NPO HEDIS NEWSLETTER

What is HEDIS®?

You may be hearing about HEDIS measures from payers, in the literature, and from NPO. So, what is HEDIS and why does it matter to you?

The **Healthcare Effectiveness Data and Information Set (HEDIS)** is a set of healthcare performance measures, developed and maintained by the National Committee for Quality Assurance (NCQA). The first version of HEDIS was available in 1991. There are currently 75 measures.

HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. HEDIS results are also used to track year-to-year performance of plans and providers. Payers became more interested in HEDIS because of a Centers for Medicare and Medicaid Services (CMS) requirement that payers have to submit Medicare HEDIS data in order to participate in Medicare Advantage.

Specifics about HEDIS can be found at: http://www.ncqa.org/HEDISQualityMeasurement.aspx

How are HEDIS measures developed?

NCQA adds, deletes, and revises measures annually. Measures are designed to be detailed and specific enough so that different organizations will calculate the measures the same way, making performance comparable for rankings, consumer and purchaser reports and payment.

NCQA states that:

> "The process is transparent and incorporates multiple points of review and broad stakeholder input. HEDIS measure development is based on our belief that measures should address important problems, be grounded in scientific evidence and be feasible to collect. The Institute of Medicine and the National Quality Forum also embrace these principles.
>
> NCQA measures are designed to be useful in public reporting, pay for performance programs and quality improvement."

After a measure is developed, it is made available for public comment. This commentary is considered and the measure is revised as needed. Measures are pilot tested by physicians and/or payers. The development, public comment, and pilot testing can take 12-24 months. A measure is then in provisional status for at least one year and undergo quality checking before public reporting. Almost all measures are National Quality Forum endorsed.

NCQA reviews HEDIS measures against evidence-based guidelines routinely checking for new scientific evidence. If the evidence changes, NCQA will, in an expedited manner, follow the usual measure development processes. Measures are retired when consistently high performance is achieved or the measure is no longer of major importance.

Who uses HEDIS and Why?

Payers, including BCBSM, Priority Health, and CMS, use HEDIS measures to drive performance improvement through pay for performance programs. BCBSM refers to the HEDIS measures it uses as its "Evidence Based Care Tracking/Reporting" initiative within its PGIP program. Priority Health uses the measures in its "PCP Incentive Program". CMS uses HEDIS in its Medicare program, both for Medicare Advantage and for its Accountable Care Organization (ACO) program.

These payers use preventive health measures such as:

- Cervical Cancer Screening,
- Colorectal Cancer Screening, and
- Childhood Immunization Status.

They also use disease management measures such as:

- Diabetes Annual Retinal Eye Exam,
- Cholesterol Management LDL-C Screening, and
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD.

Ideally, each payer would utilize the HEDIS measure exactly as it was developed. Locally, payers do institute a few modifications such as adding exclusions to a measure, i.e., one payer accepts immunization waivers (parent refused the immunization for the child) and excludes those patients from the immunization status measure.

Most payers are working to achieve very high HEDIS scores, which are required to remain a Medicare provider and are used as payers seek to gain or maintain NCQA accreditation.

Where does the data used in HEDIS measure performance come from?

Most HEDIS measures used by local payers use claims data so are based upon diagnoses and/or procedure codes. Payers use the claims submitted by the physician practices to develop scores for each physician/practice. HEDIS measures are calendar year based.

Since most HEDIS measures use claims data, accurate diagnosis and procedure coding by the physician practices is crucial.

What about the Michigan Quality Improvement Consortium (MQIC)?

Many NPO physicians are familiar with MQIC as a source of care guidelines.

From the website: "The Michigan Quality Improvement Consortium (MQIC) is a group of physicians, administrators, researchers, and quality improvement experts from 13 Michigan health plans, the Michigan Association of Health Plans, Michigan Department of Community Health, Michigan Osteopathic Association, Michigan Peer Review Organization, and Michigan State Medical Society, along with the University of Michigan Health System. The group formed in the fall of 1999 to achieve significant, measurable improvement in health care outcomes through:

- Development and implementation of common evidence-based clinical practice guidelines,
- Standard approaches to performance measurement, and
- Coordinated approach to implementation. "

MQIC uses NCQA's HEDIS specifications for measurement. MQIC believes that by using HEDIS, programming and reporting burdens on health plans are minimized. So, MQIC guidelines align with HEDIS measures and one does not contradict the other.

What does a HEDIS measure look like?

Diabetes measures are a good example of measures that most payers use. Specifically, let's use the retinal eye exam measure as an example; it requires information from the specialist to be provided to the primary care provider. The HEDIS measure definitions are very long so most payers summarize them. The BCBSM format is:

(CDC) Diabetes: Eye Exam The percentage of members 18 through 64 years of age with diabetes (type 1 and type 2) who had an eye screening for diabetic retinal disease

- 18 – 64 years of age as of December 31 of the measurement year. An eye exam performed during the measurement year, as identified by claim/ encounter or automated laboratory data.
- ICD-9 diagnosis codes: 250.xx, 357.2X, 362.0X, 366.41, 648.0X
  - 1 inpatient admission with a primary or secondary diagnosis of diabetes **OR**
  - 1 emergency department visit with a primary or secondary diagnosis of diabetes **OR**
  - 2 outpatient encounters with a diagnosis of diabetes in the measurement year or year prior to the measurement year **OR**
  - A prescription for insulin or an oral hypoglycemic/antihyperglycemic the measurement year or year prior to the measurement year.
- Exclusions: Patients with a diagnosis of gestational diabetes (648.8), polycystic ovaries (256.4) or steroid induced diabetes (249, 962.0, 251.8)
- Continuous Enrollment: The measurement year.

HEDIS® 2013 Measurement Codes:

Codes for Disease Identification: Outpatient/Ambulatory Preventive Visits

CPT	ICD-9-CM Diagnosis	HCPCS	UB-92 Revenue
99201-99205, 99211-99215, 99315, 99316, 99241-99245, 99341-99350, 99304-99310, 99318, 99324-99328, 99334-99337, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	G0344, G0402, G0438, G0439	051x, 0520-0523, 0524, 0525, 0526-0529, 0982, 0983

Retinal Eye Exam

Diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, ***or***
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Codes to Identify Eye Exams (Must be with an Eye Care Professional)

CPT	CPT Category II	HCPCS
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, 92134,	2022F, 2024F, 2026F, 3072F	S0625, S3000, S0620, S0621

First, the measure defines which patients are included (the eligible population). In this case, diabetics 18-64 years of age, defined as diabetic by having an inpatient admission or emergency department visit or 2 outpatient encounters with a diabetes diagnosis or a prescription for insulin during various time periods. The patient must have been continuously enrolled with the payer during the measurement year. Specific diabetic diagnosis codes are provided.

Also, any patients to be excluded from the eligible population are noted. In this case, gestational diabetes, polycystic ovary syndrome and steroid induced diabetes patients are excluded. Again, specific diagnosis codes are provided.

The eligible population is the denominator. Now, the numerator is defined. This is the measure for diabetic patients who have had a retinal eye exam, so the procedure codes for those eye exams are provided. This brings up what many payers call "supplemental" information. Retinal exams are not performed by the PCP, but by a specialist.

Some payers receive and process claims from those specialists who perform eye exams and then incorporate that data into the measure calculation. Payers also may have systems available for the PCP office to submit manually the information that this patient did have a retinal exam. Some payers are working to develop systems to accept this supplemental information via a registry. As systems improve, there will be less manual entry required. You will also be hearing more from NPO regarding its registry capabilities later this year.

For the 2012 calendar year, the 90th percentile score for this measure for all NCQA accredited health plans was 74%. This means that in 10% of all health plans, 74% or more of their eligible diabetic population received a retinal eye exam according to the measure criteria. For BCBSM traditional patients, ages 18-64, NPO's performance for the same time period was 38%.

We hope you found this information useful. Please let us know what questions you may have regarding performance measures so that we may address them in future communications.

Thank you.