 2021



Administrative Data

The Fundamentals of Improving Specific Measure Indicators

Data

The ultimate goal for primary care data is to guide and improve member outcomes. The data drives the quality of experience, adherence, prevention, member retention, and overall wellness for members.

Understanding the processes and how data gets from one point to the next is a key fundamental part to care. Lack of efficiencies in processes around data can impact your overall productivity, measure adherence, understanding the full scope of the member disease process, and minimize the support you would receive from the health plan.

Next steps:

- How measures perform are performing
- What could be potential root causes
- How to improve the data capture

IMMUNIZATIONS

Health Net

Final MCAL Rates for LA County by Individual Immunization for CIS

Childhood Immunization Status (CIS)

Added live attenuated influenza vaccine (LAIV) as numerator compliant for the influenza rate

Measurement Year - 2019; Date & Timestamp - 6/25/2020 3:

Data Element	General Measure Data	DTaP	IPV	MMR	HiB	Hepatitis B	VZV	Pneumo- coccal Conjugate	Hepatitis A	Rotavirus	Influenza
Measurement year	2019										
Data collection methodology (administrative or hybrid)	H										
Eligible population	13408										
Number of numerator events by administrative data in eligible population (before exclusions)		9059	10587	11665	11068	9142	11601	8898	11406	8403	4979
Current year's administrative rate (before exclusions)		67.56%	78.96%	87.00%	82.55%	68.18%	86.52%	66.36%	85.07%	62.67%	37.13%
Minimum required sample size (MRSS)	411										
Oversampling rate	0.02										
Number of oversample records	9										
Number of numerator events by administrative data in MRSS		268	308	354	326	285	356	254	341	248	146
Administrative rate on MRSS		65.21%	74.94%	86.13%	79.32%	69.34%	86.62%	61.80%	82.97%	60.34%	35.52%
Number of medical records excluded because of valid data errors	0										
Number of administrative data records excluded	9										
Number of medical data records excluded	0										
Number of employee/dependent medical records excluded	0										
Records added from the oversample list	9										
Denominator	411										
Numerator events by administrative data		90	122	284	180	52	286	77	296	91	102
Number of numerator events by medical records		38	38	7	25	56	6	43	8	29	2
Numerator events by supplemental data		178	186	70	146	233	70	177	45	157	44
Reported rate		74.45%	84.18%	87.83%	85.40%	82.97%	88.08%	72.26%	84.91%	67.40%	36.01%

IMMUNIZATION DATA

Health Net

Data supports 5 immunizations are impacting the overall rate

- Dtap
- Hep B given at birth
- Pneumococcal
- Rotavirus
- Influenza

Ways to improve care gap closure

- Submit all data to Immunization registry, including historical data
- Ensure EHRs are updated with correct CVX codes
- Bill for services given, use SL modifier for Vaccines for Children
- Ensure billing systems have ability to manage NDC edits (often cause for encounter rejections at health plan)
- Consider approaches taken that can influence the member to adhere to the recommended schedule
- Engage health plan to submit supplemental data
- Evaluate the breakdown in processes as to why services are being missed and members are not getting the vaccine or following the recommended schedule
- Develop customized reports utilizing your EHR to determine members that need to be outreached 2-3 months before vaccine is due

WELL CHILD VISITS

Final MCAL Rates for Kern County W15

Well-Child Visits in the First 15 Months of Life (W15)								
First year measure for CA DHCS MCAS reporting.								
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:45:20 PM								
Data Element	Measure Data	0 Visits	1 Visit	2 Visits	3 Visits	4 Visits	5 Visits	6 or More Visits
Measurement year	2019							
Data collection methodology (administrative or hybrid)	H							
Eligible population	551							
Number of numerator events by administrative data in eligible population (before exclusions)		19	30	42	46	73	109	232
Current year's administrative rate (before exclusions)		3.45%	5.44%	7.62%	8.35%	13.25%	19.78%	42.11%
Minimum required sample size (MRSS)	411							
Oversampling rate	0.05							
Number of oversample records	21							
Number of numerator events by administrative data in MRSS		7	14	23	28	48	60	183
Administrative rate on MRSS		1.70%	3.41%	5.60%	6.81%	11.68%	14.60%	44.53%
Number of medical records excluded because of valid data errors	11							
Number of employee/dependent medical records excluded	0							
Records added from the oversample list	11							
Denominator	411							
Numerator events by administrative data		7	10	17	18	29	22	79
Numerator events by medical records		0	3	3	9	4	5	23
Numerator events by supplemental data		0	4	6	10	19	39	104
Reported rate		1.70%	4.14%	6.33%	9.00%	12.65%	16.06%	50.12%

Health Net

GOAL 73.20

A large portion of data is coming through supplemental data, and not being billed.

Best Practice Tip:

- Identify billing or coding deficiencies to better capture the service.
- Update provider specialty in NPPES DB
- **Utilize telehealth**

Barrier:

- Babies billed under primary parent ID during first 30-60 days.
- Provider Specialty
- Follow up

Recommended schedule for Newborn to Toddler per American Academy of Pediatrics is as follows:

- 1 Month
- 2 Month
- 4 Month
- 6 Month
- 9 Month
- 12 Month
- 18 Month
- 24 Month

WELL CHILD VISITS

Final MCAL Rates for San Joaquin County W34

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:45:45 PM	
Data Element	Measure Data
Measurement year	2019
Data collection methodology (administrative or hybrid)	H
Eligible population	1376
Number of numerator events by administrative data in eligible population (before exclusions)	858
Current year's administrative rate (before exclusions)	62.35%
Minimum required sample size (MRSS)	395
Oversampling rate	0.1
Number of oversample records	40
Number of numerator events by administrative data in MRSS	239
Administrative rate on MRSS	60.51%
Number of medical records excluded because of valid data errors	31
Number of employee/dependent medical records excluded	0
Records added from the oversample list	31
Denominator	395
Numerator events by administrative data	238
Numerator events by medical records	8
Numerator events by supplemental data	1
Reported rate	62.53%

GOAL 83.90

Data supports care gap is the issue with some minor billing deficiencies

Best Practice Tip:

- Identify billing or coding deficiencies to better capture the service.
- Develop processes to engage the members to come in for service.
- Update provider specialty in NPPES DB
- **Utilize telehealth**

Barrier:

- Coding and engagement
- Provider specialty

BREAST CANCER SCREENING

Health Net

GOAL 69.92

Final MCAL Rates for Kern County BCS

Breast Cancer Screening (BCS)	
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:45:17 PM	
Data Element	General Measure Data
Measurement year	2019
Data collection methodology (administrative)	A
Eligible population	2813
Number of optional exclusions	7
Numerator events by administrative data	1428
Numerator events by supplemental data	70
Reported rate	53.25%

Data supports care gap is the issue with some minor billing deficiencies

Best Practice Tip:

- Improving data capture in the EHR
  - Capturing services under past medical history with full complete date of service (reported date on report and not the date documented)
  - Updating SNOMEDs to be attached to Past Med HX (SNOMED: 71651007, 43204002, 392521000119107, 392531000119105, 566571000119105, 572701000119102 (additional codes exist)
  - Update EHR to capture Mammograms using LOINC codes: 24605-8, 24606-6, 26175-0 , 26176-8 , 26177-6, 46356-2 (additional codes exist)
  - Work with radiology sites to send data feeds to load into the EHR
- Develop processes to engage the members to complete service.
- Work with radiology groups to set up appointments for member vs waiting for member to contact the radiology group
- Identify barriers to access to care
- Bill dx for history of bilateral mastectomy for members with bilateral mastectomy (DX Z90.13; SNOMED 428529004)

Barrier:

- Access to Care
- Data housed as PDF and not extractable from system
- Transportation (HN offers and should be engaged to support)

CPT II Coding

Current Procedural Terminology (CPT) category II CPT code set, commonly called “CPT two” codes, are codes that are 5 digit code that utilizes an alphabetical character as the 5 digit. **The codes are utilized for tracking and performance measurement,** thus reducing the need for chart collection and abstraction. The codes may be reported in addition to evaluation and management (E/M) services (CPT Category I codes).

The category II codes **are billed with $0 charge** (no revenue value) and are to supplement Category 1 CPT codes, not to replace them. This can often lead to codes not making it to the encounter/claim. The categories of codes are as follows:

Examples of CPT II codes used in HEDIS:

- A1c results (3044F-3046F)
- Blood Pressure results (3074F, 3075F, 3077F, 3078F, 3079F, 3080F)
- Medication Reconciliation (1111F)

CPT Category II codes are updated throughout the year and posted on the AMA website and make up the Quality Data Codes (QDC).

** The release of CPT II codes occur three times a year with an effective date three months after release.*

Measures Impacted by CPT II Coding

Health Net

Comprehensive Diabetes Care (CDC)			
Measure is Rotated, please refer to Intro page			
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:45:18 PM			
Data Element	General Measure Data	HbA1c Testing	HbA1c Poor Control (>9.0%)
Measurement year	2019		
Data collection methodology (administrative or hybrid)		H	H
Eligible population with required exclusions applied		2886	2886
Number of numerator events by administrative data in eligible population (before optional exclusions)		1597	1597
Current year's administrative rate (before optional exclusions)		55.36%	67.83%
Minimum required sample size (MRSS)		411	411
Oversampling rate		0.1	0.1
Number of oversample records		42	42
Number of numerator events by administrative data in MRSS		227	189
Administrative rate on MRSS		70.05%	31.63%
Number of medical records excluded because of valid data errors		0	0
Number of optional administrative data records excluded		16	16
Number of optional medical data records excluded		0	0
Number of employee/dependent medical records excluded		0	0
Number of HbA1c <7 required medical records excluded			
Number of HbA1c <7 required administrative data records excluded			
Records added from the oversample list		16	16
Denominator		411	411
Numerator events by administrative data		234	68
Numerator events by medical records		32	17
Numerator events by supplemental data		93	62
Reported rate		87.35%	36.77%

Controlling High Blood Pressure (CBP)	
Measure is Rotated, please refer to Intro page	
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:45:18 PM	
Data Element	General Measure Data
Measurement year	2019
Data collection methodology (administrative and hybrid)	H
Eligible population	4169
Number of numerator events by administrative data in eligible population (before exclusions)	1597
Current year's administrative rate (before exclusions)	38.31%
Minimum required sample size (MRSS)	411
Oversampling rate	0.1
Number of oversample records	42
Number of numerator events by administrative data in MRSS	156
Administrative rate on MRSS	37.96%
Number of medical records excluded because of valid data errors	0
Number of administrative data records excluded	11
Number of medical data records excluded	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	11
Denominator	411
Numerator events by administrative data	7
Numerator events by medical records	87
Numerator events by supplemental data	149
Reported rate	59.12%

- Improving CPT II coding improves the outcomes of the measure and reduces the reliance on medical record chart chases to providers.

Medication Reconciliation Post-Discharge (MRP)	
Measurement Year - 2019; Date & Timestamp - 6/15/2020 12:46:30 PM	
Data Element	Measure Data
Measurement Year	2019
Data collection methodology (administrative or hybrid)	H
Eligible Population	960
Number of numerator events by administrative data in eligible population (before exclusions)	353
Current year's administrative rate (before exclusions)	36.77%
Minimum required sample size (MRSS)	411
Oversampling rate	0.15
Number of oversample records	62
Number of numerator events by administrative data in MRSS	160
Administrative rate on MRSS	38.93%
Number of medical records excluded because of valid data errors	27
Number of employee/dependent medical records excluded	0
Records added from the oversample list	27
Denominator	411
Numerator events by administrative data	63
Number of numerator events by medical records	68
Numerator events by supplemental data	97
Reported rate	55.47%

Documentation

When data is abstracted from the medical record to be used as supplemental data, the documentation of codes alone (without the documentation of the service provided) does not meet compliance for HEDIS reporting or act as proof of service for the HEDIS audit. It is expected that the provider that performs the service is documenting the completed service in the medical record as it is deemed for billing medical necessity and assessments for preventive services.

Auditors will require medical record documentation for administrative measures even when specifications do not supply hybrid review requirements.

Summary

HEDIS requirements change consistently and require health plans to follow a strict timeline when reporting. Therefore, we encourage our providers to prepare for the changes by implementing processes, engage members before it is too late, and bill services.

- Purchasing the HEDIS specifications and review with internal teams vs waiting on Health Plans documentation
- Update EHRs with coding changes annually (CPT, HCPCS, ICD_10, CVX, LOINC, SNOMED)
- Update Provider information in NPPES database so health plan can have the most accurate information on providers
- Check encounters/claims for errors prior to sending to health plan to reduce the amount of rejected encounters/claims (ie. NDC edits)
- Make efforts to ensure you can standardize data collection and processes internally
- Submit historical data to Immunization registries
- Utilize CPT II coding especially for A1c value, Blood Pressure, Medication Reconciliation
- Utilize care gap reports to reconcile your data
- Utilize telehealth to complete the services where deemed appropriate

Health Net®

Applied Research Works, Inc.
COZEVA®

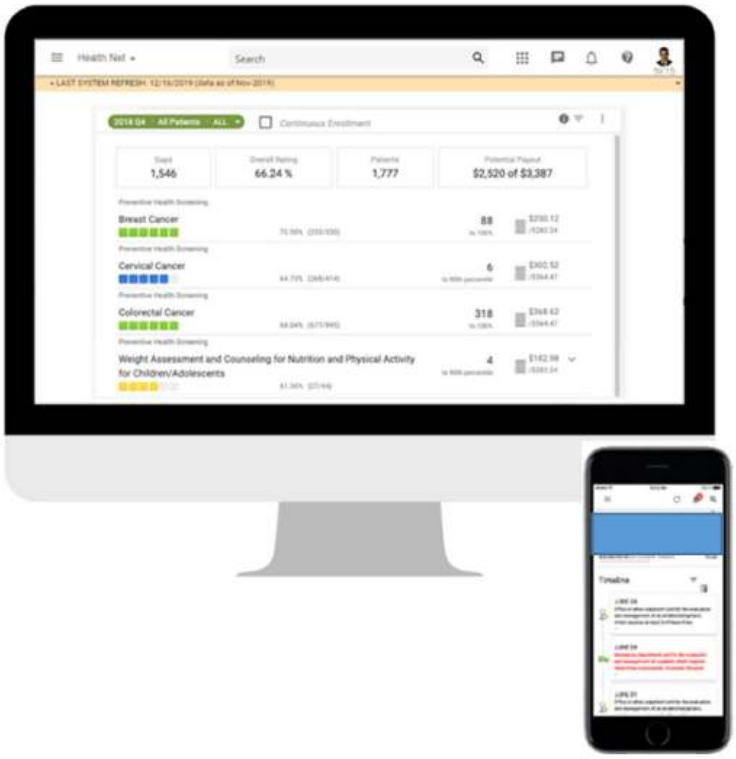
Improving supplemental data capture

What is Cozeva®?

COZEVA® is a NCQA-certified reporting and analytics platform

How it can support your organization:

- Comprehensive view of enterprise-wide performance on quality and risk measures
- Track and trend measure rates over time, compare and contract provider performance to identify outliers, and proactively take steps to improve your scores.
- View patient-level detail on gaps in care and chronic conditions to be re-coded in current year
- Close care gaps instantly by uploading proof of service documentation
- Prioritize outreach and track care gaps for measure



Applied Research Works, Inc.
COZEVA®

Training on measure requirements on the Cozeva® platform

Training modules in the Cozeva platform that will assist you in the understanding of medical record documentation requirements to meet measurement requirements.

- Tip sheets for the measures (coming soon!)
- Detailed training videos (coming soon!)

Contacts

For more details and to sign up your practice for Cozeva ® :

- Contact your assigned Health Net representative

OR

- Email at Cozeva@HealthNet.com

OR

To request access:

Go directly to Cozeva.com/registerHN

Complete the online self-registration form