HEDIS®
Adult Resource Guide

WellCare® | HERITAGE HEALTH

What's Inside

Adult Resource Guide

Adult and Behavioral Health Measures

What Is HEDIS®?

The Healthcare Effectiveness Data and Information Set (HEDIS) of performance measures is utilized by more than 90% of America's health plans. The performance measure rates generated, using the HEDIS measures' specifications, allow health plans to compare how well they perform to other health plans in the following areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

Why HEDIS Is Important

HEDIS is a tool used by health plans to measure performance of health plans by consumers and employers.

Value of HEDIS to You, Our Providers

HEDIS can help save you time while also potentially reducing healthcare costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS can also help you:

- Identify noncompliant members to ensure they receive appropriate treatment and follow-up care
- Understand how you compare with other WellCare providers as well as with the national average

Value of HEDIS to Your Patients, Our Members

HEDIS gives members the ability to review and compare plans' scores, helping them to make informed healthcare choices.

What You Can Do

- Encourage your patients to schedule healthcare visits and required metabolic testing
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant members.

If you have questions about **HEDIS** or need more information, please contact your local Provider Relations representative or Quality Practice Advisor (QPA).

Source: **www.ncqa.org**

HEDIS® Reference Guide for Adults

The following measures in the HEDIS Quick Reference Guide are in compliance with the HEDIS® 2019 Volume 2 Technical Specifications. **Reimbursement for these services will be in accordance with the terms and conditions of your provider agreement.**

Prevention and Screening

Chlamydia Screening in Women (CHL): *Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.*

Required Documentation	Key Notes
• A note indicating the date the test was performed, and the result or finding.	Sexually active members may be identified either through dispensed contraceptive prescriptions (pharmacy data) or an encounter/claim indicating sexual activity during the measurement year.

Cervical Cancer Screening (CCS): *The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:*

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Required Documentation	Key Notes
Documentation in the medical record must include both of the following: A note indicating the date when the cervical cytology was performed. The result or finding.	Exclusion Criteria: Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through Dec. 31 of the measurement year. Documentation must state complete, total or radical hysterectomy. Documentation of hysterectomy alone does not meet criteria. Reflex testing is not an acceptable screening for this measure. Biopsies do not meet criteria because they are diagnostic and are not valid for primary cervical cancer screening.

Adult BMI Assessment (ABA): *Percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.*

Required Documentation	Key Notes
For members younger than 20, the documentation must include height, weight and BMI **percentile** (must be from the same data source). • BMI percentile documented as a value (e.g., 85th percentile). • BMI percentile plotted on an age-growth chart. For members 20 years of age or older on the date of service, documentation must include weight and BMI value.	Ranges and thresholds do not count. Female members who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year are excluded from this measure.

Breast Cancer Screening (BCS): *Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between Oct. 1 two years prior to the measurement year, and Dec. 31 of the measurement year.*

Required Documentation	Key Notes
• A note indicating the date the test was performed, and the result or finding.	Unable to count biopsies, breast ultrasounds, MRIs or diagnostic screenings because they are performed as an adjunct to mammography. Exclusion Criteria: Members who have a diagnosis of bilateral mastectomy.

Colorectal Cancer Screening (COL): *Percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.*

Required Documentation	Key Notes
A note indicating the date the test was performed. A result is not required if the documentation is clearly a part of the medical history section of the record. If it is not clear, the result or finding must also be present. Any of the following count: • Annual FOBT or FIT during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year. • CT Colonography during the measurement year or the four years prior. • FIT-DNA test (cologuard) during the measurement year or the two years prior to the measurement year.	• Digital rectal exams do not count. • A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed counts. • For pathology reports that do not indicate the type of screening and for incomplete procedures: – Evidence that the scope advanced beyond the splenic flexure counts for a completed colonoscopy. – Evidence that the scope advanced into the sigmoid colon counts for a completed flexible sigmoidoscopy. Exclusion Criteria: Members with a diagnosis of colorectal cancer or total colectomy are excluded.

Care for Older Adults (COA): *Percentage of adults 66 years and older who had each of the following during the measurement year:*

- *Advance care planning*
- *Medication review*
- *Functional status assessment*
- *Pain assessment*

Required Documentation	Key Notes
1) Advance Care Planning: • The presence of an advance care plan (ACP) such as advance directive (e.g., living will, healthcare power of attorney, healthcare proxy) or actionable medical orders (e.g., POLST, Five Wishes) or • Documentation of an advance care planning discussion with the provider **and** the date when it was discussed. The documentation of the discussion must be in the measurement year, or • Notation that the member previously executed an advance care plan. 2) Medication Review: • A medication list in the medical record, **and** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed. • Documentation that the member is not taking any medication **and** the date when it was noted. 3) Functional Status Assessment: • Notation that Activities of Daily Living (ADL) were assessed • Notation that Instrumental Activities of Daily Living (IADL) were assessed • Result of assessment using a standardized functional status assessment tool • Notation that at least three of the following four components were assessed: – Cognitive status – Ambulation status – Sensory ability (hearing, vision, speech) – Other functional independence (exercise, ability to perform job) 4) Pain Assessment: • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain) and the date when it was performed. Include results of assessment using a standardized pain assessment tool.	**Examples of ACP discussion:** • The provider must note in the medical record the discussion or initiation of a discussion by the provider. Documentation that a provider asked the member if an ACP was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion. • Oral statements regarding ACPs may include conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Or, patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year. • A review of side effects for a single medication at the time of prescription alone is not sufficient. • For ADLs, note that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet or walking. • For IADLs, may assess at least four of the following: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, or handling finances. • A functional status assessment limited to an acute or single condition, event or body system does not meet criteria for a comprehensive functional status assessment. • The components of the functional status assessment may take place during separate visits within the measurement year. • Unable to count notation of pain management plan alone or pain treatment plan alone. • Screening for chest pain alone or documentation of chest pain alone does not meet criteria.

Utilization

Adolescent Well-Care Visits (AWC): *Percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.*	
Required Documentation	**Key Notes**
Documentation of a visit to a PCP or OB/GYN, the date of the visit and all of the following: • A health history • Two developmental histories (physical and mental) • A physical exam • Health education/ anticipatory guidance The Tanner stage/scale will count for Physical Development History here.	Documentation that does not count: • Allergies, medications or immunizations alone (but if all three are present, it will count) • "Appropriate for age" without mentioning the type of physical and mental development. • "Well-developed/nourished/appearing" • "Neurological exam" or "appropriately responsive" for development • Vital signs alone for the physical exam • Notations of prenatal and postpartum topics only • Health education/anticipatory guidance related to medications or immunizations or the side effect. Services specific to the assessment or treatment of an acute or chronic condition do not count toward this measure. Services rendered during an inpatient or ED visit does not count.

Access/Availability of Care

Annual Dental Visits (ADV): *Percentage of members 2–20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.*	
Required Documentation	**Key Notes**
Intentionally Left Blank	If applicable, please refer your patients for a dental screening annually. Services must be rendered by a dental provider.

Adults' Access to Preventive/Ambulatory Health Services (AAP): *Percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.*	
Required Documentation	**Key Notes**
Intentionally Left Blank	Visits: Ambulatory, telephone and online assessments.

Prenatal and Postpartum Care (PPC): *The percentage of deliveries of live births on or between Nov. 6 of the prior to the measurement year and Nov. 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.*

- *Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.*
- *Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*

Required Documentation	Key Notes
Timeliness of Prenatal Care: A prenatal visit during the first trimester, with an OB/GYN, midwife, family practitioner, or PCP, with a pregnancy-related diagnosis code, AND at least one of the following: • A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundal height (a standardized prenatal flow sheet may be used); • Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing); • An ultrasound (echocardiography) of the pregnant uterus; • A TORCH antibody panel alone: – Toxoplasma – Rubella – Cytomegalovirus – Herpes simplex • A rubella antibody test AND an ABO test on the same or different dates of service. • A rubella antibody test AND an Rh test on the same or different dates of service. • A rubella antibody test AND an ABO/Rh test on the same or different dates of service. • A prenatal visit during the first trimester, on the same or different dates of service, AND with one of the following: – A complete obstetrical history; OR – A prenatal risk assessment and counseling/education; OR • A prenatal visit with a pregnancy-related diagnosis code during the first trimester, on the same or different dates of service, AND with a least one of the following: – An obstetric panel; OR – An ultrasound (echocardiography) of the pregnant uterus. Documentation in the medical record of gestational age with either prenatal risk assessment and counseling/education or complete obstetrical history meets criteria for the Timeliness of Prenatal Care. **Postpartum Care** Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP. The medical record must include the date the visit occurred and at least one of the following: • Pelvic exam, or • Evaluation of weight, BP, breasts (notation of "breastfeeding" counts) and abdomen, or • Notation of postpartum care, including but not limited to: "postpartum care," "PP care," "PP check," "6 week check" or completion of a preprinted "postpartum care" form • A Pap test alone is acceptable for the Postpartum Care rate. A colposcopy alone does not count.	Intentionally Left Blank

Respiratory Conditions

Medication Management for People with Asthma (MMA): *Percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:*

- *Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.*
- *Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.*

Required Documentation	Key Notes
Intentionally Left Blank	Asthma Controller Medications: For the complete list of FDA-approved asthma medications and NDC codes, please visit **www.ncqa.org**. Mast cell stabilizers are removed from the list.

Asthma Medication Ratio (AMR): *The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.*

Required Documentation	Key Notes
Intentionally Left Blank	Asthma Controller Medications: For the complete list of FDA-approved asthma medications and NDC codes, please visit **www.ncqa.org**. Mast cell stabilizers are not on the list.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR): *The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, and who received appropriate spirometry testing to confirm the diagnosis.*

Required Documentation	Key Notes
Intentionally Left Blank	Complete a spirometry testing and code respectively.

Pharmacotherapy Management of COPD Exacerbation (PCE): *Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1–Nov. 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:*

- *Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event*
- *Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event*

Required Documentation	Key Notes
Intentionally Left Blank	Systemic Corticosteroid Medications: Dispensed prescription for systemic corticosteroid on or 14 days after the episode date. Bronchodilator Medications: Dispensed prescription for a bronchodilator on or 30 days after the episode date. Betamethasone has been removed from the prescription list.

Behavioral Health

You can also find Behavioral Health measures under the following domain headings:
Measures Collected Using Electronic Clinical Data Systems, Overuse/Appropriateness and Access/Availability of Care.

Follow-up After Emergency Department Visit for Mental Illness (FUM): *The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:*

1. *The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.*
2. *The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.*

Required Documentation	Key Notes
Intentionally Left Blank	• Excludes ED visits that result in an admission on same day or within 30 days of ED visit. • The follow-up visit after the ED visit can be with any practitioner. • Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary. • If follow-up visit does not occur within 7 days, schedule the appointment to occur within the 30 day timeframe.

Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA): *The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit for AOD. Two rates are reported:*

1. *The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.*
2. *The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.*

Required Documentation	Key Notes
Intentionally Left Blank	• Excludes ED visits that result in an admission on same day or within 30 days of ED visit. • The follow-up visit after the ED visit can be with any practitioner. • Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary.

Follow-Up After Hospitalization for Mental Illness (FUH): *The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:*

- *The percentage of discharges for which the member received follow-up within 30 days after discharge.*
- *The percentage of discharges for which the member received follow-up within 7 days after discharge.*

Required Documentation	Key Notes
Intentionally Left Blank	• Excludes discharges followed by readmission or direct transfer to non-acute inpatient setting within the 30-day follow-up period. • Indicates the follow-up visit with a mental health practitioner. • Member must be 6 years or older as of the date of discharge. • Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary. • If follow-up visit does not occur within 7 days, schedule the appointment to occur within the 30-day time frame. • Does not include visits that occur on the date of discharge.

Antidepressant Medication Management (AMM): *Percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.*

- *Effective Acute Phase Treatment – Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)*
- *Effective Continuation Phase Treatment – Percentage of members who remained on an antidepressant medication for at least 180 days (6 months)*

Required Documentation	Key Notes
Intentionally Left Blank	For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**. Please take the opportunity to consider reviewing the patient's antidepressant therapy regimen and ensuring medication adherence for a clinically appropriate duration of time. Patient may not realize it can take several weeks before symptomatic improvement is experienced.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): *The percentage of members age 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.*

Required Documentation	Key Notes
A note indicating the date of glucose test or HbA1c during the measurement year.	For a complete list of medications and NDC codes, please visit **www.ncqa.org**. Please refer to the Preferred Drug List (PDL) on the state-specific WellCare website for Medicaid drug coverage. To increase compliance, consider using standing orders to get labs completed.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD): *The percentage of members ages 18-64 with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C and an HbA1c test during the measurement year.*	
Required Documentation	**Key Notes**
A note indicating the dates of LDL-C and HbA1c during the measurement year.	To increase compliance, consider using standing orders to get labs completed.

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC): *The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.*	
Required Documentation	**Key Notes**
A note indicating the date of the LDL-C during the measurement year.	To increase compliance, consider using standing orders to get labs completed.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): *The percentage of members ages 19-64 during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.*	
Required Documentation	**Key Notes**
Intentionally Left Blank	To increase compliance, consider using long acting injections vs. oral medication. Oral Antipsychotic Medications: For a complete list of medications and NDC codes, please visit **www.ncqa.org**. Please refer to the Preferred Drug List (PDL) on the state-specific WellCare website for Medicaid drug coverage.

Cardiovascular Conditions

Controlling High Blood Pressure (CBP): *The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.*	
Required Documentation	**Key Notes**
Notation of the most recent BP in the medical record. A diagnosis code for essential hypertension should be documented in the medical record. The BP reading must occur **on or after** the date of the second diagnosis of hypertension. Documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider.	• BPs taken during an acute inpatient stay, ER visit, taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests do not count. • Documentation of member reported BP readings do not count. • The member is not compliant if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete. • Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "Consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the only notations of HTN in the medical record. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH): *Percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.*	
Required Documentation	**Key Notes**
Intentionally Left Blank	For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**.

Statin Therapy for Patients with Cardiovascular Disease (SPC): *The percentage of males ages 21-75 and females ages 40-75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who meet the following criteria:*

- *Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.*
- *Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.*

Required Documentation	Key Notes
Notation of the high or moderate-intensity statin medication and date prescribed.	Diagnosis is indicated as members having ischemic vascular disease (IVD). High and Moderate-Intensity Statin Medication List: For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**.

Diabetes

Comprehensive Diabetes Care (CDC): *The percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had each of the following:*

- *Hemoglobin A1c (HbA1c) testing*
  - *HbA1c poor control (>9.0%)*
  - *HbA1c control (<8.0%)*
  - *HbA1c control (<7.0%)*
- *Eye exam (retinal) performed*
- *Medical attention for nephropathy*
- *BP control (<140/90 mm Hg)*

Required Documentation	Key Notes
Hemoglobin A1c (HbA1c) testing: Measure compliance based on most recent HbA1c of the measurement year. • HbA1c screening may include: A1c, HbA1c, HgbA1c, Hemoglobin A1c, Glycohemoglobin A1c, Glycohemoglobin, Glycated hemoglobin, Glycosylated hemoglobin. **Dilated Eye exam (retinal):** Performed by an eye care provider (Ophthalmologist or Optometrist) in current year, or a negative exam in the previous year or bilateral eye enucleation anytime during member's history through Dec. 31 of current year. Documentation must include who completed the procedure or reviewed the results, the date of when the procedure was done and the results. Blindness is not an exclusion for a diabetic eye exam. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. **Medical attention for Nephropathy:** Either evidence of nephropathy (visit to nephrologist, renal transplant, positive urinemacroalbumin test, or prescribed ACE/ARB therapy) or a nephropathy screening test – the date when a urine microalbumin test was performed and the result, or evidence of nephropathy. **BP control (<140/90 mm Hg):** Compliance is based on the most recent BP of the measurement year. *Recheck non-compliant BP during office visit.	ACE/ARB Therapy: For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**. BPs taken during an acute inpatient stay, ER visit, an office visit in which a procedure is being performed (sigmoidoscopy, etc.), surgical procedure, or major diagnostic procedure (stress test, radiology procedure, endoscopy, etc.) do not count. Documentation of member reported BP readings do not count. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. The intent of the eye exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while those who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year. Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

Statin Therapy for Patients with Diabetes (SPD): *The percentage of members ages 40-75 during the measurement year with diabetes who do* ***not*** *have clinical atherosclerotic cardiovascular disease (ASCVD) and who meet the following criteria:*

- **Received Statin Therapy:** *Members who were dispensed at least one statin medication of any intensity during the measurement year.*
- **Statin Adherence 80%:** *Members who remained on statin medication of any intensity for at least 80% of the treatment period.*

Required Documentation	Key Notes
Notation of the high or moderate-intensity statin medication and date prescribed.	High and Moderate-Intensity Statin Medications List: For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**.

Musculoskeletal Conditions

Osteoporosis Management in Women Who Had a Fracture (OMW): *The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.*

Required Documentation	Key Notes
Intentionally Left Blank	Note: Fractures of finger, face and skull are not included in this measure. FDA-approved Osteoporosis therapies: For a complete list of medications and NDC codes, visit **www.ncqa.org**.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART): *Percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).*

Required Documentation	Key Notes
Intentionally Left Blank	DMARDs Medications: For a complete list of medications and NDC codes, visit **www.ncqa.org**.

Medication Management

Medication Reconciliation Post-Discharge (MRP): *Percentage of discharges from Jan. 1 to Dec. 1 of the measurement year for members 18 year of age and older for whom medications were reconciled on or within 30 days of discharge (31 total days).*

Required Documentation	Key Notes
Documentation must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • Documentation of the member's current medications with a notation that the discharge medications were reviewed. • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.	Only documentation in the outpatient chart counts.

Annual Monitoring for Patients on Persistent Medications (MPM): *Percentage of members 18 years of age and older and who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rate separately and as a total rate.*

- *Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).*
- *Annual monitoring for members on diuretics.*
- *Total rate (the sum of the two numerators divided by the sum of the two denominators).*

Required Documentation	Key Notes
ACE/ARB and Diuretic Agents • A lab panel performed in current year and the result, or a serum potassium and serum creatinine performed in current year and the result.	To increase compliance, consider using standing orders to get labs done.

Transitions of Care (TRC): *Percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:*

- *Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or the following day.*
- *Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or the following day.*
- *Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.*
- *Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).*

Required Documentation	Key Notes
Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated in is not limited to the day of admission or the following day; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria.	Follow-up post discharge to complete coordination of care and complete medication reconciliation through 30 days (31 total days) after discharge. Follow-up care can include office, home and telehealth visits.

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC): *Percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.*

Required Documentation	Key Notes
Within 7 days of discharge	Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary. Involve the patient's caregiver regarding the follow-up plan after discharge. Note: Members in hospice are excluded from the eligible population.

Overuse/Appropriateness

Potentially Harmful Drug-Disease Interactions in the Elderly (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 anti-convulsants, SSRIs, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or tricyclic antidepressants.*
- *Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, H2 receptor antagonists or anti-cholinergic 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). A lower rate represents better performance for all rates.

Required Documentation	Key Notes
Intentionally Left Blank	Potentially harmful drugs: For a comprehensive list of medications and NDC codes, please visit **www.ncqa.org**.

Use of Imaging Studies for Low Back Pain (LBP): *Percentage of members 18-50 years old with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT Scan) within 28 days of the diagnosis.*

Required Documentation	Key Notes
Intentionally Left Blank	The measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB): *Percentage of adults 18–64 years of age seen in an ED, Outpatient or Observation setting with a diagnosis of acute bronchitis and who were not dispensed an antibiotic prescription.*

Required Documentation	Key Notes
Intentionally Left Blank	Intentionally Left Blank

Use of High-Risk Medications in the Elderly (DAE):

- *Percentage of members 66 years of age and older who received at least one dispensing event for a high-risk medication.*
- *Percentage of members 66 years of age and older who received at least two different dispensing events for the same high-risk medication.*

Required Documentation	Key Notes
Intentionally Left Blank	• For a complete list of medications and NDC codes, please visit **www.ncqa.org**. • For both rates, a lower rate represents better performance.

Use of Opioids at High Dosage (UOD): *The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] >120 mg).*

Required Documentation	Key Notes
Intentionally Left Blank	• NOTE: A lower rate indicates better performance. • Guideline on opioid prescribing for chronic, non-malignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MME) and recommends avoiding increasing dosages ≥90mg MME or to "carefully justify" dosages ≥90mg MME (CDC, 2016). • For members who are already taking doses ≥90mg MME, the CDC recommends that providers should "explain in a nonjudgmental manner" the risks and benefits of continuing high-dose opioids, and should offer these members the opportunity to taper to a safer, lower dose. • For a complete list of medications, please visit **www.ncqa.org**

Use of Opioids From Multiple Providers (UOP): *For 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 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 member receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).*

Required Documentation	Key Notes
Intentionally Left Blank	• Guidelines on opioid prescribing for chronic, non-malignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MME) and recommends avoiding increasing dosages ≥90mg MME or to "carefully justify" dosages ≥90mg MME (CDC, 2016). • For members who are already taking doses ≥90mg MME, the CDC recommends that provider should "explain in a nonjudgmental manner" the risks and benefits of continuing high-dose opioids, and should offer these members the opportunity to taper to a safer, lower dose. • For a complete list of medications, please visit **www.ncqa.org**

FIRST-YEAR 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 whose new episode of opioid use lasts at least 15 days in a 30-day period.*
2. *The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.*

Required Documentation	Key Notes
Note: A lower rate indicates better performance.	• Exclusions: members in hospice • Do not include denied claims when identifying the eligible population • Do not include supplemental data when identifying the eligible population • Administrative measure

Risk Adjusted Utilization

FIRST-YEAR MEASURE

Hospitalization Following Discharge From a Skilled Nursing Facility (HFS): *For members 18 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.*

Required Documentation	Key Notes
Data are reported in the following categories: • Count of skilled nursing facility discharges to the community (SND). • Count of observed 30-day hospitalizations • Count of expected 30-day hospitalizations • Count of observed 60-day hospitalizations • Count of expected 60-day hospitalizations	Exclusions: • Members in hospice are excluded • Members living long-term in an institution any time during the measurement year • Supplemental data may not be used for this measure • Administrative measure

Measures Collected Using Electronic Clinical Data Systems

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS): *The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.*

Required Documentation	Key Notes
• Selection of the appropriate assessment should be based on the age of the member. – PHQ-9: For 12 years of age and above. – PHQ-9 Modified for Teens: For ages 12–18. The PHQ-9 assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a Web-based portal.	Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms. • For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms. • The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criterion symptoms and effects on functioning, and has been shown to be highly accurate in discriminating patients with persistent major depression, partial remission and full remission. • The PHQ-9 assessment does not need to occur during a face-to-fact encounter; it can be completed over the telephone or through a web-based portal.

Depression Remission or Response for Adolescents and Adults (DRR) *The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.*

- ***ECDS Coverage:*** *Members for whom a health plan can receive any electronic clinical quality data.*
- ***Follow-Up PHQ-9:*** *The percentage of members who have a follow-up PHQ-9 score documented within the four to eight months after the initial elevated PHQ-9 score.*
- ***Depression Remission:*** *The percentage of members who achieved remission within four to eight months after the initial elevated PHQ-9 score.*
- ***Depression Response:*** *The percentage of members who showed response within four to eight months after the initial elevated PHQ-9 score.*

The PHQ-9 assessment does not need to occur during a face-to-face encounter. For example, it can be completed over the telephone or through a web-based portal.

Required Documentation	Key Notes
Follow-ups with patients who have depression. The member's PHQ-9 score at visits.	Reliable follow-up is associated with improved response and remission scores.

Depression Screening and Follow-Up for Adolescents and Adults (DSF): *The percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.*

- ***Depression Screening:*** *The percentage of members who were screened for clinical depression using a standardized tool.*
- ***Follow-Up on Positive Screen:*** *The percentage of members who screened positive for depression and received follow-up care within 30 days.*

Required Documentation	Key Notes
Documentation of a depression screening performed using an age-appropriate standardized instrument. Documentation of a negative finding from a subsequent PHQ-9 qualifies as evidence of a follow-up.	• Acceptable tools for the Adolescent population include: PHQ-9; PHQ-9M; PRIME MD-PHQ-2; BDI-FS; MFQ; CES-D; PROMIS Depression. • Acceptable tools for the Adult population include: PHQ-9; PRIME MD-PHQ2; BDI-II or BDI-FS; CES-D; DEPS; DADS; GDS; CSDD; EPDS; M-3; PROMIS Depression, CUDOS. The following counts as a follow-up: outpatient or telephone follow-up visit, depression case management encounter, a behavioral health encounter, dispensed antidepressant medication, assessment on the same day and subsequent to the positive screen.

Unhealthy Alcohol Use Screening and Follow-Up (ASF): *The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate follow-up care.*

- ***Unhealthy Alcohol Use Screening:*** *The percentage of members who had a systematic screening for unhealthy alcohol use.*
- ***Alcohol Counseling or Other Follow-up Care:*** *The percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within two months of a positive screening.*

Required Documentation	Key Notes
A documented result for an unhealthy alcohol use screening. Counseling or other follow up within 60 days after date of first positive screening.	• Acceptable assessment tools for the adult population include: AUDIT (score >8); AUDIT-C (score >4 for men; score >3 for women); Single Question Screening; "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >1). • Counseling refers to one or more counseling sessions (a minimum of 5-15 minutes) which may include at least one of the following: – Feedback on alcohol use and harms – Identification of high risk situations for drinking and coping strategies – Increase the motivation to reduce drinking – Development of a personal plan to reduce drinking Documentation of receiving alcohol misuse treatment.

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.*

Required Documentation	Key Notes
13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent pneumococcal polysaccharide vaccine (PPSV23).	Encourage members to receive their Pneumococcal Vaccination.

FIRST-YEAR MEASURE

Adult Immunization Status (AIS): *The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.*

Required Documentation	Key Notes
• A note indicating the specific antigen name and the immunization date, or an immunization certificate prepared by a healthcare provider that has the dates of administration. • Document history of specific disease, anaphylactic reactions or contraindications for a specific vaccine.	Encourage members to receive their vaccinations.

FIRST-YEAR MEASURE

Prenatal Immunizations Status (PRS): *The percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.*

Required Documentation	Key Notes
• A note indicating the specific antigen name and the immunization date, or an immunization certificate prepared by a healthcare provider that has the dates of administration. • Document history of specific disease, anaphylactic reactions, or contraindications for a specific vaccine.	Encourage members to receive their vaccinations.

Source: HEDIS® 2019 Volume 2 Technical Specifications

How to Be a Quality Star

What is the Medicare star rating?

The Medicare star rating system was created by the Centers for Medicare & Medicaid Services (CMS) and evaluates the relative quality of private health plans offered to Medicare beneficiaries. CMS scores Medicare health plans on a one- to five-star scale, with five stars representing the highest quality. Members can use these ratings as a way to gauge the quality of care, ease of access to care, provider responsiveness and beneficiary satisfaction of the health plan.

Quick Reminders to Help You Boost Your Ratings...

Don't keep your patients waiting too long

- Has the member been in the waiting room for more than 30 minutes?

Getting to know your patients' special needs

- Accommodate those who are frail/elderly or non-English speaking

Keep in touch with patients

- Make sure each patient has an annual wellness visit and preventive screenings
- Allow extra time during appointments for questions and answers
- Reach out to patients who have not been seen

Scheduling appointments appropriately

- Urgent – less than 24 hours
- Non-urgent – within one week
- Routine/preventive – within one month

Schedule these important screenings as needed

- Colorectal cancer screening
- Diabetes care
- Breast cancer screening
- Controlling hypertension

Why is the Medicare Star Rating System Important?

Star ratings are available to:

- Help members make health plan decisions
- Increase premium dollars, rewarding strong performance for physicians affiliated with Independent Physician Associations (IPAs)
- Provide richer benefits for members
- Allow WellCare to expand

★ 2019 Medicare STAR Measures

DOMAIN 1: Staying Healthy, Screening, Tests and Vaccines	DOMAIN 2: Managing Chronic (Long Term) Conditions	DOMAIN 3: Member Experience with Health Plan	DOMAIN 4: Member Complaints, Problems Getting Services & Improvement in the Health Plan's Performance	DOMAIN 5: Health Plan Customer Service	PART D MEASURES
Adult BMI Assessment	Care of Older Adults: Functional Status Assessment	Care Coordination	Complaints about the Health Plan	Call Center: Foreign Language Interpreter & TTY Availability	Appeals Auto Forward
Annual Flu Vaccine	Care of Older Adults: Medication Review	Customer Service	Health Plan Quality Improvement	Plan Makes Timely Decision About Appeals	Appeals Upheld
Breast Cancer Screening	Care of Older Adults: Pain Assessment	Getting Appointments and Care Quickly	Members choosing to Leave the Plan	Reviewing Appeals Decisions	Call Center: Foreign Language Interpreter & TTY Availability
Colorectal Cancer Screening	Controlling Blood Pressure	Getting Needed Care			Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)
Improving or Maintaining Mental Health	Diabetes Care: Blood Sugar Controlled	Rating of Healthcare Quality			Complaints about the Drug Plan
Improving or Maintaining Physical Health	Diabetes Care: Eye Exam	Rating of Health Plan			Drug Plan Quality Improvement
Monitoring Physical Activity	Diabetes Care: Kidney Disease Monitoring				Getting Needed Prescription Drugs
	Osteoporosis Management in Women Who Had a Fracture				Medication Adherence for: Diabetes, Hypertension (RAS antagonists), Cholesterol (statins)
	Plan All-Cause Readmissions				Medication Adherence for Diabetes Medications
	Rheumatoid Arthritis Management				Members Choosing to Leave the Plan
	Special Needs Plan (SNP) Care Management				MPF (Medicare Plan Finder) Price Accuracy
	Improving Bladder Control				Rating of Drug Plan
	Medication Reconciliation Post-discharge				
	Reducing the Risk of Falling				
	Statin Therapy for Patients with Cardiovascular Disease				

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