Healthcare Effectiveness Data and Information Set (HEDIS) and Quality Management Programs

Provider Practice Transformation Manual 2022

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What is HEDIS?

- HEDIS stands for Healthcare Effectiveness Data and Information Set
- HEDIS is a widely used set of performance measures in the managed care industry, which is developed and maintained by the National Committee for Quality Assurance (NCQA).
- HEDIS is a set of standardized quality measures. This standardization helps the public compare the performance of organizations across the nation. HEDIS measures are also part of Horizon Blue Cross Blue Shield of New Jersey's (Horizon BCBS NJ) contracts with the state, Centers for Medicare and Medicaid Services (CMS) and our NCQA accreditation.
- HEDIS includes more than 96 measures across six domains of care:
  - Effectiveness of Care
  - Access/Availability of Care
  - Experience of Care
  - Utilization and Risk Adjusted Utilization
  - Health Plan Descriptive Information
  - Measures Reported Using Electronic Clinical Data Systems
- HEDIS measures focus on prevention, screenings and conditions across all body systems, access to care, satisfaction with care, as well as utilization of specific procedures and care settings.
- NCQA defines each measure, specifically identifying eligibility and compliance criteria.
- HEDIS-acceptable codes are published each **October** in the Value Set Directory (VSD), which is part of the final specifications published by NCQA.
  - Every HEDIS measure is linked to specific coding criteria.
  - Only HEDIS-acceptable codes count toward numerator compliance for specific HEDIS measures.

What is Your Role in Quality?

Process Requirements

- HEDIS data collection is a year-round process using claims data as the primary source.
- Complete and accurate coding of all claim submissions from the provider's office is a priority and will ensure the integrity of the data.
  - Claim submissions should be timely to avoid delays in monthly updates to tracking reports.
- NCQA allows plans to collect additional HEDIS data through a hybrid process called Medical Record Review (MRR), which is conducted **January** through **May**.
  - Medical records are collected through fax, Managed File Transfer (MFT), email, HorizonDocs document exchange platform and by a Quality Auditor.
  - Quality Auditors or Clinical Quality Improvement Liaisons (CQILs) request medical records from provider offices to search for information that may exist in the chart that was either never submitted via code on a claim, or was submitted but with a non- HEDIS (Value Set) code.

- Partnering with BCBSNJ to allow remote access to your electronic medical record (EMR) system during this time will reduce the administrative burden for your staff and expedite the review process. Contact your Clinical Quality Improvement Liaison or Horizon BCBSNJ contact to coordinate.

• Practices are encouraged to review their gap lists and submit documentation for members who meet criteria for permanent exclusion from a measure, when applicable. Contact your CQIL or Horizon BCBSNJ contact to receive your monthly HEDIS measures gap lists.

What is HorizonDocs?

HorizonDocs is a web-based centralized document repository that allows Horizon BCBSNJ to securely exchange documents with providers. Key features of HorizonDocs includes:

- Web-based tool, accessible via NaviNet Provider Portals (Horizon BCBSNJ and Horizon NJ Health)
- Documents organized by Category and Sub-Category (e.g. HEDIS Chart Chase, Disputes, Quality, etc.)
- Email notification to designated users when Horizon sends document
- Documents sent to Providers based on TIN
- Users are assigned permission to view documents based on sensitivity level of a document
    - Sensitive Clinical
    - Sensitive Non Clinical
    - General
- Providers assign their users permissions based on the type of documents they should be able to view

Horizon implemented HorizonDocs to establish a means for Horizon and providers to exchange documents, that is:

- Easy, fast, secure
- Provides proof of submission
- Better document exchange experience
- HorizonDocs will eventually replace all other modes of exchanging documents including secure blue emails, fax, and MFT

Please reach out to your CQIL or Horizon BCBSNJ contact for HorizonDocs training or questions.

Medicare Advantage Care Coordination Program

BCBS National Coordination of Care program to support Blue Cross and Blue Shield Medicare Advantage (MA) members was launched nationally on **January 1, 2020**. This program aims to increase the quality of members' care, wherever they access care. Horizon successfully completes provider education and receives medical records in efforts to close care gaps for members we host (e.g. members of other Blues Plans seen by a Horizon BCBSNJ provider).

Enhancements to this communication platform will allow the process of requesting gap closures and medical records from other Blues Plans for Horizon members.

Quality Resource Center

Horizon BCBSNJ launched a Resource Center, which contains materials and resources that will assist network providers with quality improvement efforts. The Quality Resource Center can be accessed visiting HorizonBlue.com/QualityResourceCenter and signing into NaviNet. Please access the Resource Center for a copy of the following materials, but not limited to:

- Quality Program Manual
- Women's Health R&R Program Manual
- Supplemental Data Provider Instructions
- Educational Webinars
- HEDIS Measure Educational Materials
- Electronic Health Record (EHR) Data Feed Submission Process Instructions

What is the Medicare Stars Program

The Centers for Medicare & Medicaid Services (CMS) developed Star Ratings to measure the clinical quality of the services health plans provide. There are 46 Quality Measures categorized into nine domains:

1. Staying healthy: screening, test and vaccines
2. Managing chronic long-term conditions
3. Member experience with health plan
4. Member complaints and changes in the health plan's performance
5. Health plan customer service
6. Drug plan customer service
7. Member complaints and changes in the drug plan's performance
8. Member experience with drug plan
9. Drug safety and accuracy of drug pricing

The Stars Rating is comprised of:

- HEDIS
- Health Outcomes Survey
- CAHPS
- Pharmacy Performance Part C and Part D

CMS uses a 5 Star Quality Rating System to measure Medicare beneficiaries' experience with their health plans and the health care system.

Fixed Cut Points:

- The Star Ratings program uses a 5 Star ratingfor specific measures.
- These thresholds are also called “cut points.” Using cut points allow plans, nationally, to establish baseline data for each measure.
- CMS determines cut points by applying a clustering algorithm to all the measures’ numeric value scores. The clustering algorithm results in the creation of the five levels of the Star Rating.

Scoring:

- Star rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.
- Each measure is calculated by the measure numerator divided by the denominator. This percentage has an associated Stars Rating.

4 and 5 Star Plans get Quality Bonus Payments which leads to better member benefits.

HEDIS Timeline

HEDIS hybrid chart review takes place in the Spring every year, and looks back at the experience in the prior year. For a few measures, the look-back period is longer. For example, the Colorectal Cancer Screening (COL) measure looks back 10 years, and the Breast Cancer Screening (BCS) measure looks back 27 months. Be sure to read the measure definition, as each one will include the look-back period tied to that measure. Typically the measure looks back from **December 31** of the measurement year.

February – May HEDIS team is remotely “chasing” data (medical record review) until **May**
June Results are reported to NCQA
September NCQA releases results for all plans in the Quality Compass
October NCQA publishes the final HEDIS specifications for HEDIS current year

*Quality Compass lets health plans examine quality improvement and benchmark plan performance through online access to health plan HEDIS and CAHPS performance data.

CAHPS Survey-Practice Tips

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the CMS, and is a family of surveys that focuses on patient experience. The CAHPS survey is a 68 question survey that is in the field from March through May annually. The CAHPS Survey measures the patient's perception of care they receive from their healthcare provider and health plan over the previous six months.

- The CAHPS surveys support and promote the assessment of consumers' experiences with health care.
- The CAHPS surveys cover topics important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of physicians and practitioners, the ease of access to health care services and the members' perceptions of the services provided by the health plan.
- More details on the CAHPS surveys and how they apply to Medicare Advantage and Medicaid plans can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/.
- Practices can encourage patients to participate in the CAHPS survey. Obtaining feedback helps practices identify areas of opportunity and guide performance improvement activities for both the health plan and physicians.

The Survey Measures:

- Annual Flu Vaccine
- Getting Needed Care
- Getting Care Quickly
- Customer Service
- Care Coordination
- Provider Communication
- Getting Needed Prescription Drugs
- Overall Rating of Drug Plan
- Overall Rating of Health Care
- Overall Rating of Health Plan
- Overall Rating of Personal Doctor
- Overall Rating of Specialist

CAHPS results are an important component of a health plan's overall Star Ratings. In fact, it is the heaviest weighted component of the overall Star Rating (35.5%). Multiple interventions by the patient care team can lead to higher Star Ratings in areas related to clinical care.

The 5-Star Quality Rating System is important to Medicare Advantage plans and the benefits offered to Horizon BCBSNJ members. By maintaining a 4-Star or higher rating, Horizon BCBSNJ will be able to offer improved benefits to your patients, our members, which will help them achieve their health care goals.

For more information on the CAHPS performance improvement and the Horizon BCBSNJ CAHPS Coaching Program, please reference Playbook for Patient Engagement which gives you tips and best practices to improve CAHPS and your patient experience.

Getting Needed Care		
Questions	**Best Practices**	**Resources**
1. In the last six months, how often was it easy to get the care, tests or treatment you needed? 2. In the last six months, how often did you get an appointment to see a Specialist as soon as you needed?	1. Develop and use standing orders whenever possible. 2. Implement and monitor referral tracking process.	1. Playbook for Patient Engagement which gives you tips and best practices to improve CAHPS and your patient experience. 2. Family Practice Management Toolbox Practice Improvement – Referral Management retrieved from aafp.org/fpm/toolBox/
Getting Care Quickly		
Questions	**Best Practices**	**Resources**
1. In the last six months, when you needed care right away, how often did you get care as soon as you needed? 2. In the last six months, how often did you get an appointment for a checkup or routine care as soon as you needed? 3. Wait time includes time spent in the waiting room and exam room. In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?	1. Ensure same-day appointment availability. 2. Break up wait time perception by moving patients from the waiting room into an exam room to take vitals. 3. Contact your patients when delays are expected using phone, text or email. 4. Advise patients of the best days or times to schedule appointments. 5. Consider alternative methods to traditional office visits, such as telehealth. 6. Determine the busiest times of the day and consider scheduling to accommodate them. 7. Leverage patient portals for secure bidirectional messaging and appointment scheduling.	1. Playbook for Patient Engagement which gives you tips and best practices to improve CAHPS and your patient experience. 2. Family Practice Management Toolbox Practice Improvement retrieved from aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=24 3. Appointment Availability Standards retrieved from HorizonBlue.com/access

Care Coordination		
Questions	**Best Practices**	**Resources**
1. In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? 2. In the last six months, when your personal doctor ordered a blood test, X-ray or other test, how often did someone from your personal doctor's office follow up to give you those results? 3. In the last six months, when your personal doctor ordered a blood test, X-ray or other test, how often did you get those results as soon as you needed them? 4. In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking? 5. In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? 6. In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	1. Prior to appointments, speak with patients' specialists or obtain recent progress notes to review the care they have provided. 2. Remind patients to bring any paperwork they received from the specialist and have it added to the office EMR, if applicable. 3. Implement and monitor the referral tracking process. 4. Consider releasing normal test results to the portal and notifying patients of release. 5. Create a system to follow up on diagnostic or lab results. Implement timeframe and workflow for abnormal test result notification and follow up. 6. Establish a medication reconciliation process. 7. Remind patients to bring his or her prescriptions to office visits. 8. Conduct education for all newly- prescribed medication along with distribution of corresponding educational materials.	1. Playbook for Patient Engagement which gives you tips and best practices to improve CAHPS and your patient experience. 2. Agency for Healthcare Research and Quality CAHPS Survey and Tools to Advance Patient- centered Care, retrieved from ahrq.gov/cahps/index.html 3. Horizon BCBSNJ Participating Physician and Other Health Care Professional Office Manual, 2018

Overall Rating of Health Care		
Questions	**Best Practices**	**Resources**
1. Using any number from zero to 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?	1. Conduct patient experience or satisfaction surveys throughout the year to gain insight into member feedback following office visits. Use this feedback to drive performance improvement activities around areas of opportunity. 2. Consider convening a Patient Family Advisory Council to solicit additional feedback. 3. Be sure to conduct ongoing education and training for all care team members and reinforce the importance of creating a positive experience for the patient.	1. Playbook for Patient Engagement which gives you tips and best practices to improve CAHPS and your patient experience. 2. Nordrum, J. T., Kennedy, D. M. (2016) Seven Principles for Improving Service and Patient Satisfaction Family Practice Management 2016 May-June; 23(3):15-19, retrieved from aafp.org/fpm/2016/0500/p15.html

Medicare Health Outcomes Survey (HOS)

The HOS is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of factional health outcomes measurement.

Each year between August and November a random sample of Medicare beneficiaries is drawn and surveyed. Two years later, the baseline respondents are surveyed again.

For survey breakdown and instruments visit: https://www.hosonline.org/en/survey-instrument/

Improving or Maintaining Physical Health

- Routinely assess patients' pain and mobility using standardized assessment tools
- Develop solid patient care plans that include self-management support strategies, including goal setting, action planning, problem solving,and follow-up to help patients take an active role in improving their health
- Coordinate interventions with disease management, pain management, and referrals to physical therapy and case management

Improving or Maintaining Mental Health

- Routinely assess the emotional status of your patients – especially ones that may negatively impact their health (depression, sadness, anxiety, loneliness, addiction)
- Partner with behavioral health services or treat as appropriate
- Integrate motivational interviewing to improve treatment engagement and mental and physical outcomes

Monitoring Physical Activity

- Routinely assess patients' current physical activity level
- Discuss health benefits of starting, maintaining or increasing physical activity as appropriate for their individual health status
- Develop physical activity plans with patients that match their abilities
- Encourage participation in fitness and exercise programs as appropriate.
- Refer patients with limited mobility to physical therapy to learn safe and effective exercises
- Management of Urinary Incontinence
- Routinely assess patients for bladder control and other symptoms.
- Discuss treatment options for bladder control issues that may arise as patient ages
- Provide patients with educational materials

Results and Recognition (R&R)Programs

Statement of Purpose

Horizon BCBSNJ leverages the R&R Program to improve clinical outcomes performance on HEDIS measures and promote the quality of care received by our members. Horizon BCBSNJ and providers have experienced improved HEDIS performance since the inception of the R&R Program in 2016.

The R&R program launched in June of 2016 was for only Medicaid providers. In 2017, the program was expanded to include the Medicare population and in 2018 the Fully Integrated Duel Eligible-Special Needs Plan (FIDE-SNP) population. Specialty Programs, which include Women's Health/OBGYN, Endocrinology, Ophthalmology and Cardiology were added in 2020. Also in 2020 the R&R incentive has expanded to include Electronic Health Record data feeds.

Partnering to Improve Quality

The R&R program provides a variety of opportunities that lead to better care and improved health outcomes for members. It offers financial incentives to providers that are tied to improved performance for specific HEDIS measures through high-touch collaboration with Horizon BCBSNJ. Through this program, providers are offered and educated on best practices for preventive screenings, immunizations and treatment of chronic conditions, as well as how to optimize the capture of data reflecting quality improvement outcomes. Each practice in the program receives a dedicated Clinical Quality Improvement Liaison (CQIL) as a single point of contact on quality who provides a comprehensive overview of the R&R program for all Lines of Business. The CQILs offer education, support, and resources to promote and achieve shared savings and incentives through improved quality performance and practice transformation.

The primary goal of the R&R program is to maintain and improve the health and quality of care received by our members. Improvements in HEDIS performance reflect the value proposition of the R&R program and its ability to enhance the member experience and promote better care.

To join the R&R Program, please fill out the R&R Contact Form online:

For Primary Care Provider R&R: surveymonkey.com/r/RRCONTACTFORM

For Specialty R&R (Endocrinology, Women's Health/OBGYN, Ophthalmology, and Cardiology): surveymonkey.com/r/RRCONTACTFORM

This will allow us to communicate with you about educational materials, webinar schedules and any incentives you may earn. This is a voluntary program and receipt of a completed contact form or SurveyMonkey survey validates your commitment to work with Horizon BCBSNJ to improve quality and receive incentives for reaching the targeted benchmarks.

R&R Program Structure

As part of the R&R Program, we offer providers:

- Incentive Payments for Primary Care Providers and Specialists (Endocrinology, Ophthalmology, Cardiology and Women's Health):
  - Medicaid - Additional payments for every quality performance gap closed over the percentile NCQA Benchmarks

  - Medicare Stars: Additional payments for every performance gap closed once once you reach the identified Stars rating.
  - Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP): Additional payments for every quality performance gap closed once you reach the identified Stars rating.
  - Incentive payments are released through Electronic Fund Transfer (EFT) with detailed payment reports.
- Monthly quality report cards and patient level detail gap reports
  - Support and education for you and your staff on quality improvement and report analysis
  - Detailed gap reports utilized as a reference for care gaps

General Prospective Best Practices

- Identify staff roles and utilize a checklist to implement pre-visit planning processes to proactively identify quality care gaps in preparation for patient's office visit.
- Outline staff roles and utilize a checklist to perform daily provider-led team huddles.
- Develop and implement standing order sets to capture quality preventive and chronic management care (i.e. protocols and standard orders for labs, prescription refills, breast cancer and colorectal screening).
- Conduct comprehensive annual well care visits for all population starting at age 3 years.
- Develop electronic health record (EHR) standing orders sets capturing applicable coding requirements (i.e. CPT II codes).
- Revise super bills (paper coding forms) to capture applicable coding requirements.
- Develop and implement documentation templates (i.e. Children and Adolescent Well-care Visits (WCV) with required components in EHR.
- Enhance job descriptions to ensure clinical staff function at the top of their license.
- Utilize patient-focused educational materials available from the Horizon *Healthy Journey* Program.

Value Based Programs

Overview of Horizon BCBSNJ's Value-Based Program

Horizon BCBSNJ's Value-Based Program is deeply rooted in the fundamentals of the triple aim and its primary intent is to improve patient outcomes, while also enhancing the patient experience and reducing overall costs. Value-Based Program partners (VBP partners) coordinate patients' health care needs and help ensure patients receive the highest quality of care in the right setting and at the right time. This approach provides personalized and comprehensive care that enables patients to be engaged in their health care.

Under Horizon BCBSNJ's Value-Based Program,Horizon BCBSNJ contracts with VBP partners (including Accountable Care Organizations (ACOs), practice aggregator organizations and provider practices) who coordinate with their Value-Based care providers to engage in Horizon BCBSNJ's Value-Based Program. VBP partners and their Primary Care Physicians (PCPs) are accountable for

coordinating patients' wellness and preventive services, and providing for the patients' chronic and acute care needs. If patients require specialty care or other services, the physician and his/her team will coordinate the appropriate care with other qualified health care professionals. Horizon BCBSNJ's program encourages value-based physician practices and other health care professionals (Value-Based Providers) to lead the care team through the transformation process by creating a team-oriented culture that collaborates with local resources and proactively manages patient care.

Program Year

The Program Year runs with the calendar year (**January 1** through **December 31** of each year). Horizon BCBSNJ will measure VBP partner's performance each Program Year.

Program Model

The Value-Based adult shared savings Program components include meeting clinical quality metric thresholds and reducing total cost of care trends. For specific details, please refer to your Value Based Program Agreement. Primary care practices and other health care entities (i.e., ACOs, practice aggregator organizations and others) are able to participate in the Value-Based Program by meeting all of the following conditions:

- Participate in both the Horizon Managed Care, PPO Networks and Medicare Advantage
- Must include Primary Care practices, consisting of Internal Medicine or Family

Medicine specialties, treating adult Horizon BCBSNJ members; and

- VBP partners must have 5,000 or more attributed members (VBP partners with fewer than 5,000 attributed members have other options for participating in a Horizon BCBSNJ Value-Based Program via virtual aggregation)
- For more detailed information, please refer to your Value-Based Program manual or contact your Horizon Value-Based Programs Specialist.

Support for your patients through Horizon *Healthy Journey*

Our Horizon *Healthy Journey* program strives to support you in providing quality care and improving health outcomes for your patients. We focus on the importance of preventive health screenings through education and engagement with our MLTSS, FIDE-SNP and Braven Health members and health care professionals.

The Horizon *Healthy Journey* program offers support through the following:

Personal Touch: Our care team conducts one-on-one calls for health screening reminders, health education and chronic disease management.

All Stages of Life: Our members can count on us to support them from birth to their senior years.

Awareness: Our educational materials and health screening reminders are tailored to a member's specific needs.

Rewards and Incentives: We want our members to have an active role in their wellness journey. They can earn rewards for participating in activities that can improve their health or prevent illness.

Preventive health screenings supported by Horizon *Healthy Journey*

Adult Measures:

- Immunizations
- Annual wellness visits
- Asthma medication management
- Cancer screenings – including breast, cervical, colorectal and prostate
- Chlamydia screening
- Diabetes care – hemoglobin A1c and diabetic eye exam
- Fall prevention
- Osteoporosis management in women
- Prenatal and Postpartum care
- Statin therapy for patients with cardiovascular disease

Pediatric Measures:

- Asthma medication management
- Immunizations
- Follow-up care for children prescribed ADHD medication
- Lead screening
- Wellness visits

Horizon *Healthy Journey* vendor collaboration

We understand it may be difficult for members to complete their screenings on time. Horizon *Healthy Journey* collaborates with vendors to offer additional support and education for Medicare Advantage and Braven Health members. As a participating provider, you may hear from the following vendors who work on our behalf.

Vendor - Magellan Rx

Service(s) Rendered

A team of pharmacists that contact patientsfor the following:

- Osteoporosis management in women — education on the risks of osteoporosis and the importance of completing a Bone Density Mineral test/DEXA scan.
- Statin therapy for patients with cardiovascular disease — education for patients at risk for cardiovascular disease who may benefit from statin therapy

Vendor - BiolQ

Service(s) Rendered

A specialized team of professional technicians that perform in-home screenings for:

- Colorectal Cancer
- Hemoglobin A1C

Vendor - Quest HealthConnect

Service(s) Rendered

A specialized team of licensed, credentialed and professional technicians who perform in-home screenings for:

- Bone Density Mineral test/DEXA scan

For questions about preventive health screenings or our program, please contact the Horizon *Healthy Journey* team at **1-844-754-2451**, Monday through Friday, from 8:30 a.m. to 5 p.m.

General Retrospective Best Practices

Hardwire your office's billing process to capture required coding.

1. Capture required codes in EHR order sets/super bills
2. Confirm codes interface with billing system
3. Confirm billing staff capture "zero charge" codes on claim
4. Confirm clearinghouse submits "zero charge" codes on Horizon BCBSNJ claims

Reference the Horizon *Healthy Journey* Provider Tips for Optimizing HEDIS Results Booklet. (This booklet is updated yearly and includes R&R program, HEDIS measures, Best Practices and acceptable HEDIS Value Set Codes for billing and closing gaps via medical claims submissions).

Retrospective Strategies

- Utilize patient level detail reports to identify care gaps.
- Utilize disease registry and clinical chart reviews to identify evidence of compliance with care gaps.
- Use report cards and feedback to evaluate provider performance for each provider in comparison to the practice compliance rate. Share reports with providers on a monthly to quarterly basis. Identify patterns and trends with low performing providers.
- Submit evidence of measure compliance via:
  - Supplemental data submission.
    The Supplemental Data is a standardized process that allows Horizon to collect supplemental information for the Healthcare Effectiveness Data Information Set® (HEDIS) measures. Supplemental information refers to additional clinical data about a member, beyond administrative claims, received by a health plan about delivery of health services to a plans members for calculating HEDIS measures.

There are two types of supplemental data. Standard and Non-standard.

- **Standard** supplemental data are electronic files (EMR data feeds/extracts) that come from providers who rendered services to members. Production of these files follows clear policies and procedures, and standard file layouts remain stable from year to year.
- **Non-standard** supplemental data is data used to capture missing service data not received through administrative sources, or in the standard files, like medical records.

- Plans must have clear policies and procedures that describe how the data is collected, validated and used for HEDIS reporting.
  - All supplemental data sources are subject to regular audits.
  - To become familiar with supplemental data definitions and audit requirements, please visit the NCQA website at ncqa.org for the most current requirements.
- Office visit claim (proactive as part of daily operations)
- Office visit claim adjustment process (retrospective)

Preparing for a Successful Year of Quality Improvement and Practice Transformation

There are four pillars to improving quality through practice transformation: Team Based Approach, Building Strategies to Address Care Gaps, Data and Technology, and Collaborative Learning. These four actions lead to improving patient experience of care, continuous quality improvement, improving health of populations, and reducing cost of healthcare.

- **Team Based Approach:** Each practice in the Results & Recognition Program receives a dedicated Clinical Quality Improvement Liaison asa single point of contact on quality who provides a comprehensive overview of the R&R program for all lines of businesses, education, support and resources to promote and achieve shared savings and incentives through improved quality performance and practice transformation. A team based approach includes collaborating with your Clinical Quality Improvement Liaison and other Horizon BCBSNJ departments, maintaining open lines of communication, and actively engaging in the Results & Recognition Program and other Horizon BCBSNJ Quality Management (QM) programs. Other QM programs include the Horizon *Healthy Journey* program, which supports providers on educating and engaging Members and health care professionals.

- **Build Strategies to Address Care Gaps:** The QM Department provides educational materialsto providers on best practices that can be incorporated into their practices, as illustrated throughout this Provider Practice TransformationManual, and Provider Tips for Optimizing HEDIS Results booklet. Strategy building consists of identify ways to improve health outcomes, and patient engagement and satisfaction, which includes identifying health disparities. By improving quality performance and outcomes, you can aim to achieve shared savings and additional incentives.

- **Data and Technology:** Providers can utilize monthly data reports and technology to build a successful year in quality improvement. Your dedicated Clinical Quality Improvement Liaison will provide your site with monthly Quality Performance Reports and Gap Lists, outlining HEDIS Measure compliance rates and Member gap details. By optimizing your Electronic Health Record systems and accurately submitting data through correct coding on claims, Horizon can capture quality data on preventive screenings and services. Horizon accepts supplemental data medical records to close quality gaps through a review of required documentation.

- **Collaborative Learning:** To create an environment of collaborative learning, Horizon provides resources and tools, such as Provider Practice Transformation Manual and Provider Tips for Optimizing HEDIS Results booklet, monthly educational webinars, and a dedicated Clinical Quality Improvement Liaison. Through this partnership, Horizon CQILs educate providers on HEDIS measure descriptions and compliance criteria, quality improvement and practice transformation. Horizon BCBSNJ welcomes your feedback to develop a strong partnership towards practice transformation and quality improvement success.

Health Education Workshops

Health education workshops provide important health information for the community. Our workshops are developed internally by Horizon NJ Health educators, and reviewed by subject matter experts. We utilize evidence-based, best practice research by institutions like the Centers for Disease Control and Prevention, National Institutes of Health and other federal government agencies. These workshops are led by Horizon NJ Health educators with extensive experience and expertise in community health education and population health.

Workshops discuss:

- Facts about the disease
- Early detection, diagnosis and treatment
- Risk factors
- Health behaviors and lifestyles

If you or your organization is looking to do a health education workshop, look to Horizon BCBSNJ for the latest topics in:		
Cancer	• Breast cancer • Cervical cancer – HumanPapillomavirus (HPV)	• Skin cancer prevention • Prostate cancer
Heart health	• Cholesterol • Heart disease	• Hypertension
Healthy eating	• Eating healthy on a budget	• Nutrition and physical activity
Mental health	• Coping with chronic illness and loss • Bully prevention	• Substance use
Healthy living	• Immunizations • Adolescent health • Men's health • Women's health	• Preventive health • Diabetes • Obesity • Smoking cessation
Senior health	• Stress management • Fall prevention	• Medication management
Other	• Lead poison prevention	• Asthma

Community Health Promotion Workshops - For Members and Community Partners

- Prevention Health
- Chronic Illness Management
- COVID-19 related safety resources
- Medicaid 101

Professional Development - For Providers/School Nurses

- Medicaid Literacy
- Communicating Effectively With Doctors
- Increase Utilization/Compliance (e.g., Immunizations/Screenings)

Cooking Demos, Healthy Habits with NJ – For Members and Community Partners.

To learn more about Horizon NJ Health's health education workshops, connect with our Health Education team: HNJHAnswers@horizonNJhealth.com.

Everything you need to know about HEDIS and its Impact

HEDIS Performance

HEDIS is a set of standardized performance measures designed to ensure that the public has the information it needs to compare organization performance. Certified HEDIS auditors rigorously audit HEDIS results, using a process designed by NCQA, a non-for-profit organization best known for assisting and reporting on the quality of the nation's managed care plans through accreditation and performance measurement programs.

Roadmap

HEDIS Audit begins when we complete NCQA's HEDIS ROADMAP (Record of Administration, Data Management and Processes) questionnaire document. The purpose is to record information about our data systems and data reporting structure and processes. Upon completion of the ROADMAP, it is submitted to our HEDIS-Certified Auditors for review and to organize their onsite visit where these auditors meet with us to further review the information in the ROADMAP. This is an important part of the HEDIS Compliance Audit, a yearly process to ensure the validity and integrity of our reported HEDIS data. HEDIS measures cannot be publicly reported until approved by NCQA-Certified HEDIS Auditors.

Chart Chase

Chart Chase, or also called chart abstraction, is a manual process of collecting important information from our member's medical records (or charts) and transcribing that information into a HEDIS certified software. Our Chart Chase team (composed of clinical and non-clinical staff) first reaches out to our providers, requesting them to send us our member's medical charts. Our team is in search of compliant members or members who have closed their gaps in care for certain HEDIS measures such as Immunizations for Adolescents, Prenatal & Postpartum Care, etc.

NCQA Accreditation

NCQA Health Plan Accreditation is a widely recognized, evidence-based program dedicated to quality improvement and measurement.

A comprehensive framework to help us align and improve our operations in areas that are most important to NJ State, employers and consumers. It has the only evaluation program that bases results on actual measurement of clinical performance (HEDIS measures) and consumer experience (CAHPS measures). It helps us determine improvement areas, provide a framework for us to implement best practices and satisfy NJ State requirements.

Total HEDIS Measures

HEDIS Performance Measurement includes more than 96 measures across 6 Domains of Care:

1) Effectiveness of Care,

2) Access/Availability of Care,

3) Experience of Care,

4) Utilization and Risk Adjusted Utilization,

5) Health Plan Descriptive Information, and

6) Measures Collected Using Electronic ClinicalData Systems.

Examples of HEDIS measures are: Cervical Cancer Screening (CCS), Controlling High Blood Pressure (CBP), Prenatal and Postpartum Care (PPC), etc. The audited HEDIS measure results are collected and reported separately for populations covered by Medicare, Medicaid, Braven and Federal Employee Program (FEP). HEDIS Measure rates are calculated based on HEDIS strict specifications. We strive to continuously maintain and increase our HEDIS rates.

Section 3: Overuse/Appropriateness

Overuse/Appropriateness HEDIS Measures	
Measures	**Description of the Measure**
Appropriate Treatment for Upper Respiratory Infection (URI)	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	The percentage of adolescent females 16 – 20 years of age who were screened unnecessarily for cervical cancer. **Note**: A lower rate indicates better performance.
Non-Recommended PSA-Based Screening in Older Men (PSA)	The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening. **Note**: A lower rate indicates better performance
Potentially Harmful Drug- Disease Interactions in Older Adults (DDE)	The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Report each of the three rates separately and as a total rate. • A history of falls and a prescription for antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs) • Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents. • Chronic kidney disease and prescription for Cox-2 selective NSAIDs or nonaspirin NSAIDs. • Total rate (the sum of the three numerators divided by the sum of the three denominators). Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). **Note**: A lower rate indicates better performance for all rates.

Section 3: Overuse/Appropriateness

Overuse/Appropriateness HEDIS Measures (Continued)	
Measures	**Description of the Measure**
Risk of Continued Opioid Use (COU)	The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported: 1. The percentage of members with at least 15 days of prescription opioids in a 30-day period. 2. The percentage of members with at least 31 days of prescription opioids in a 62-day period. **Note:** A lower rate indicates better performance.
Use of High-Risk Medications in Older Adults (DAE)	The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication. Three rates are reported: 1. The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class. 2. The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses. 3. Total rate (the sum of the two numerators divided by the denominator, duplicating for members in both numerators) The measure reflects potentially inappropriate medication use in older adults, both for medications where any use is inappropriate (Rate 1) and for medications where use under all but specific indications is potentially inappropriate (Rate 2). **Note:** A lower rate represents better performance.
Use of Imaging Studies for Low Back Pain (LBP)	The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Section 3: Overuse/Appropriateness

Overuse/Appropriateness HEDIS Measures (Continued)	
Measures	**Description of the Measure**
Use of Opioids at High Dosage (HDO)	The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year. **Note:** A lower rate indicates better performance.
Use of Opioids from Multiple Providers (UOP)	The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported. 1. **Multiple Prescribers**. The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. 2. **Multiple Pharmacies**. The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. 3. **Multiple Prescribers and Multiple Pharmacies**. The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmaciesduring the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates). **Note**: A lower rate indicates better performance for all three rates.
Best Practices	- Reference the Centers for Disease Control and Prevention "Be Antibiotics Aware: Smart Use, Best Care": cdc.gov/patientsafety/features/be-antibiotics-aware.html - Reference The American Cancer Society Guidelines for the Prevention and Early Detection of Cervical Cancer: cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html - Reference the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Section 3: Experience of Care

Experience of Care HEDIS Measures	
Measures	**Description of the Measure**
CAHPS Health Plan Survey 5.0H, Adult Version (CPA)	This measure provides information on the experiences of commercial and Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations. Results summarize member experiences through ratings, composites and question summary rates Four global rating questions reflect overall satisfaction: 1. Rating of All Health Care. 2. Rating of Health Plan. 3. Rating of Personal Doctor. 4. Rating of Specialist Seen Most Often. Five composite scores summarize responses in key areas: 1. Claims Processing (commercial only). 2. Customer Service. 3. Getting Care Quickly. 4. Getting Needed Care. 5. How Well Doctors Communicate. Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for one item summarizing the following concept: 1. Coordination of Care. **Note:** Medicare member experience with the organization is assessed through the Medicare CAHPS survey. Medicare CAHPS is not a HEDIS measure, Medicare CAHPS is maintained and administered by CMS on behalf of Medicare Advantage (MA) plans.

Experience of Care HEDIS Measures (Continued)	
Measures	**Description of the Measure**
CAHPS Health Plan Survey 5.0H, **Child Version (CPC)**	This measure provides information on parents' experience with their child's Medicaid organization. Results summarize member experiences through ratings, composites and individual question summary rates. Four global rating questions reflect overall satisfaction: 1. Rating of All Health Care. 2. Rating of Health Plan. 3. Rating of Personal Doctor. 4. Rating of Specialist Seen Most Often. Four composite scores summarize responses in key areas: 1. Customer Service. 2. Getting Care Quickly. 3. Getting Needed Care. 4. How Well Doctors Communicate. Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for one item summarizing the following concept: 1. Coordination of Care.
Children With Chronic Conditions (CCC)	This measure provides information on parents' experience with their child's Medicaid organization for the population of children with chronic conditions. Three composites summarize satisfaction with basic components care essential for successful treatment, management and support of children with chronic conditions: 1. Access to Specialized Services. 2. Family Centered Care: Personal Doctor Who Knows Child. 3. Coordination of Care for Children with Chronic Conditions. Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: 1. Access to Prescription Medicines. 2. Family Centered Care: Getting Needed Information.

Section 3: Utilization and Risk Adjusted Utilization

Utilization and Risk Adjusted Utilization HEDIS Measures	
Utilization	
Measures	**Description of the Measure**
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care in the following categories: • Outpatient Visits including telehealth. • ED Visits.
Antibiotic Utilization (ABX)	This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender: • Total number of antibiotic prescriptions. • Average number of antibiotic prescriptions per member per year (PMPY). • Total days supplied for all antibiotic prescriptions. • Average days supplied per antibiotic prescription. • Total number of prescriptions for antibiotics of concern. • Average number of prescriptions PMPY for antibiotics of concern. • Percentage of antibiotics of concern for all antibiotic prescriptions. • Average number of antibiotics PMPY reported by drug class: - For selected “antibiotics of concern.” - For all other antibiotics.
Frequency of Selected Procedures (FSP)	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.
Inpatient Utilization - General Hospital/Acute Care (IPU)	This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total inpatient (the sum of Maternity, Surgery and Medicine)

Section 3: Utilization and Risk Adjusted Utilization

Utilization and Risk Adjusted Utilization HEDIS Measures (Continued)	
Risk Adjusted Utilization	
Measures	**Description of the Measure**
Acute Hospital Utilization (AHU)	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year reported by Surgery, Medicine and Total.
Emergency Department Utilization (EDU)	For members 18 years of age and older, the risk-adjusted ratio of observed to expected ED visits during the measurement year.
Hospitalization Following Discharge From a Skilled Nursing Facility (HFS)	For members 65 years of age and older, the percentage of skilled nursing facility discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.
Hospitalization for Potentially Preventable Complications (HPC)	For members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Note: For Commercial and Medicaid, report only members 18 – 64 years of age.

Section 3: Measures Collected Through the Medicare Health Outcomes Survey

Measures Collected Through the Medicare Health Outcomes Survey HEDIS Measures	
Measures	**Description of the Measure**
Fall Risk Management (FRM)	The two components of this measure assess different facets of fall risk management. • **Discussing Fall Risk**. The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner. • **Managing Fall Risk**. The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.
Management of Urinary Incontinence in Older Adults (MUI)	The following components of this measure assess the management of urinary incontinence in older adults. • **Discussing Urinary Incontinence**. The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who discussed their urinary leakage problem with a health care provider. • **Discussing Treatment of Urinary Incontinence**. The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who discussed treatment options for their current urine leakage problem. • **Impact of Urinary Incontinence**. The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

Measures Collected Through the Medicare Health Outcomes Survey HEDIS Measures (Continued)	
Measures	**Description of the Measure**
Medicare Health Outcomes Survey (HOS)	This measure provides a general indication of how well a Medicare organization manages the physical and mental health of its members. The survey measures each member's physical and mental health status at the beginning and the end of a two-year period. A two-year change score is calculated and each member's physical and mental health status is categorized as better, the same or worse than expected, considering risk adjustment factors. Organization-specific results are assigned as percentages of members whose health status was better, the same or worse than expected.
Physical Activity in Older Adults (PAO)	The two components of this measure assess different facets of promoting physical activity in older adults. • **Discussing Physical Activity**. The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity. • **Advising Physical Activity**. The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase ormaintain their level exercise or physical activity.

Section 3: Measures Collected Through the CAHPS® Health Plan Survey

Measures Collected Through the CAHPS Health Plan Survey HEDIS Measures	
Measures	**Description of the Measure**
Flu Vaccinations for Adults Ages 18–64 (FVA)	The percentage of commercial and Medicaid members 18 – 64 years of age who received a flu vaccination between **July 1** of the measurement year and the date when the CAHPS 5.0H survey was completed.
Flu Vaccinations for Adults Ages 65 and Older (FVO)	The percentage of Medicare members 65 years of age and older who received a flu vaccination between **July 1** of the measurement year and the date when the Medicare CAHPS survey was completed.
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: **Advising Smokers and Tobacco Users to Quit** • A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. **Discussing Cessation Medications** • A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. **Discussing Cessation Strategies** • A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.
Pneumococcal Vaccination Status for Older Adults (PNU)	The percentage of Medicare members 65 years of age and older who have ever received one or more pneumococcal vaccinations.

Section 4 – Pharmacy Information – Medicare STARS Measures and Pharmacy Coverage

Medication Adherence			
Description: Percent of plan members with a prescription in one of the below measures who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.			
Measure Definitions	**Description**	**Metric**	**Weighting***
Measure: D10 - Medication Adherence for Diabetes Medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. ("Diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic drug, a meglitinide drug,or an SGLT2 inhibitor. Plan members who take insulin are not included)	This measure is defined as the percent of Medicare Part D Beneficiaries 18 years and olderwho adhere to their prescribed drug therapy across classes of diabetes medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the numberof member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiariesare only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period.	3

Medication Adherence (Continued)			
Description: Percent of plan members with a prescription in one of the below measures who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.			
Measure Definitions	**Description**	**Metric**	**Weighting***
Measure: D11 - Medication Adherence for Hypertension (RAS antagonists)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. ("Blood pressure medication" means an ACE (angiotensin convertingenzyme) inhibitor, an ARB (angiotensin receptor blocker), or a direct renin inhibitor drug.)	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two blood pressure medications fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries with ESRD diagnosis or coverage dates, or that received one or more prescriptions for sacubitril/valsartan anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.	3

Medication Adherence (Continued)			
Description: Percent of plan members with a prescription in one of the below measures who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.			
Measure Definitions	**Description**	**Metric**	**Weighting***
Measure: D12 -Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	This measure is defined as the percent of Medicare Part D Beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in thetherapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.	3

Section 4 – Pharmacy Information – Medicare STARS Measures and Pharmacy Coverage

Best Practices for Medication Adherence – to improve this treatment rate:
90 day supply with refills, discussion with member in office about medication adherence, ensuring office staff is aware of member's next appointment visit- if not contact us to help set it up, ensure member has refills after every office visit whether or not they ask for it, confirm medication list with member at every office visit, and patient education about their disease state(s) and medication(s)

Medication Therapy Management (MTM) for Comprehensive Medication Review (CMR)
Description: Some plan members are in a program called a Medication Therapy Management program to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan.

Measure Definitions	Description	Metric	Weighting*
Measure: D13 - MTM Program Completion Rate for CMR	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications	The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications. This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Beneficiaries who were in hospice at any point during the reporting period are excluded. Members must have three of the following chronic conditions: Alzheimer's, diabetes, dyslipidemia, hypertension, depression or multiple sclerosis.	1

Best Practices for Medication Therapy Management for Comprehensive Medication Review – to improve this treatment rate:			
Ensure every member who is eligible for a CMR is warm transferred to a Horizon BCBSNJ pharmacist - **1-888-706-2820**			
Statin Use in Patients with Diabetes (SUPD)			
Description: To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs.			
Measure Definitions	**Description**	**Metric**	**Weighting***
Measure: D14 - Statin Use in Persons with Diabetes (SUPD)	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percentof plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.	This measure is defined as the percent of Medicare Part D beneficiaries 40 – 75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40 – 75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40 – 75 years old with at least two diabetes medication fills during the measurement period (denominator). Beneficiaries who have any of the following diagnosis are excluded from the measure: Rhabdomyolysis or myopathy, pregnancy, lactation or fertility, liver disease, pre-diabetes, polycystic ovary syndrome.	3

Section 4 – Pharmacy Information – Medicare STARS Measures and Pharmacy Coverage

Best Practices for SUPD – to improve this treatment rate:
Ensure every patient who is eligible and is not contraindicated or excluded from the measure gets a statin added to their medication regimen

* Weighting Definition: The summary and overall ratings are calculated as weighted averages of the measure stars. For Star Ratings, CMS assigns the highest weight to the improvement measures, followed by the outcomes and intermediate outcomes measures, then by patient experience/complaints and access measures, and finally the process measures. New measures to the Star Ratings are given a weight of 1 for their first year in the ratings. In subsequent years the weight associated with the measure weighting category is used. In calculating the summary and overall ratings, a measure given a weight of 3 counts three times as much as a measure given a weight of 1.

Here are the STARS Rating Cut Points associates with the five pharmacy STARS Measures listed below:

Star and Cutpoints	Adherence: Diabetes	Adherence: RAS	Adherence: Statin	Statin Use in Patients with Diabetes (SUPD)	Medication Therapy Management (MTM)
5 Star	≥91%	≥90%	≥91%	≥88%	≥89%
4 Star	≥87% to <91%	≥87% to <90%	≥87% to <91%	≥84% to <88%	≥81% to <89%
3 Star	≥85% to <87%	≥82% to <87%	≥83% to <87%	≥80% to <84	≥72% to <82%
2 Star	≥80% to <85%	≥74% to <82%	≥78% to <83%	≥76% to <80%	≥54% to <72%
1 Star	<80%	<74%	<78%	<76%	<54%

Section 4 – Pharmacy Information – Medicare STARS Measures and Pharmacy Coverage

Medication Coverage Issues for Medicare Members			
Term	**Definition**	**Solution**	**Formulary Exception**
Medication Not on Formulary	Medication is not on the member's formulary	Switch to a formulary alternative	Can be submitted if formulary alternative has been tried and failed
Prior Authorization	Medication is on the member's formulary	Submit necessary paperwork to obtain a prior authorization through Prime, Cover My Meds, etc.	
Transition Fill	Medication is not on the member's formulary but member is given a 30 day supply to give member and provider enough time to transition to a formulary alternative	Switch to a formulary alternative	Can be submitted if formulary alternative has been tried and failed
Pharmacy Benefits Manager (PBM) Prime			
Prime Clinical Phone Number	**1-800-693-6651**		
Prime Website - all documents needed	myprime.com		

References: NCQA HEDIS MY 2022 Technical Notes