HEDIS General Guidelines
MY 2024

WellSense HEALTH PLAN

What is HEDIS?

- HEDIS stands for Healthcare Effectiveness Data and Information Set.
- HEDIS measures and specifications objectively evaluate and compare performance and quality across health plans, including Medicare, Medicaid and Marketplace plans.
- HEDIS is administered by the National Committee for Quality Assurance (NCQA).
- The Centers for Medicare & Medicaid Services (CMS) contracts with NCQA to collect HEDIS measures for the Star Ratings program.
- HEDIS measures are focused on prevention, screenings, specific conditions, access to care, satisfaction with care and how care is utilized.

What types of data are collected?

- Administrative: Claims, encounters and pharmacy data
- Supplemental: Files sent in by providers during the year
- Hybrid: Medical record reviews (January to May of each year)
  - HEDIS medical record review is a retrospective review of services, performance and quality of care from the prior calendar year.
- Survey: Member experience and satisfaction collected via survey
- Electronic clinical data systems (ECDS): Electronic health records, health information exchanges, case management systems and administrative data
  - NCQA has started to transition some measures to ECDS, which eliminates traditional hybrid collection for those measures.

What is new, retired or revised in 2024?

- There are no new measures for HEDIS MY 2024.
- All optional exclusions have been changed to required exclusions.
- Retired measures for HEDIS MY 2024:
  - COL - Colorectal Cancer Screening (only COL-E will be reported)
  - SPR - Use of Spirometry Testing in the Assessment and Diagnosis of COPD
  - ADD - Follow-Up Care for Children Prescribed ADHD Medication (only ADD-E will be reported)
  - APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics (only APM-E will be reported)
  - NCS - Non-Recommended Cervical Cancer Screening in Adolescent Females
  - AMB - Ambulatory Care
  - IPU - Inpatient Utilization—General Hospital/Acute Care
- One measure was revised for HEDIS MY 2024:
  - The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).

Best practices and measures tips:

Use the HEDIS best practices and tips below to ensure that your practice gets full credit for the high level of care quality you deliver to your patients.

Claims and coding:

- Submit claim/encounter data for each service completed with appropriate billing codes.
- Utilizing CPT Category II codes provides more complete information for performance measurement and decreases the need for medical record requests.
- Detailed documentation and appropriate coding can eliminate unnecessary hybrid chart chases and help exclude members from measures if clinically appropriate.
- Some measures collect more than one data element, so be sure to submit codes required for all elements.
- For FQHCs billing a T1015 encounter code, it's essential to use the correct diagnosis code and list the actual CPT/HCPCS procedure codes on the claim to identify the services included in the encounter.

Clinical practice:

- Ensure members' next well visits/preventative care visits are scheduled when members check out.
- Send reminders to members regarding appointments and preventive screenings.
- Use your EMR to create alerts and flags for the required HEDIS services.
- Use telephone or telehealth options to close gaps in care.
- Provide members with education on disease processes and the rationale for tests.
- When discussing needed screenings, ask open-ended questions to identify any barriers to care or treatment.
- Some measures require the last result of the measurement year (MY) to be compliant (e.g. CBC, GSD). Monitor the last result for these measures and consider bringing the member back in before the end of the MY if the value was out of range.

Documentation

- Use specific dates for events documented on problem lists and history sheets.
    - Documenting terms such as "recent," "most recent," "at a prior visit" or "colonoscopy up to date" are not acceptable as they aren't specific enough to know when an event occurred.
- Document any scheduled screenings and the name of the providers who will be performing.
- Non-adherence doesn't close a care gap unless exclusions apply. Exclusions need to be accurately documented and coded.
- Ensure the CPT and ICD-10 codes submitted are supported by documentation in the chart.

Medication adherence

- Ensure that currently prescribed medications are appropriate and therapy should continue. Follow up to assess the effectiveness of the medication.
- Review with members the benefits of taking their medications and negative consequences for stopping them or missing doses.

- Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence.
- Encourage members to develop a medication routine, including utilizing pillboxes or other organizers and alarms if needed to keep on schedule.
- Assess members for barriers to medication adherence (e.g., cost, understanding benefits or side effects, getting medications filled on time from the pharmacy).
- Make sure members are aware of mail order and 90-day refill options.

HEDIS glossary

- **Denominator**: The number of members who qualify for the measure criteria based on NCQA technical specifications.

- **Eligible population**: All members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement for the measure.

- **Measurement year (MY)**: In most cases, a 12-month timeframe during which a service was rendered. This is generally the calendar year of January 1 – December 31 prior to the reporting year.

- **Numerator**: The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.

- **Reporting year**: The timeframe when data is collected and reported for service dates from the measurement year, which is usually the year prior (e.g., For MY 2024, the Report Year is 2025). In some cases, the service dates may go back more than one year.

- **Required exclusion**: Members are excluded from a measure denominator based on a diagnosis and/or procedure captured in their claim/encounter/pharmacy data. If applicable, the required exclusion is applied after claims data are processed within certified HEDIS software while the measure denominator is being created.

- **Sub-measure**: A measure may be broken down into more specific data elements of care. These data elements are known as sub-measures.

- **Supplemental data (non-standard)**: Data collected prospectively and that aren't in a standard file layout. Medical record reviews are an example.

- **Supplemental Data (standard)**: Data collected from sites via a standardized file process to close gaps.