healthfirst®
Health Insurance for New Yorkers

2021 Healthfirst **Provider Guidebook** for Quality Measures

Introduction

Purpose

At Healthfirst, we are committed to providing access to quality care to members in our community. We understand that it is not an easy task for providers to deliver preventive care while also managing chronic conditions among high-risk patients. This guidebook will help you navigate quality measures, including:

- Healthcare Effectiveness Data Information Set (HEDIS®) from the National Committee for Quality Assurance (NCQA),
- the Centers for Medicare and Medicaid Services Part D Medication Adherence Measures,
- the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey, and
- the Health Outcomes Survey (HOS) through the Centers for Medicare and Medicaid Services (CMS)

How to use this guidebook:

To use this guidebook effectively, you will want to pay attention to the:

- Details and specifications for quality measures
- Best practices and billing and coding references on how to achieve incentive measures (including the 2021 HQIP), and
- Indication on which measures can be achieved through telehealth

In addition to this guidebook, the following supports and resources are available to help you throughout 2021:

- **Optimizing Telehealth to Achieve 2021 HEDIS®**, with tips and codes to achieve certain 2021 HEDIS measures through telehealth. Those measures are flagged throughout this book, so be sure to use the reference guide for further information.
- **2021 HEDIS Codebook**, with details on numerator requirements and denominator parameters as well as codes that best reflect services rendered.
- **2021 Clinical Support Resource** with a list of vendors that Healthfirst is working with to help achieve key HEDIS measure goals. For most, covered services are managed directly by Healthfirst and will be offered to eligible members only.
- **Remote EMR Access:** Healthfirst can securely connect to your electronic medical record (EMR) to access records needed for medical-record reviews and audits. This can help reduce your practice's administrative burden.

If you participate in the Healthfirst Quality Incentive Program (HQIP), you may have received an email in May with the **2021 HQIP Program Guide**. This features details on measures and their associated benchmarks.

We hope that these tools and resources will be helpful throughout your 2021 efforts in clinical quality. Be sure to reach out to your Clinical Quality Manager or Network Account Manager with questions.

2021 Healthfirst Quality Incentive Program (HQIP)

The year 2020 tested both the depth of our resilience and the agility with which we could deploy adjustments to counter the challenges that the coronavirus (COVID-19) presented. This year, 2021, marks a year of new beginnings. The 2021 HQIP represents our advance toward a new era of "normalcy." This year's program focuses on redefining the patient experience–whether that means continuing the use of telehealth or safely optimizing in-person visits wherever and whenever possible.

As we enter this new era of "normalcy," we are excited to announce that we will launch a new and improved version of the Healthfirst Quality APP in 2022. As you know, the Healthfirst Quality APP is available to you through the Healthfirst Provider Portal at **hfproviderportal.org**. With this tool, you can conduct required HQIP reporting and view important quality data. We can't wait to share with you an enhanced version of the Quality APP, as it will feature a sleek new user interface. The new design will help you easily identify areas of opportunity in the 2021 HQIP, understand performance trends and their effects on your earnings, download care gap reports, and see how your performance compares to similar providers in your area.

We are thrilled to be on this 2021 journey with you, and we thank you for your unwavering commitment to quality care. Please take your time to review the Guidebook and the associated materials mentioned. As you navigate through this guide, please don't hesitate to contact your assigned Clinical Quality Manager or Network Account Manager if you need additional information.

HEDIS®: Adult Prevention

Breast Cancer Screening (BCS)*

Description: Women 50–74 years old should have a mammogram every two years.

> **TIP:** Follow up with patients who are almost due or overdue for a mammogram. Help them with scheduling and resolve any barriers that keep them from getting screened.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send supplemental encounter data to Healthfirst for mammograms documented in the chart
- Submit claims with ICD-10 diagnosis codes for history of mastectomies documented in the chart
- Submit codes on claims for frailty and/or advanced illness conditions when appropriate; these may exclude the member from the BCS measure
- See **Appendix 2** for details on supplemental data submissions
- See **Appendix 3** for more details on the advanced illness and frailty exclusions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document mammograms noted in preventive health flowsheets, with date and findings
- Document mammograms in progress notes, with date and findings; simply noting "up to date" is not sufficient
- Document mastectomies noted in past medical history, with date
- Use EMR trigger reminders to document mammography dates and findings and to know when the next mammogram is due
- Note that biopsies, breast ultrasounds, or MRIs do not count for BCS because they are not primary breast cancer screening methods
- Educate members on the importance of regular breast cancer screening during preventive health visits

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

- Follow up with patients who have overdue mammogram referral orders and help resolve their barriers to getting screened; contact Healthfirst for assistance with scheduling mammograms
- Leverage National Breast Cancer Awareness Month, in October, to outreach by phone or letter to patients needing screening

Measure Definition for Breast Cancer Screening			
Denominator	Numerator	Exclusions	Product Lines
Female members 50–74 years of age as of December 31 of the measurement year	Members in the denominator who had a mammogram between October 1 two years prior to the measurement year and December 31 of the measurement year	■ Members in hospice care any time during the measurement year ■ Members 50 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members receiving palliative care during the measurement year	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Important Billing Codes	
Mammography	CPT 77061, 77062, 77063, 77065, 77066, 77067 HCPCS G0202, G0204, G0206

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Care of Older Adults (COA) Measures

Description: Adults 66 years of age and older should have each of the following documented annually:

- Medication Review by a prescribing practitioner or clinical pharmacist (MR)*
- Pain Assessment (PA)
- Functional Status Assessment (FSA)

> **TIP:** Annual Wellness Visits are perfect for closing out COA care opportunities. Use a Health Assessment tool as an efficient way to document annual COA services in your medical records.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Submit claims or supplemental encounter data to Healthfirst for functional status assessments, pain assessments, and medication reviews
- See Important Billing Codes table below for MR, FSA, and PA codes
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

General

- Review Prevention Screening and Services to ensure you and your patients agree on key health screenings, self-management, and maintenance care
- Work together with your patients to address the many preventive goals and service areas that should be completed each calendar year

For Medication Review

- In your medical records, be sure to have a list of current medications and a notation that medications were reviewed, signed, and dated by a prescribing practitioner or clinical pharmacist
- Medication review can be conducted telephonically by a prescribing practitioner or clinical pharmacist
- If your patient is not taking any medication, be sure to make a note of this in your documentation.
- Ensure patients know their daily medications and can identify medications that may put older patients at risk
- An outpatient visit is not required to meet criteria
- For patients not taking prescribed medications, document that in the chart; review and note any over-the-counter (OTC) medications or supplements

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

For Pain Assessment

- Include documentation on the completion of a standardized pain assessment tool (such as 1–10 scale or faces scale) and/or documentation that the patient was assessed for pain
- As part of a service, a pain assessment can be performed telephonically by multidisciplinary care team members such as registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, etc.
- Incorporate pain assessment as part of the standardized vital sign process
- Incorporate pain assessment as a standardized template within your EMR if applicable
- Unless specifically asked, patients may not volunteer information that they are living with chronic pain

For Functional Status Assessment

- Include documentation of a functional status assessment through one of the following:
  - Completion of a standardized FSA tool (such as SF-36, Katz ADL index, Klein-Bell Scale)
  - Assessment of at least four of the following Activities of Daily Living (ADLs): bathing, dressing, eating, transferring, toileting, walking
  - Assessment of at least five Instrumental Activities of Daily Living (IADLs), such as grocery shopping, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, etc.
- Preformatted templates containing a check box that ADLs and/or IADLs were assessed is acceptable
- As part of a service, a functional status assessment can be performed telephonically by multidisciplinary care team members such as registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, etc.
- The components of a functional status assessment can occur over multiple visits during the measurement year
- Incorporate as a standardized template within your EMR if applicable (see example)

Example Standardized EMR Template

As of this date	Basic activities in my daily life	I can do this without help	I need some help	I can't do this
	Bathing			
	Dressing			
	Eating			
	Toileting			
	Walking			
As of this date	**Other activities in my daily life**	**I can do this without help**	**I need some help**	**I can't do this**
	Grocery Shopping			
	Transportation/ Driving			
	Meal Preparation			
	Functional Status			

Resources

Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Care of Older Adults" or just click **here.**

Measure Definition for Care of Older Adults			
Denominator	Numerator	Exclusions	Product Lines
Members 66 years of age and older	Members in the denominator who were assessed in the measurement year for each of the following: ■ Medication Review conducted by a prescribing practitioner or clinical pharmacist, and a current Medication List documented in the chart, or Transitional Care Management services performed ■ Annual Functional Status Assessment ■ Annual Pain Assessment	Members in hospice care any time during the measurement year	Medicare Special Needs Plan (SNP)

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Important Billing Codes	
Functional Status Assessment	CPT 99483 CPT Category II 1170F – Functional Status Assessed HCPCS G0438 – Annual wellness visit; with prevention plan; initial visit G0439 – Annual wellness visit; with prevention plan; subsequent visit
Medication Review*	CPT 90863, 99605, 99606, 99483 CPT Category II 1160F – Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
Medication List*	CPT Category II 1159F – Medication list documented in medical record HCPCS G8427 – Eligible clinician attests to documenting in the medical record that they obtained, updated, or reviewed the patient's current medications
Pain Assessment	CPT Category II 1125F – Pain severity quantified; pain present 1126F – Pain severity quantified; no pain present
Transitional Care Management*	CPT 99483, 99495, 99496

** NOTE: For the* ***Medication Review*** *numerator, either a Transitional Care Management Code or a Medication Review code, along with a Medication List code (one of each), is needed to meet criteria.*

Cervical Cancer Screening (CCS)*

Description: Women 21–64 years of age should have a Pap test every one to three years; alternatively, women 30–64 years of age should have a Pap test with high-risk human papillomavirus (hrHPV) co-testing every one to five years. Women 30–64 who had cervical hrHPV testing performed within the last five years.

TIP: Set up reminders in your office system a year before cervical cancer screenings are due.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for Pap tests and high-risk human papillomavirus (hrHPV) tests
- Also submit ICD-10 codes for history of total hysterectomy (with no residual cervix) on claims when applicable (measure exclusion)
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document Pap tests and hrHPV tests in lab reports
- Document Pap tests and hrHPV tests in progress notes with dates **and** results
- Document Pap tests and hrHPV tests on preventive health flowsheets, with dates and results
- Past Medical History should include documentation of "complete," "total," or "radical" hysterectomy
- Implement EMR trigger reminders to know when patients are due for Pap tests and hrHPV co-tests
- Utilize preventive health flowsheets to document Pap/hrHPV test dates, test results, and when patients are next due

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Cervical Cancer Screening			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Female members 24–64 years of age	Members in the denominator who meet one of the following: ■ Women 21–64 years of age with cervical cytology (Pap) during the measurement year or two years prior ■ Women 30–64 years of age with cervical cytology (Pap) and hrHPV co-testing during the measurement year or four years prior to the measurement year. NOTE: Evidence of hrHPV testing within the last five years also captures patients who had co-testing; thus additional methods to identify co-testing are not necessary.	■ Members in hospice care any time during the measurement year ■ Members who had a hysterectomy with no residual cervix any time prior to December 31 of the measurement year ■ Members receiving palliative care during the measurement year	■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Important Billing Codes	
Absence of Cervix (Hysterectomy)	**ICD-10 Diagnosis** Z90.710 – Acquired absence of both cervix and uterus Z90.712 – Acquired absence of cervix with remaining uterus
Cervical Cytology (Pap test)	**CPT** 88141, 88142, 88143, 88147, 881448, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175 **HCPCS** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
High-risk HPV Tests	CPT: 87620, 87621, 87622, 87624, 87625 HCPCS: G0476

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Chlamydia Screening (CHL)*

Description: Women 16–24 years of age who are sexually active should be screened annually for chlamydia.

TIP: Set up reminder alerts in your office system to ensure members have a yearly chlamydia test.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental lab data to Healthfirst for chlamydia tests
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document Chlamydia tests on lab reports
- Document Chlamydia tests in progress notes, with dates and results
- Document Chlamydia tests in preventive health flowsheets, with dates and results
- Implement EMR trigger reminders to know when patients are due for chlamydia tests
- Utilize preventive health flowsheets to document chlamydia test dates, test results, and when patients are next due
- If no electronic record available, standardize progress notes with subheaders (with test date and result)

Measure Definition for Chlamydia Screening

Denominator	Numerator	Exclusions	Product Lines
Female members 16–24 years of age who are identified as sexually active	Members in the denominator who were screened for chlamydia in the measurement year	■ Members in hospice care any time during the measurement year	■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

Based on HEDIS® 2021. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Colorectal Cancer Screening (COL)*

Description: Adults 50–75 years of age should be screened for colorectal cancer by one of the following:

- Colonoscopy every 10 years
- CT colonography or flexible sigmoidoscopy every five years
- FIT-DNA test (Cologuard®) every three years
- Fecal occult blood test (FOBT) every year

> **TIP:** Follow up with patients who have overdue colorectal cancer screening orders and, whenever possible, help resolve their barriers to getting screened. If they need help with scheduling, refer them to Healthfirst.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Submit claims or supplemental data to Healthfirst for colorectal cancer screening dates and test results, history of colorectal cancer, or history of a total colectomy
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document colorectal cancer screenings on lab reports, surgical reports, and in progress notes with type of screening, dates, **and** results
- Document colorectal cancer screenings on preventive health flowsheets, with type of screening, dates, and results
- If exact dates are not known, document screening type, month, and year
- Implement EMR trigger reminders to know when patients are due for colorectal cancer screening
- Utilize preventive health flowsheets to know when patients are due for colorectal cancer screening

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Colorectal Cancer Screening			
Denominator	Numerator	Exclusions	Product Lines
Members 51–75 years of age as of December 31 of the measurement year	Members in the denominator who had one of the following: ■ Colonoscopy in the measurement year or nine years prior ■ CT colonography or flexible sigmoidoscopy in the measurement year or four years prior ■ FIT-DNA (Cologuard®) in the measurement year or two years prior ■ Fecal occult blood test (FOBT, gFOBT, iFOBT, or FIT) in the measurement year	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members with either colorectal cancer or a total colectomy any time on or prior to December 31 of the measurement year ■ Members receiving palliative care during the measurement year	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Controlling High Blood Pressure (CBP)*

Description: Adults 18–85 years of age with hypertension should have their blood pressure (BP) adequately controlled (<140/90).

> **TIP:** During visits, if the member's BP is 140/90 or higher, recheck the BP at the end of the visit. Often the rechecked BP will read as adequately controlled.

How to Achieve this Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for BP dates of BP values
- Use an outpatient service code with the blood pressure value codes as referenced on page 55 and 56 of the **2021 HEDIS Codebook**. Note this is required
- See **Appendix 2** for details on supplemental data submissions
- Submit procedure codes for BP values on claims – this can decrease chart requests time during the chart review season
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Use an outpatient, telephone, online assessments, nonacute inpatient, or remote BP monitoring value service code with the blood pressure value codes as referenced on page **48** and **53** of the **2021 HEDIS Code Book**. Note this is required.

Best Practices and Tips

- Document BP values in vital signs and in progress notes, with date
- Document BP values in standardized electronic and paper Vital Signs charting tools
- Add an alert or notation to offer multiple BP checks for those with high BP (140/90 or higher) as a reminder to recheck the BP later in the visit
- BP readings can be member-reported during a telehealth visit, telephonic visits, e-visit, or virtual check-in, as long as they are taken on a digital device and must be recorded, dated, and maintained in member's legal health record.
- Ensure members with hypertension have a checkup visit before the end-of-year holidays to ensure their BP is taken at least annually
- When managing hypertension (HTN), consider:
  - The new normal range and goal for those with HTN
  - Utilizing practice workflows
  - Empowering members with tools
  - Making non-pharmacologic therapy a core to your care planning

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

    - Listening to your patient's experience
    - Evaluating barriers such as social determinants of health
- Use the proper cuff size when taking BP
- Record all BP readings taken during appointment
- Routinely monitor member's BP in both left and right extremities
- Take a second BP reading during the visit when the first BP reading is 140/90 or higher
- Frequent follow-ups for members with uncontrolled BP
- When possible, prescribe 90-day HTN medication for members
- Help members understand why control of high BP is important

Resources

- Utilize the Quality Program Resources section at **hfproviders.org**. Be sure to select the filter for "Blood Pressure Control" or click **here**.

Measure Definition for Controlling High Blood Pressure			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Members 18–85 years of age as of December 31 of the measurement year identified as having hypertension. Members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior and June 30 of the measurement year (count services that occur over both years). Visit type need not be the same for the two visits.	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled (<140/90) during the measurement year.	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members 81+ years of age with frailty ■ All members with evidence of end-stage renal disease (ESRD) or kidney transplant or receiving dialysis ■ Female members with a diagnosis of pregnancy during the measurement year ■ Members receiving palliative care during the measurement year	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

Based on HEDIS® 2021. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Important Billing Codes	
BP – Systolic values	CPT Category II 3074F – Most recent systolic blood pressure less than 130 mm Hg 3075F – Most recent systolic blood pressure 130–139 mm Hg 3077F – Most recent systolic blood pressure greater than or equal to 140 mm Hg
BP – Diastolic values	CPT Category II 3078F – Most recent diastolic blood pressure less than 80 mm Hg 3079F – Most recent diastolic blood pressure 80–89 mm Hg 3080F – Most recent diastolic blood pressure greater than or equal to 90 mm Hg
BP – Value codes	Outpatient service codes are required. Please see pages 55 and 56 in the **2021 HEDIS Codebook** for a list of codes

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HEDIS®: Pediatric Prevention

Childhood Immunization Status (CIS)*

Description: Children should have complete immunizations on or before their second birthday. These can occur in combination or single doses. The vaccines include:

DTaP = 4, IPV = 3, HepB = 3, Hib = 3, PCV = 4, VZV = 1, MMR = 1

> **TIP:** CIS visits must be 14 days apart. When children come in for one immunization, schedule the next one two weeks out to close out CIS care opportunities.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for vaccinations given to the member or documented in the chart; also send claims for vaccine contraindications
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document immunization in a vaccination record, with date and antigen
- Document immunization in an EMR
- Utilize immunization records retrieved from state, county, and/or city immunization registries
- Utilize standardized EMR or paper charting tools to assist with updating records and knowing when due for a vaccine completion during the visit
- Access immunization registries during office visits to enter vaccination history

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Immunization" or click **here**.

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Childhood Immunization Status			
Denominator	Numerator	Exclusions	Product Lines
Members who turned two years of age during the measurement year	Members in the denominator with evidence of all the following immunizations by their second birthday: ■ DTaP = 4 ■ IPV = 3 ■ HepB = 3 ■ Hib = 3 ■ PCV = 4 ■ VZV = 1 ■ MMR = 1	■ Members in hospice care any time during the measurement year ■ Members who had a contraindication for a specific vaccine	■ Medicaid ■ QHP ■ HFIC

Based on HEDIS® 2021. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Immunizations for Adolescents (IMA)*

Description: Adolescents should have the following immunizations on or before their 13th birthday:

- Meningococcal - between 11th and 13th birthdays
- Tdap - between 10th and 13th birthdays
- HPV vaccines - between 9th and 13th birthdays.

TIP: Schedule well-care visits and administer immunizations when adolescents are out of school or as part of sports physicals.

How to Achieve this Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for vaccinations given to the member or documented in the chart; also send claims for vaccine contraindications
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Document immunization in a vaccination record, with date and antigen
- Document immunization in the EMR
- Document Immunization records retrieved from state, county, and/or city immunization registries
- Utilize standardized EMR or paper charting tools to assist with updating records and knowing when due for a vaccine during the visit
- Access immunization registries during office visits to enter vaccination history
- For the two-dose HPV vaccination series, there must be at least 146 days between the first and second doses of the HPV vaccine
- For the three-dose HPV series, the vaccines must be given on three different dates of service

Resources

Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Immunization" or click **here**.

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Immunizations for Adolescents			
Denominator	Numerator	Exclusions	Product Lines
Members who turned 13 years of age during the measurement year	Members in the denominator and evidence of meningococcal, Tdap, and HPV antigen or combination vaccine	■ Members in hospice care any time during the measurement year ■ Members who had a contraindication for a specific vaccine	■ Medicaid ■ QHP ■ HFIC

Based on HEDIS® 2021. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Child and Adolescent Well-Care Visits (WCV)*

Description: Members 3–21 years of age who had at least one well-care visit with a PCP or an Ob/Gyn practitioner during the measurement year.

TIP: When members have an office visit, proactively schedule the next annual well-care visit

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Well-care visit services provided during a telehealth visit meet the criteria
- Specialized health exams such as those conducted for sports physicals or adoption services also count for the WCV measure
- Submit claims or supplemental encounter data to Healthfirst for annual well-care visits completed
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- The PCP should bill with the suggested preventive codes listed in the **2021 HEDIS Code Book** to count toward the measure

Resources

- Refer to Healthfirst if parents/guardians need assistance with getting children to their appointments (e.g., transportation)
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Well-Child Visits" or click **here**.

Measure Definition for Child and Adolescent Well-Care Visits			
Denominator	Numerator	Exclusions	Product Lines
Members who turned 3–21 years of age during the measurement year.	Members in the denominator who had one or more well-care visits during the measurement year.	Members in hospice care any time during the measurement year.	■ Medicaid ■ QHP ■ CHP ■ HFIC

Important Billing Codes	
Well-Care Visits	CPT 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 HCPCS G0438, G0439 ICD-10 Diagnosis Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z02.5, Z76.1, Z76.2

Well-Child Visits – 30 Months (W30)*

Description: Children should have the following number of well-child visits with a PCP (two rates are reported):

- Well-Child Visits in the First 15 Months: Children should have six (6) or more well-child visits from birth through 15 months of age.
- Well-Child Visits for Age 15 Months–30 Months: Children should have two (2) or more well-child visits from 15 months plus one day through 30 months of age.
- In the 2021 HQIP, these two rates will be reported together in a single '0–30 months' rate by adding the 0–15 months numerator and denominator to the 15–30 months numerator and denominator.

TIP: When members have an office visit, schedule the next one to make sure six or more well-care visits are completed by 15 months of age (rate 1), or two or more well-care visits are completed by 30 months of age (rate 2).

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Well-child visit services provided during a telehealth visit meet the criteria
- Submit claims or supplemental encounter data to Healthfirst for well-care visits completed
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- The PCP should bill with the suggested preventive codes listed in the **2021 HEDIS Code Book** to count toward the measure

Resources

- Refer to Healthfirst if parents/guardians need assistance with getting children to their appointments (e.g., transportation)
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Well-Child Visits" or click **here**.

Measure Definition for Child and Adolescent Well-Care Visits			
Denominator	Numerator	Exclusions	Product Lines
■ Well-Child Visits in the First 15 Months: Children who turned 15 months old during the measurement year. ■ Well-Child Visits for Age 15 Months–30 Months: Children who turned 30 months old during the measurement year.	■ Well-Child Visits in the First 15 Months: Children should have six or more well-child visits from birth through 15 months of age. ■ Well-Child Visits for Age 15 Months–30 Months: Children should have two or more well-child visits from 15 months and one day through 30 months of age (visits must be at least 14 days apart).	Members in hospice care any time during the measurement year.	■ Medicaid ■ QHP ■ CHP ■ HFIC

Important Billing Codes	
Well-Care Visits	CPT 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 HCPCS G0438, G0439 ICD-10 Diagnosis Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z02.5, Z76.1, Z76.2

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*

Description: Children and adolescents 3–17 years of age who had an outpatient visit with a PCP or Ob/Gyn and who had services for the following annually:

- Body Mass Index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

> **TIP:** Well-care visits can be planned any time of year, but especially when they are out of daycare, school, or preparing for their sports physical.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Submit claims or supplemental encounter data to Healthfirst with codes to indicate the WCC services were completed
  - BMI percentile documentation
  - Counseling for nutrition
  - Counseling for physical activity
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

BMI Percentile

- BMI percentile, along with height and weight, can be documented as a part of Vital Signs or in Progress Notes
- BMI percentiles may be documented as a value ("90th percentile") or may be plotted on age-growth chart
- As a part of the telehealth visit, member-reported biometric values (height, weight, BMI percentile) must be recorded, dated, and maintained in the member's legal health record

Counseling for Nutrition

- Document and maintain a nutrition counseling checklist with:
  - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

- Educational materials on nutrition your patients may have received during a face-to-face visit
- Nutrition guidance
- Weight or obesity counseling

- Note: Referral to WIC may be used to meet criteria for the Counseling for Nutrition indicator

Counseling for Physical Activity

- Document and maintain a counseling checklist with:
  - Discussion on current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
  - Educational materials on nutrition your patients may have received during a face-to-face visit

Other

- Standardized paper and electronic charting tools can help you remember to complete documentation during the visit.
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count.
- The Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephonic visit, e-visit, or virtual check-in meet criteria.

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Weight Management" or click **here**.

Measure Definition for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Denominator	Numerator	Exclusions	Product Lines
Members 3–17 years of age as of December 31 of the measurement year	Members in the denominator who had an outpatient visit with a PCP or Ob/Gyn and who had evidence of the following during the measurement year: ■ BMI percentile documentation ■ Counseling for nutrition ■ Counseling for physical activity	■ Members in hospice care any time during the measurement year ■ Female members who have a diagnosis of pregnancy during the measurement year	■ Medicaid ■ QHP ■ HFIC

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Timeliness of Prenatal and Postpartum Care (PPC)*

Description: Pregnant women should have an initial prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment with the health plan, and should have a postpartum care visit between seven and 84 days after delivery.

> **TIP:** Schedule prenatal visits within the first trimester, and schedule postpartum visits upon discharge after delivery, to ensure timely care.

How to Achieve This Measure and Close This Care Opportunity

- Telephonic visits, e-visits, and virtual check-ins are eligible for use in reporting timeliness of prenatal care and postpartum care
- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for:
  - Prenatal visits within the first trimester (on or before or within 42 days of enrollment)
  - Postpartum visits between seven and 84 days after delivery
- Services can be completed through telephonic visits, e-visits, or virtual check-ins
- See **Appendix 2** for details on supplemental data submissions
  - Supplemental data is particularly important when using global Obstetrical Care billing codes
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Prenatal Care Documentation Tips

- Document screenings and labs such as
  - Screening test in the form of an obstetric panel, or
  - TORCH antibody panel, or
  - A rubella antibody test/titer with a Rh incompatibility (ABO/Rh) blood typing, or
  - Ultrasound of a pregnant uterus
- Documentation of last menstrual period (LMP), expected date of delivery (EDD), or gestational age in conjunction with either of the following:
  - Prenatal risk assessment and counseling/education
  - Complete obstetrical history
- Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence it occurred

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Postpartum Care Documentation Tips

- Use a preprinted "Postpartum Care" form to document
  - Pelvic exam
  - Evaluation of weight, BP, breasts, and abdomen
- Perineal or cesarean incision/wound check counts as a postpartum visit
- Postpartum visit can be with an Ob/Gyn practitioner or midwife, family practitioner, or other PCP

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Prenatal and Postpartum Care" or click **here**.
- Refer to Healthfirst if patients need assistance with getting to their appointments (e.g., transportation).
- American College of Obstetricians and Gynecologists (ACOG) forms or prenatal flow sheets are an excellent way to document care.

Measure Definition for Timeliness of Prenatal and Postpartum Care

Denominator	Numerator	Exclusions	Product Lines
Members with live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year Note that the denominator is based on deliveries, not members	Members in the denominator who had each of the following (two separate rates): ■ Timeliness of Prenatal Care: initial prenatal visit must be within first trimester or within 42 days of enrollment with health plan ■ Postpartum Care visit must occur between seven and 84 days after delivery	Members in hospice care any time during the measurement year	■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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HEDIS®: Acute Care Management

Appropriate Testing for Pharyngitis (CWP)

Description: Children three years of age and older with pharyngitis should have a strep test within three days before or after an antibiotic prescription is filled for pharyngitis.

> **TIP:** Ensure the office has strep test and throat cultures on hand during the school year and the flu season.

How to Achieve This Measure and Close This Care Opportunity

- Always test for group A streptococcus (strep) when prescribing antibiotics to members three years of age and older with pharyngitis
- Submit claims or supplemental lab data to Healthfirst for group A streptococcus tests or throat cultures
  - Prescribe antibiotics for pharyngitis only when positive for group A streptococcus
  - It is important to bill for strep tests performed within three days before or after an antibiotic prescription is filled
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Train your entire office and clinical staff on how to be supportive of parents/guardians who have concerns about not receiving antibiotics
- Review patient materials and tips that may help you explain to parents/guardians how their family will benefit by avoiding antibiotics
- Consider stocking and distributing patient materials in languages most helpful to your patients

Resources

- Educational resources on appropriate antibiotic use are available at the **CDC.gov** website for **Antibiotic Prescribing and Use in Doctor's Offices**.
- **Adult and Pediatric Antibiotic Prescribing Guidelines** at the New York State Department of Health website.

Measure Definition for Appropriate Testing for Pharyngitis			
Denominator	Numerator	Exclusions	Product Lines
Members three years of age and older with a diagnosis of pharyngitis and who were also dispensed an antibiotic between July 1 of the year prior to the measurement year and June 30 of the measurement year	Members in the denominator who had a group A streptococcus test done on the day, or between three days before or after, the antibiotic was dispensed	Members in hospice care any time during the measurement year Pharyngitis episodes are excluded when the member has a diagnosis for a comorbid condition (including HIV, cancer, COPD, cystic fibrosis, emphysema, and immune system disorders) during the 12 months prior to, or on, the pharyngitis diagnosis date	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Important Billing Codes	
Group A strep test	CPT 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880 LOINC 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2
Pharyngitis	ICD-10 Diagnosis J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

CPT® is a registered trademark of the American Medical Association.

Avoidance of Antibiotic Treatment with Acute Bronchitis/ Bronchiolitis (AAB)

Description: Antibiotics should not be prescribed for members three months of age and older with a diagnosis of acute bronchitis/bronchiolitis.

TIP: Avoid prescribing antibiotics for acute bronchitis unless a comorbid condition or other infection is also present.

How to Achieve This Measure and Close This Care Opportunity

- Prescribe antibiotics for acute bronchitis only when the patient has a comorbidity or other infection for which antibiotics are appropriate, such as:
  - Cancer or HIV
  - Chronic obstructive pulmonary disease (COPD), cystic fibrosis, or emphysema
  - Immune system disorders
  - Pneumonia, tuberculosis, or pertussis
  - Other bacterial infections
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Train your entire office and clinical staff on how to be supportive of parents/guardians who have concerns about not receiving antibiotics
- Review patient materials and tips that may help you explain to parents/guardians how their family will benefit by avoiding antibiotics
- Consider stocking and distributing patient materials in languages most helpful to your patients

Resources

- Educational resources on appropriate antibiotic use are available at the **CDC.gov** website for **Antibiotic Prescribing and Use in Doctor's Offices**.
- **Adult and Pediatric Antibiotic Prescribing Guidelines** at the New York State Department of Health website.

Measure Definition for Avoidance of Antibiotic Treatment with Acute Bronchitis

Denominator	Numerator	Exclusions	Product Lines
Members three months of age and older who were diagnosed with acute bronchitis/bronchiolitis at an outpatient, telephonic visit, an e-visit, or virtual check-in, an observation visit, or an ED visit on or between July 1 of the year prior and June 30 of the measurement year.	Members in the denominator who were not dispensed an antibiotic on the day of, or three days after, the acute bronchitis/bronchiolitis diagnosis	■ Members in hospice care any time during the measurement year ■ Acute bronchitis episodes are excluded when the member has a diagnosis for a comorbid condition (including HIV, cancer, COPD, cystic fibrosis, emphysema, and immune system disorders) during the 12 months prior to or on the acute bronchitis/bronchiolitis diagnosis date	■ Medicare ■ Medicaid ■ EP ■ HARP ■ QHP ■ HFIC

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Aminoglycosides	■ Amikacin ■ Gentamicin	■ Streptomycin ■ Tobramycin
Aminopenicillins	■ Aminopenicillins	■ Ampicillin
Beta-lactamase inhibitors	■ Amoxicillin-clavulanate ■ Ampicillin-sulbactam	■ Piperacillin-tazobactam
First-generation cephalosporins	■ Cefadroxil ■ Cefazolin	■ Cephalexin
Fourth-generation cephalosporins	■ Cefepime	
Ketolides	■ Telithromycin	
Lincomycin derivatives	■ Clindamycin	■ Lincomycin
Macrolides	■ Azithromycin ■ Clarithromycin ■ Erythromycin	■ Erythromycin ethylsuccinate ■ Erythromycin lactobionate ■ Erythromycin stearate
Miscellaneous antibiotics	■ Aztreonam ■ Chloramphenicol ■ Dalfopristin-quinupristin ■ Daptomycin	■ Linezolid ■ Metronidazole ■ Vancomycin
Natural penicillins	■ Penicillin G benzathine-procaine ■ Penicillin G potassium ■ Penicillin G procaine	■ Penicillin G sodium ■ Penicillin V potassium ■ Penicillin G benzathine
Penicillinase-resistant penicillins	■ Dicloxacillin ■ Nafcillin	■ Oxacillin
Rifamycin derivatives	■ Rifampin	

Quinolones	Ciprofloxacin Gemifloxaci Levofloxacin	Moxifloxacin Ofloxacin
Second-generation cephalosporins	■ Cefaclor ■ Cefotetan ■ Cefoxitin	■ Cefprozil ■ Cefuroxime
Sulfonamides	■ Sulfadiazine	■ Sulfamethoxazole-trimethoprim
Tetracyclines	■ Doxycycline ■ Minocycline	■ Tetracycline
Third-generation cephalosporins	■ Cefdinir ■ Cefditoren ■ Cefixime ■ Cefotaxime ■ Cefpodoxime	■ Ceftazidime ■ Ceftibuten ■ Ceftriaxone
Urinary anti-infectives	■ Fosfomycin ■ Nitrofurantoin ■ Nitrofurantoin macrocrystals	■ Nitrofurantoin macrocrystals-monohydrate ■ Trimethoprim

HEDIS®: Chronic Care Management

Asthma Medication Ratio (AMR)

Description: Children and adults 5–64 years of age diagnosed with persistent asthma should have a ratio of controller medications to total asthma medications of 0.50 or greater.

> **TIP:** Prescribe asthma controller medication to members with persistent asthma. Follow up quarterly (office visit, call, or telehealth) to ensure asthma is in control and medication ratio is good.

How to Achieve This Measure and Close this Care Opportunity

- Prescribe asthma controller medications to patients with persistent asthma when clinically appropriate
- Follow up to ensure they fill their controller prescriptions and are taking them as directed
  - See **Asthma Controller Medications** table below
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Keep in mind that members living with persistent asthma are not filling their asthma controller medications consistently and are often admitted to hospital and emergency departments (EDs)
- Schedule quarterly follow-up visits or calls to ensure the member's asthma is in control and his/her medication ratio is good

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Asthma" or click **here.** **NHLBI Asthma Diagnosis and Management Guidelines** are available at the **nhlbi.nih.gov** website

Measure Definition for Asthma Medication Ratio	
Numerator	Members in the denominator who have a ratio of dispensed controller medications to total asthma medications of 0.50 or greater during the measurement year, calculated as follows: **Step 1:** For each member, count the units of asthma controller medications dispensed during the measurement year Note: One unit equals one inhaler canister, one injection, one infusion, or a 30-day or less supply of an oral medication **Step 2:** For each member, count the units of asthma reliever medications dispensed during the measurement year **Step 3:** For each member, sum the units calculated in Step 1 and Step 2 to determine units of total asthma medications **Step 4:** For each member, calculate the ratio of controller medications to total asthma medications using the following formula (use the .5 rule to round to the nearest whole number): Units of Controller Medications (Step 1) divided by Units of Total Asthma Medications (Step 3) **Step 5:** Sum up the total number of members who have a ratio of 0.50 or greater in Step 4
Denominator	Members 5–64 years of age who met at least one of the following criteria during both the measurement year and the year prior to the measurement year: ■ At least one ED visit or one acute inpatient encounter, with a principal diagnosis of asthma ■ At least four outpatient visits, observation visits, telephonic visits, e-visits, or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication (visit type need not be the same for the four visits) ■ At least four asthma medication dispensing events ■ At least four asthma medication dispensing events for any controller or reliever medication
Exclusions	Members in hospice care any time during the measurement year Members diagnosed with other chronic respiratory conditions (including Emphysema, Chronic Obstructive Pulmonary Disease [COPD], Cystic Fibrosis, Obstructive Chronic Bronchitis, Chronic Respiratory Conditions due to fumes/vapors) Members diagnosed with Acute Respiratory Failure
Product Lines	Medicaid, EP, QHP, HARP, HFIC

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Asthma Controller Medications		
Antiasthmatic combinations	■ Dyphylline-guaifenesin	
Antibody inhibitors	■ Omalizumab	
Anti-interleukin-4	■ Dupilumab	
Anti-interleukin-5	■ Benralizumab ■ Mepolizumab	■ Reslizumab
Inhaled steroid combinations	■ Budesonide-formoterol ■ Fluticasone-salmeterol	■ Fluticasone-vilanterol ■ Formoterol-mometasone
Inhaled corticosteroids	■ Beclomethasone ■ Budesonide ■ Ciclesonide	■ Flunisolide ■ Fluticasone ■ Mometasone
Leukotriene modifiers	■ Montelukast ■ Zafirlukast	■ Zileuton
Methylxanthines	■ Theophylline	

Asthma Reliever Medications		
Short-acting, inhaled **beta-2 agonists**	■ Albuterol	■ Levalbuterol

Comprehensive Diabetes Care (CDC) – Eye Exam*

Description: Adults 18–75 years of age diagnosed with diabetes should have a retinal or dilated eye exam by an eye care professional annually (or can be every two years when negative for retinopathy).

> **TIP:** Encourage diabetic members to have a retinal eye exam every year. Help schedule appointments or refer them to Healthfirst for assistance.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for retinal eye exam results documented in the chart
- Claims from optometrists must be sent to Davis Vision
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Recommended CPT Category II Codes:
  - 2022F – Dilated retinal exam with interpretation by an ophthalmologist or optometrist documented and reviewed
  - 3072F – Low risk for retinopathy due to no evidence of retinopathy in the prior year (this code can be used only with a date of service in the current measurement year)

Best Practices for Chart Documentation

- Retinal eye exams on diabetic flow sheets, with date, eye care provider, and retinopathy result
- Retinal eye exams on consultation reports from eye care providers, with date and retinopathy result
- Retinal eye exams in progress notes, with date, eye care provider, and retinopathy result
- Chart documentation must clearly indicate the member had a dilated or retinal eye exam read by an optometrist, ophthalmologist, or a system that provides an artificial intelligence (AI) interpretation and must include the exam date and retinopathy result
  - Example: "Negative Retinal Exam June 2020 with Eye Care Associates"

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Diabetes Care" or click **here.**

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Diabetes Care – Eye Exam			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Members 18–75 years of age identified as having diabetes by: ■ Pharmacy data: dispensed insulin or oral hypoglycemic/anti-hyperglycemics during the measurement year or year prior -OR- ■ Claims/encounters with a diabetes diagnosis during the measurement year or year prior, either one of the following: ● Two or more outpatient visits (office visit, observation stay, ED visit, or non-acute facility stay) ● One or more inpatient hospital stays	■ Members in the denominator who had one or more of the following: ● Retinal or dilated eye exam read by an optometrist, ophthalmologist, or a system that provides an artificial intelligence (AI) interpretation in the measurement year ● Negative retinal or dilated eye exam (negative for retinopathy) read by an optometrist, ophthalmologist, or a system that provides an artificial intelligence (AI) interpretation in the year prior to the measurement year ● Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members who have only gestational or steroid-induced diabetes or polycystic ovarian syndrome ■ Members who are receiving palliative care	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Comprehensive Diabetes Care (CDC) – HbA1c Control*

Description: The percentage of members 18–75 years of age with diabetes whose most recent hemoglobin A1c (HbA1c) lab test in the measurement year has a controlled blood sugar result < 8.0% and/or ≤ 9.0%.

TIP: Establish quarterly appointment with diabetic members to ensure their diabetes is well managed.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly. The APP will provide a customized report with results specific to this sub measure; please use this report throughout the year to out reach the members and ensure their A1c is in control.
- Send claims or supplemental lab data to Healthfirst for HbA1c lab results
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Recommended CPT Category II Codes:
  - 3052F – Most recent HbA1c greater than or equal to 8.0% and less than or equal to 9.0%
  - 3046F – Most recent HbA1c greater than 9.0%
  - 3051F - Most recent HbA1c greater than or equal to 7.0% and less than 8.0%

Best Practices and Tips

- Document HbA1c results and dates:
  - on lab reports
  - from in-office testing
  - on consultation reports from specialists
  - in progress notes – always note both the test date and the result
  - on diabetic flow sheets
  - When managing diabetes, consider:
  - the normal range and goal for HbA1c
  - utilizing practice workflows
  - empowering members with tools

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

- making non-pharmacologic therapy a core to your care planning
- listening to your patient's experience
- evaluating barriers such as social determinants of health

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Diabetes Care" or click **here**.

Measure Definition for Diabetes Care – HbA1c Control			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Members 18–75 years of age identified as having diabetes by: ■ Pharmacy data: dispensed insulin or oral hypoglycemic/anti-hyperglycemics during the measurement year or year prior -OR- ■ Claims/encounters with a diabetes diagnosis during the measurement year or year prior, either one of the following: ● Two or more outpatient visits (office visit, observation stay, ED visit, non-acute facility stay), telephonic visits, e-visits, or virtual check-ins ● One or more inpatient hospital stays	Members in the denominator whose most recent HbA1c lab test in the measurement year has a controlled blood sugar result: ■ HbA1c < 8.0% ■ HbA1c ≤ 9.0%	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members who have only gestational or steroid-induced diabetes ■ Members receiving palliative care during the measurement year	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP ■ HFIC

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Comprehensive Diabetes Care (CDC) – Nephropathy Attention

Description: Members 18–75 years of age with diabetes who had medical attention for nephropathy during the measurement year.

> **TIP:** An in-office urine dipstick test with protein results counts for this measure.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental data to Healthfirst for urine protein labs, nephropathy attention services, or evidence of advanced kidney disease
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Common billing codes:
  - 81000–81003 – Urinalysis by dipstick or tablet reagent (with protein results)
  - 4010F – ACE inhibitor or ARB therapy prescribed or currently being taken
  - 3060F/3061F – Positive/Negative microalbumin test result
  - 3066F – Documentation of treatment for nephropathy (on dialysis, treated for ESRD, chronic renal failure (CRF), acute renal failure (ARF), renal insufficiency, or a nephrologist visit

Best Practices and Tips

- Include ACE/ARB on current medication lists or document Nephropathy Attention in consultation reports from nephrologists or in progress notes
- Document urine protein tests and dates:
  - on lab reports
  - on diabetic flowsheets
  - on consultation reports from specialists
  - in progress notes
  - from in-office testing
- Chart documentation for urine protein tests must include both the test date and the protein result value
- Establish quarterly appointment with diabetic members to ensure their diabetes is well managed

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Diabetes Care" or click **here**.

Measure Definition for Diabetes Care – Nephropathy Attention			
Denominator	Numerator	Exclusions	Product Lines
Members 18–75 years of age identified as having diabetes by: ■ Pharmacy data: dispensed insulin or oral hypoglycemic/anti-hyperglycemics during the measurement year or year prior -OR- ■ Claims/encounters with a diabetes diagnosis during the measurement year or year prior, either one of the following: ● Two or more outpatient visits (office visit, observation stay, ER visit, or non-acute facility stay) ● One or more inpatient hospital stays	Members in the denominator who had one or more of the following in the measurement year: ■ Urine protein tests for nephropathy screening or monitoring ■ An ACE inhibitor or ARB medication prescribed or dispensed ■ Evidence of stage 4 chronic kidney disease, ESRD, or kidney transplant ■ A visit with a nephrologist	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members who have only gestational or steroid-induced diabetes or polycystic ovarian syndrome ■ Members who are receiving palliative care	■ Medicare ■ HFIC

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Kidney Health Evaluation for Patients With Diabetes (KED)

Description: Members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

> **TIP:** Add EMR alerts for members due for the following lab tests: estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Submit supplemental encounter data to Healthfirst for at least one glomerular filtration rate (eGFR) and one urine albumin-creatinine ratio (uACR) done during the measurement year
  - See **Appendix 2** for details on supplemental data submissions
- Submit codes on claims for frailty and/or advanced illness conditions when appropriate; these may exclude the member from the KED measure
- See **Appendix 3** for more details on the advanced illness and frailty exclusions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Visit the Claims and Billing section at **hfproviders.org** and search for "Corrected Claims Submissions" or click **here**.

Measure Definition for Kidney Health Evaluation for Patients with Diabetes			
Denominator	Numerator	Exclusions	Product Lines
Members between 18–85 years of age and identified as diabetic during the measurement year or the year prior by claim/encounter and/or by pharmacy.	Members in the denominator who had at least one glomerular filtration rate (eGFR) and one urine albumin-creatinine ratio (uACR) done during the measurement year.	■ Members in hospice care any time during the measurement year ■ Members with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year ■ Members receiving palliative care during the measurement year ■ Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: ● Enrolled in an Institutional SNP any time during the measurement year ● Living long-term in an institution any time during the measurement year ■ Members with frailty and advanced illness	■ EP ■ HARP ■ Medicaid ■ Medicare ■ HFIC

Best Practices and Tips

- Check to see if members are due for lab tests at each visit
- Review patient materials and tips

Important Billing Codes	
Estimated Glomerular Filtration Rate Lab Test	CPT 80047, 80048, 80050, 80053, 80069, 82565 LOINC 48642-3, 48643-1, 50044-7
Quantitative Urine Albumin Lab Test	CPT 82043 LOINC 14957-57, 1754-1, 21059-1
Urine Creatinine Lab Test	CPT 82570 LOINC 20624-3, 2161-8, 35674-1

Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Description: Members 18 years and older with multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit (8 total days).

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
  - Send claims to Healthfirst for visits that meet the criteria
  - Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Schedule follow-up appointment within seven (7) days of discharge. Encourage appointments on the day of discharge. Possible options for follow-up visit include:
  - Same-day visit in hospital clinic
  - Primary care physician
  - Mobile mental health team
  - Telehealth visit
- Send discharge plan to provider conducting follow-up visit via secure message/fax

Providers conducting follow-up visit should document visits with value set codes found in the **2021 HEDIS Code Book**.

Measure Definition for Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Denominator	Numerator	Exclusions	Product Lines
An ED visit on or between January 1 and December 24 of the measurement year where the member was 18 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members.	The percentage of emergency department (ED) visits for members 18 years and older with multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit (eight total days). The following meet criteria for follow-up: ■ An outpatient visit ■ A telephone visit ■ Case management visits ■ An observation visit ■ An e-visit or virtual check-in	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within seven days after the ED visit, regardless of the principal diagnosis for admission.	■ Medicare

Osteoporosis Management in Women Who Had a Fracture (OMW)

Description: Women 67–85 years of age who suffered a fracture and had a bone mineral density (BMD) test or were dispensed a drug to treat or prevent osteoporosis within six months after the fracture.

> **TIP:** Time is limited! BMD tests must be completed and/or osteoporosis medications must be dispensed within six months after the fracture to count for this measure.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Have your patient complete a bone mineral density (BMD) test within six months of a fracture
- Prescribe osteoporosis medications to female patients within six months of fracture when clinically appropriate; follow up to ensure they fill their prescriptions
- Submit claims or supplemental data to Healthfirst for BMD tests and/or osteoporosis injection medications within six months of fracture
- See **Appendix 2** for details on supplemental data submissions
- See **Appendix 4** for a list of osteoporosis medications
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Endocrinologists are great partners for the decision-making related to patient treatment options, including osteoporosis medications
  - Contact Healthfirst Network Management for assistance in locating a specialist
- Follow the CMS and ICD-10 coding guidelines when billing fractures to ensure claims for after-care (such as home health) are not identified as a new fracture:
  - 7th character A is for active treatment of the fracture (X-ray, ED, surgery, etc.)
  - 7th character D is for after the patient has completed active treatment for the fracture (routine care in healing or recovery phase)

Resources

- Visit the Claims and Billing section at **hfproviders.org** and search for "Corrected Claims Submissions" or click **here**.
- Utilize the Quality Program Resources at **hfproviders.org** and search for "osteoporosis" or click **here**.
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Care of Older Adults" or click **here**.

Measure Definition for Osteoporosis Management in Women Who Had a Fracture			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Female members 67–85 years of age who suffered a fracture between July 1 of the year prior to the measurement year and June 30 of the measurement year Fractures are identified by: ■ An outpatient, ED, or observation visit for a fracture -OR- ■ An acute or non-acute inpatient discharge with a diagnosis of a fracture Note that fractures of finger, toe, face, and skull are not included in this measure	Members in the denominator who had any of the following: ■ BMD test within 180 days after the fracture ■ Treated with a long-acting osteoporosis therapy medication while inpatient if member was hospitalized for the fracture ■ Dispensed a drug to treat or prevent osteoporosis within 180 days after the fracture	■ Members in hospice care any time during the measurement year ■ Members 67–80 years of age with both frailty and advanced illness ■ Members 67 years of age and older who live long term in an institution or facility ■ Members 81 years of age and older with frailty ■ Members who had a BMD test within 24 months prior to the fracture ■ Members who were dispensed a drug to treat or prevent osteoporosis within 12 months prior to the fracture ■ Members who are receiving palliative care	■ Medicare

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Osteoporosis Medication	
Biphosphonates:	■ Alendronate ■ Alendronate-cholecalciferol ■ Ibandronate ■ Risedronate ■ Zoledronic acid
Other agents:	■ Abaloparatide ■ Denosumab ■ Raloxifene ■ Romosozumab ■ Teriparatide

Transitions of Care (TRC)*

Description: Members 18 years of age and older with a hospital discharge should have each of the following:

- **Notification of Inpatient Admission:** Documentation of receipt of notification of inpatient admission on the day of admission through two (2) days after the admission (three total days).
- **Receipt of Discharge Information:** Documentation of receipt of discharge information on the day of discharge through two (2) days after the discharge (three total days).
- **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).

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
  - Use EMR trigger reminders for follow-up appointments post-discharge
  - Send claims or supplemental data to Healthfirst for medication reconciliations completed within 30 days after discharge from a hospital or other inpatient facility
  - See **Appendix 2** for details on supplemental data submissions
  - Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
  - Discharge medications reconciled with the current medication list in outpatient medical record (recommended CPT Category II Code: 1111F)

Best Practices and Tips

- Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria for "Notification of Inpatient"
- Use codes 98966-99496 for Telephone "Patient Engagement After Inpatient Discharge" visits
- Medication reconciliation post-discharge does not require member to be present

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Transitions of Care			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Members 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on members.	Members in the denominator who had each of the following: ■ Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). ■ Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days). ■ 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).	Members in hospice care any time during the measurement year.	■ Medicare ■ Medicaid ■ HARP ■ EP

Statin Therapy for Patients with Cardiovascular Disease (SPC)*

Description: Males 21–75 years of age and females 40–75 years of age with atherosclerotic cardiovascular disease (ASCVD) should take a high-intensity or moderate-intensity statin medication.

TIP: Prescribe a high-intensity or moderate-intensity statin to members with ASCVD if clinically appropriate. Follow up to ensure they picked up their prescriptions.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Prescribe a high-intensity or moderate-intensity statin medication to patients with ASCVD when clinically appropriate
- Follow up to ensure they fill their statin prescriptions and are taking them as directed
- See **Appendix 4** for a list of high-intensity and moderate-intensity statin medications

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Blood Pressure Control" or click **here**. Refer to the 2018 American College of Cardiologists (ACC)/American Heart Association (AHA) **Cholesterol Clinical Practice Guidelines** at **acc.org**.
- ACC's Statin Intolerance Tool at **tools.acc.org/StatinIntolerance**.
- AHA's **Cholesterol Toolkit for Professionals**.

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Statin Therapy for Patients with Cardiovascular Disease			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Male members 21–75 years of age and female members 40–75 years of age with clinical ASCVD, identified by either one of the following: ■ Myocardial Infarction (MI), Coronary Artery Bypass Grafting (CABG), Percutaneous Coronary Intervention (PCI), or other revascularization procedure in the year prior to the measurement year ■ Diagnosed with Ischemic Vascular Disease (IVD) in both the measurement year and the year prior	Members in the denominator who had at least one high-intensity or moderate-intensity medication dispensed during the measurement year	■ Members in hospice care any time during the measurement year ■ Members 66 years of age and older with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Female members with a diagnosis of pregnancy or undergoing in vitro fertilization in the measurement year or the year prior ■ Dispensed a prescription for clomiphene in the measurement year or year prior ■ ESRD or cirrhosis in the measurement year or year prior ■ Myalgia, myositis, myopathy, or rhabdomyolysis in the measurement year ■ Members who are receiving palliative care	■ Medicare ■ Medicaid ■ EP ■ HARP ■ HFIC

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Statin Use in Persons with Diabetes (SUPD)

Description: Adults 40–75 years of age with diabetes may need to take a statin medication to lower their risk of developing heart disease.

> **TIP:** Evaluate diabetic members to determine if a statin prescription is clinically appropriate. Follow up to ensure they picked up their prescriptions.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated weekly
- Prescribe a statin medication to diabetics 40–75 years of age when clinically appropriate
- Follow up to ensure they fill their statin prescriptions and are taking them as directed
- See **Appendix 4** for a list of statin medications
- Note that this measure is based entirely on dispensed pharmacy claims, so there is no opportunity for supplemental data or claims/encounter submissions

Resources

Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Diabetes Care" or click **here**.

Measure Definition for Statin Use in Persons with Diabetes			
Denominator	Numerator	Exclusions	Product Lines
Diabetic members 40–75 years of age with Medicare Part D pharmacy benefits Diabetics are identified by two or more diabetes medication fills during the measurement year	Members in the denominator who had a statin medication dispensed	None	■ Medicare

Based on the PQA Statin Use in Persons with Diabetes measure.

Use of Spirometry Testing in the Assessment Diagnosis of COPD (SPR)

Description: Adults 40 years of age and older with a new diagnosis of COPD or newly active COPD should have appropriate spirometry testing to confirm the diagnosis.

> **TIP:** Schedule a spirometry test as soon as possible for members newly diagnosed with COPD. Review controller medications to ensure they are working.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Have your patient complete spirometry testing within six months of a new COPD diagnosis
- Submit claims or supplemental data to Healthfirst for spirometry tests within the time frame
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Schedule spirometry testing to confirm a COPD diagnosis and to determine the severity of the disease
  - Knowing the COPD severity can help determine the disease's impact on patient health and his/her risk of future exacerbations
- If appropriate, have the patient visit quarterly to:
  - review clinical goal(s) and care plan
  - utilize practice workflows
  - empower members with self- management tools
  - make non-pharmacologic therapy a core to your care planning
  - listen to your member's experience
  - evaluate barriers such as social determinants of health

Resources

- Utilize the resources at **hfproviders.org** and search for "Smoking Cessation" or click **here**.

Measure Definition for Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Members 40 years of age and older who have been identified as having a new diagnosis of COPD or newly active COPD by an outpatient, ED, or acute inpatient visit	Members in the denominator who had spirometry testing between two years prior through six months after COPD diagnosis	Members in hospice care any time during the measurement year	■ Medicare ■ Medicaid ■ EP ■ HARP ■ HFIC

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HEDIS®: Behavioral Health

Diabetes Screening for People with Schizophrenia/Bipolar Disorder and on Antipsychotic Medications (SSD)

Description: Adults 18–64 years of age with schizophrenia or bipolar disease who were dispensed an antipsychotic should have an annual glucose screening test or an HbA1c screening test.

> **TIP:** A good time to schedule or address SSD is during a well-check visit. This is a perfect time to close out all preventive health and mental health care opportunities.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
- Send claims or supplemental encounter data to Healthfirst for completed HbA1c or glucose lab screening tests
- See **Appendix 2** for details on supplemental data submissions
- Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**

Best Practices and Tips

- Complete glucose or HBA1c screening tests annually for members on antipsychotic medications
- Be aware that telehealth visits are used to identify members with schizophrenia or bipolar disorder
- When managing members with schizophrenia or bipolar disorder, consider:
  - the normal range and goal for the diabetes screening test
  - utilizing practice workflows
  - empowering members with tools
  - making non-pharmacologic therapy a core to your care planning
  - listening to your patient's experience
  - evaluating barriers such as social determinants of health

Measure Definition for Diabetes Screening for People with Schizophrenia/ Bipolar Disorder and on Antipsychotic Medications			
Denominator	Numerator	Exclusions	Product Lines
Members 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication during the measurement year	Members in the denominator with a glucose test or HbA1c test performed in the measurement year	■ Members in hospice care any time during the measurement year ■ Members with diabetes ■ Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior	■ Medicaid ■ HARP

Follow-Up After Emergency Department Visit for Mental Illness (FUM)*

Description: The percentage of emergency department (ED) visits for members six 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 (31 total days).
2. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

How to Achieve This Measure and Close This Opportunity

Discharging Providers:

1. Check Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database for member's utilization history and existing physical and behavioral health providers to connect the member to post-discharge care- **psyckesmedicaid.omh.ny.gov/cleartrust/ct_logon.jsp?CTAuthMode=SECURID&language=en**.
   PSYCKES also contains information on if the member has an ACT team and/or is Health Home enrolled.
2. Schedule follow-up appointment within seven days of discharge. Encourage appointments on the day of discharge. Possible options for follow-up visit include:
   - Same-day visit in hospital clinic (no limitations on type of provider who can conduct the follow-up visit)
   - Primary care physician
   - Mobile mental health team
   - Telehealth visit with Behavioral Health or Mental Health practitioner
3. Send discharge plan to provider conducting follow-up visit via secure message/fax

Providers conducting follow-up visit:

1. Document visits with value set codes found in the **2021 HEDIS Code Book**
2. Connect member to psychiatrist/mental health practitioner if needed

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Follow-up After Emergency Department Visit for Mental Illness			
Denominator	Numerator	Exclusions	Product Lines
Members 6 years of age and older with ED visits with a principal diagnosis of mental illness or intentional self-harm. The denominator for this measure is based on ED visits, not members. If members have more than one ED visit, all eligible ED visits on or between January 1 and December 1 (no more than one visit per 31-day period) in the measurement year will be included	Members in the denominator who received a follow-up visit with any practitioner with principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder. Two rates are reported: 1. Follow-up visit within 30 days (31 total days). 2. Follow-up visit within 7 days (8 total days).	Members in hospice are excluded from the eligible population	■ Medicaid ■ Medicare ■ HARP ■ EP ■ HFIC

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*

Description: 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 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 (31 total days).
2. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

How to Achieve This Measure and Close This Opportunity

Discharging Providers:

1. Check Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database for member's utilization history and existing physical and behavioral health providers to connect the member to post-discharge care. **psyckesmedicaid.omh.ny.gov/cleartrust/ct_logon.jsp?CTAuthMode=SECURID&language=en**. PSYCKES also contains information on if the member has an ACT team and/or is Health Home enrolled.
2. If member was in Emergency Department for alcohol or other drug use, collect member's written consent to share substance use information with other providers.
3. Schedule follow-up appointment within seven days of discharge. Encourage appointments on the day of discharge. Possible options for follow-up visit include:
   - Same-day visit in hospital clinic (no limitations on type of provider who can conduct the follow-up visit)
   - Primary care physician
   - Mobile mental health team
   - Telehealth visit with Behavioral Health or Mental Health practitioner
   - Send discharge plan to provider conducting follow-up visit via secure message/fax

Providers conducting follow-up visit:

1. Document visits with value set codes found in the **2021 HEDIS Code Book**
2. Connect member to psychiatrist/mental health practitioner if needed

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence			
Denominator	Numerator	Exclusions	Product Lines
Members 13 years of age and older with ED visits with a principal diagnosis of alcohol or other drug (AOD) dependence. The denominator for this measure is based on ED visits, not members. If members have more than one ED visit for AOD, all ED visits on or between January 1 and December 1 (no more than one visit per 31-day period) in the measurement year will be included	Members in the denominator who received a follow-up visit with any practitioner with with a principal diagnosis of AOD. Two rates are reported: 1. Follow-up visit within 30 days (31 total days). 2. Follow-up visit within 7 days (8 total days).	Members in hospice are excluded from the eligible population	■ Medicaid ■ Medicare ■ HARP ■ EP ■ HFIC

Viral Load Suppression*

Description: Members who are confirmed HIV-positive, whose most recent HIV viral load test had a result of less than 200 copies/mL during the measurement year.

Measure Definition for Viral Load Suppression			
Denominator	Numerator	Exclusions	Product Lines
Members two years of age and older who are confirmed HIV-positive through a match with the HIV Surveillance System.	Members with a HIV viral load less than 200 copies/mL for the most recent HIV viral load test during the measurement year.	None	■ Medicaid ■ HARP ■ EP ■ QHP

Best Practices and Tips

- Use EMR trigger reminders for viral load testing
- Offer member education resources

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Centers for Medicare and Medicaid Services Part D Medication Adherence Measure

Medication Adherence Measures (ADH)*

Description: Members who are taking cholesterol (statins), hypertension (RAS antagonists), and/or diabetes (non-insulin) medications should fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking the medication.

TIP: Prescribe 90-day fills for members on cholesterol, hypertension, and/or diabetes medications. Refer members with adherence barriers and concerns to the Healthfirst MedConnect Program at 1-844-850-9386.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated weekly
- Note that this measure is based entirely on dispensed pharmacy claims, so there is no opportunity for supplemental data or claims/encounter submissions
- See the **Adherence Medications** table for a list of medications in each targeted drug class
  - Diabetes meds, excluding insulin
  - Cholesterol meds
  - Hypertension meds

Best Practices and Tips

- Set your electronic medical record to a 90-day supply
- Review reports on your patients' last date of refill and remaining refill amounts in the Healthfirst Quality APP on a biweekly basis
- Discuss outreach opportunities with pharmacies that serve patients of yours who have low medication adherence
- Schedule a follow-up appointment with patients to check in on their medication regimens and ensure they have enough refills to last until the next appointment date
- Reach out to pharmacies to check on patients who may not have picked up their medications after their appointments
- Talk to your patients about their chronic condition and the importance of adhering to their medication
- Ensure your patients have medication refills

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

- Discuss free resources that can help your patients resolve issues that may affect their adherence (e.g., cost, transportation, education)
- Educate your patients on reminder techniques such as pill boxes, alarms, and apps

Resources

- Healthfirst MedConnect: Free service that can help connect your patients to pharmacy technicians who can provide medication education, refill reminders, schedule appointments with providers, and set up medication pickups and deliveries. Call **1-844-850-9386**.
- My Advocate™: Free service to help your patients enroll in federal, state, and local social programs that offer qualified members discounts for expenses such as Medicare Part B premiums, Medicare Part D prescription drug premiums, copays, and more. Call **1-866-294-6043**.
- Elderly Pharmaceutical Insurance Coverage (EPIC) Program: Free program that helps qualified Medicare members with Medicare Part D drug costs. Call **1-800-332-3742**.
- CVS Caremark: Free home deliveries available. To set up mail-order prescriptions through CVS Caremark, e-prescribe to:

  CVS Caremark Mail Order Pharmacy
  9501 E. Shea Blvd.
  Scottsdale, AZ 85260
  Phone: (877) 864-7744 | Fax: (800) 378-0323
  Pharmacy NABP or NCPDP#: 0322038

  Once prescriptions are received, CVS Caremark will call first-time users of the service to set up their account. Should patients have any questions, they can contact CVS Caremark directly at **1-800-552-8159**.
- Community pharmacy enhanced services networks (CPESN) is a group of independent pharmacies that offer enhanced medication adherence services for patients. To find a pharmacy near you, visit **collaboration.cpesn.com/finder**.
- Medly offers same-day free delivery. Text or call **1-800-620-2561** or visit **healthfirst.medlypharmacy.com**.
- Capsule offers same day-free delivery with limitations depending on distance. Ask your provider or call **1-212-675-3900**.
- ExactCare® offers free, mailed blister packaging services and medication assessments over the phone. Call **1-877-355-7225**.
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Medication Adherence" or click **here**.

Measure Definition for Medication Adherence Measures			
Denominator	**Numerator**	**Exclusions**	**Product Lines**
Medicare members with conditions of Cholesterol, Hypertension, and Diabetes and have at least two unique fills within each targeted drug class in order to be included in the measure Targeted Drug Classes: ■ Diabetes meds: ● Biguanides ● Sulfonylureas ● Thiazolidinediones ● DPP-IV inhibitors ● Incretin mimetics ● Meglitinides ● SGLT2 inhibitors ■ Cholesterol (Statin) meds ■ Hypertension (RAS Antagonist) meds	Number of members in the denominator who have a proportion of days covered (PDC) of 80% or higher for the targeted drug classes Three separate rates are calculated, one for each targeted drug class PDC Calculation: 1. Determine the number of days between the first fill of the medication during the measurement period and the end of the measurement period. End of measurement period is defined as end of enrollment period, death, or measurement period end date. 2. Determine the number of days covered by the prescription fills during the denominator period. Use the prescriptions' date of service and days' supply to count the number of days the patient was "covered" by at least one drug within the targeted drug class(es). Adjust for overlapping drug fills. 3. Calculate the PDC by dividing the number of covered days found in Step 2 by the number of measurement period days found in Step 1.	■ Members who have one or more prescriptions for insulin are excluded from the Diabetes Adherence denominator ■ Members with an ESRD diagnosis during the measurement period are excluded from the Diabetes and Hypertension (RAS Antagonists) Adherence denominators ■ Members with a first fill of medication 90 days before the end of the measurement period ■ Members who have one or more prescriptions for sacubitril/valsartan are excluded from the RAS Antagonists denominator	■ Medicare

Based on the PQA Adherence Measures.

Medication Adherence Medications		
Medication Adherence – Diabetes Medications	Non-Insulin Diabetes Medications	**Biguanides** metformin **Sulfonylureas** chlorpropamide glimepiride (+/- pioglitazone) glipizide (+/- metformin) glyburide (+/- metformin) tolazamide tolbutamide **Thiazolidinediones** pioglitazone (+/- alogliptin, glimepiride, metformin) rosiglitazone (+/- metformin) **DPP-4 Inhibitors** alogliptin (+/- metformin, pioglitazone) linagliptin (+/- empagliflozin, metformin) saxagliptin (+/- metformin, dapagliflozin) sitagliptin (+/- metformin, simvastatin) **Incretin Mimetics** albiglutide dulaglutide exenatide liraglutide lixisenatide semaglutide **Meglitinides** nateglinide repaglinide (+/- metformin) **Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors** canagliflozin (+/- metformin) dapagliflozin (+/- metformin, saxagliptin) empagliflozin (+/- metformin, linagliptin) ertugliflozin (+/- sitagliptin, metformin)

Medication Adherence Medications		
Medication Adherence – Hypertension Medications	RAS Antagonists	**ARBs** azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlopdipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide nebivolol) **ACE Inhibitors** benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) **Direct Renin Inhibitor** aliskiren (+/- amlodipine, hydrochlorothiazide)
Medication Adherence – Cholesterol Medications	Statin Medications	atorvastatin (+/- amlodipine, ezetimibe) fluvastatin lovastatin (+/- niacin) pitavastatin pravastatin rosuvastatin simvastatin (+/-ezetimibe, niacin, sitagliptin)

Efficiency Measures

90-Day Fills for Adherence Medications*

Description: The overall percentage of pharmacy claims filled for medication adherence measure drugs that are dispensed as 90-day fills.

TIP: 90-day prescriptions can lead to better medication adherence.

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated weekly
- Note that this measure is based entirely on dispensed pharmacy claims, so there is no opportunity for supplemental data or claims/encounter submissions
- See the **Adherence Medications** table for a list of medications in each targeted drug class
  - Diabetes meds, excluding insulin
  - Cholesterol meds
  - Hypertension meds

Best Practices and Tips

- Set your electronic medical record to a 90-day supply
- Review reports on your patients' last date of refill and remaining refill amounts in the Healthfirst Quality APP on a weekly basis
- Many members who receive Extra Help can save money on copays when switching to a 90-day supply

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Resources

- Healthfirst MedConnect: Free service that can help connect your patients to pharmacy technicians who can provide medication education, refill reminders, schedule appointments with providers, and set up medication pickups and deliveries. Call **1-844-850-9386**.
- My Advocate™: Free service to help your patients enroll in federal, state, and local social programs that offer qualified members discounts for expenses such as Medicare Part B premiums, Medicare Part D prescription drug premiums, copays, and more. Call **1-866-294-6043**.
- Elderly Pharmaceutical Insurance Coverage (EPIC) Program: Free program that helps qualified Medicare members with Medicare Part D drug costs. Call **1-800-332-3742**.
- CVS Caremark: Free home deliveries available. To set up mail-order prescriptions through CVS Caremark, e-prescribe to:

  CVS Caremark Mail Order Pharmacy
  9501 E. Shea Blvd.
  Scottsdale, AZ 85260
  Phone: (877) 864-7744 | Fax: (800) 378-0323
  Pharmacy NABP or NCPDP#: 0322038

Once prescriptions are received, CVS Caremark will call first-time users of the service to set up their account. Should patients have any questions, they can contact CVS Caremark directly at **1-800-552-8159**.

- Medly offers same-day free delivery. Text or call 1-800-620-2561 or visit **healthfirst.medlypharmacy.com**.
- Capsule offers same-day free delivery with limitations depending on distance. Call **1-212-675-3900**.
- Community pharmacy enhanced services networks (CPESN) is a group of independent pharmacies that offer enhanced medication adherence services for patients. To find a pharmacy near you, visit **collaboration.cpesn.com/finder**.
- ExactCare® offers free, mailed blister packaging services and medication assessments over the phone. Call **1-877-355-7225**.
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Medication Adherence" or click **here**.

Measure Definition for 90-Day Prescriptions			
Denominator	Numerator	Exclusions	Product Lines
Total number of pharmacy claims filled by members in medication adherence measure denominators	Out of the denominator, the total number of pharmacy claims that are filled for 84 days or more	None	■ Medicare

Formulary Compliance Rate*

Description: The overall percentage of pharmacy claims filled that are on formulary.

TIP: Prescribe generics when possible, as many generic and low-cost brand-name options offer similar efficacy and safety.

Best Practices and Tips

- **Prescribe generics when possible.** Most drug classes have multiple generic and low-cost brand-name options. These options offer similar efficacy and safety at a lower price. All formularies include generic drugs, and generics are typically in the lowest tier of pricing for members.
- **Implement real-time prescription benefit checks into your EHR.** Using a real-time benefits checker, a prescriber can see the formulary status and pricing information of a drug for a patient and receive alternative medication choices that may have preferred formulary status or incur lower cost to the patient.

Resources

- Visit **healthfirst.org/formularies** and go to the Medicare Plans section.

Measure Definition for Formulary Compliance Rate

Denominator	Numerator	Exclusions	Product Lines
Total number of pharmacy claims filled by members that are written by a provider in the practice for members attributed to the practice	Out of the denominator, the total number of pharmacy claims filled that are on formulary	None	■ Medicare

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Telehealth Privileging

Description: Providers who offer telemedicine on a HIPAA-compliant platform are approved and properly privileged by Healthfirst to provide telehealth services (post state of emergency).

Resources:

- Utilize resources, key updates, and information in the Telehealth resources section at **hfproviders.org** or by **clicking here**.

Please reach out to your Healthfirst Network Account Manager to initiate the formal privileging process.

Measure Definition for Telehealth Privileging			
Denominator	Numerator	Exclusions	Product Lines
Number of unique practices/providers in the organization	Number of unique practices privileged/ providers accessible through telehealth in the organization	None	All excluding Senior Health Partners

Preventable Admission Measures

Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Description: Members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit (8 total days).

How to Achieve This Measure and Close This Care Opportunity

- Use the Healthfirst Quality APP to view open care opportunities; data is updated monthly
  - Send claims to Healthfirst for visits that meet the criteria
  - Search by acronym for codes and descriptions in the **2021 HEDIS Code Book**
- Schedule follow-up appointment within seven (7) days of discharge. Encourage appointments on the day of discharge. Possible options for follow-up visit include:
  - Same-day visit in hospital clinic
  - Primary care physician
  - Mobile mental health team
  - Telehealth visit
- Send discharge plan to provider conducting follow-up visit via secure message/fax

Providers conducting follow-up visit should document visits with value set codes found in the **2021 HEDIS Code Book**.

Measure Definition for Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Denominator	Numerator	Exclusions	Product Lines
An ED visit on or between January 1 and December 24 of the measurement year where the member was 18 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members.	The 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 seven days of the ED visit (eight total days). The following meet criteria for follow-up: ■ An outpatient visit ■ A telephone visit ■ Case management visits ■ An observation visit ■ An e-visit or virtual check-in	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within seven days after the ED visit, regardless of the principal diagnosis for admission.	■ Medicare ■ Medicaid ■ HARP ■ EP

Hospital Inpatient Prevention Quality Indicators – Adults (PQI)*

Description: High-quality outpatient care should prevent avoidable hospital admissions for adult members due to the following:

- Asthma
- Bacterial Pneumonia
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes (Short-Term or Long-Term Complications, Uncontrolled Diabetes, or Lower-Extremity Amputation)
- Hypertension (HTN)
- Heart Failure (HF)
- Urinary Tract Infection (UTI)

TIP: Members with these conditions and a recent ED visit or admission should be seen within 30 days of discharge. Consider quarterly appointments to ensure the condition is managed, the care plan is working, and medication adherence is consistent.

Best Practices and Tips

- Set up a quarterly appointment tracking for members with these conditions
- See members within 30 days of a change in health status
- Recommend mail-order or home-delivery service to members who have trouble getting to their pharmacy
- Promote smoking cessation programs
- To help keep conditions managed, collaborate with pharmacists, especially those who are participating in Healthfirst's Pharmacy Quality Incentive Program

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Hospital Inpatient Prevention Quality Indicators – Pediatrics (PDI)*

Description: High-quality outpatient care should prevent avoidable hospital admissions for pediatric members due to the following:

- Asthma
- Diabetes
- Gastroenteritis
- Urinary Tract Infection (UTI)

TIP: Members with these conditions and a recent ED visit or admission should be seen within 30 days of discharge. Consider quarterly appointments to ensure the condition is managed, the care plan is working, and medication adherence is consistent.

Best Practices and Tips

- Set up a quarterly appointment tracking for members with these conditions
- See members within one week of a change in health status
- Recommend mail-order or home-delivery service to members who have trouble getting to their pharmacy
- Refer parents or guardians of members with asthma to the Healthfirst Pediatric Asthma Care Management team
- Consultation with an asthma specialist is highly recommended for any child with an ER visit or hospitalization for asthma
- To keep conditions managed, collaborate with pharmacists, especially those who are participating in Healthfirst's Pharmacy Quality Incentive Program

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Asthma" or "Diabetes Care" or click **here**.
- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Readmission Reduction" or click **here**.

** 2021 incentive measure. Not all of these measures will apply to all providers. Please check the HQIP Program Guide and other Healthfirst communications for details on applicable measures.*

Measure Definition for Hospital Inpatient Prevention Quality Indicators – Pediatrics			
Denominator	Numerator	Exclusions	Product Lines
Members 6–17 years of age	Members in the denominator who had an inpatient admission for one of the following: ■ Asthma ■ Diabetes Short-Term Complications ■ Gastroenteritis ■ Urinary Tract Infection (UTI) Note: Observation stays are not included in the numerator. Members leaving the hospital against medical advice are included in the numerator.	■ Obstetric admissions ■ Transfers from other inpatient facilities ■ Condition-specific exclusions: ● Asthma = with cystic fibrosis and respiratory anomalies ● Gastroenteritis = with gastrointestinal abnormalities or with bacterial gastroenteritis ● UTI = with kidney/urinary tract disorder, or with high or intermediate immuno-compromised state, or with transplant, or with hepatic failure or cirrhosis	■ Medicaid

Based on AHRQ Quality Indicators™, Version 2019.

Plan All-Cause Readmissions (PCR)

Description: Adults 18+ years of age who had an acute inpatient and observation stay should not be readmitted within 30 days.

> **TIP:** Call members within two days of discharge and schedule follow-up visits within three to five days of discharge to help prevent readmissions.

How to Achieve This Measure and Close This Care Opportunity

- Call members within two days of discharge to discuss any questions they might have with:
  - Discharge instructions, including review and reconciliation of their medications
  - Filling their discharge medications
  - Scheduling follow-up appointments (best practice is within three to five days of discharge)
  - Arranging transportation for appointments
- During the post-discharge follow-up visit:
  - Ask what factors led to hospitalization
  - Reconcile discharge medications with current outpatient regimen; give copy of medication reconciliation to patient
  - Determine the need for follow-up care (med changes, testing, appointments)
  - Instruct patient in self-management; have patient repeat back and write down instructions
  - Ensure the next appointment is made, as appropriate

Best Practices and Tips

- Ensure all patients with multiple conditions are visiting your office routinely (e.g., quarterly)
- At each visit, review their condition and preventive screenings to prevent unplanned admissions:
- The clinical goal and care plan
- Utilize practice workflows
- Empower members with self- management tools
- Make non-pharmacologic therapy a core to your care planning
- Listen to your member's experience
- Evaluate barriers such as social determinants of health

Resources

- Utilize the Quality Program Resources at **hfproviders.org**. Be sure to select the filter for "Readmission Reduction" or click **here**.

Measure Definition for Plan All-Cause Readmissions			
Denominator	Numerator	Exclusions	Product Lines
Acute inpatient or observation stay discharges between January 1 and December 1 of the measurement year for members 18 years of age and older For discharges with acute-to-acute direct transfers, only the final discharge is included in the measure Note that the denominator is based on discharges, not members	Discharges in the denominator with an unplanned acute readmission within 30 days for any diagnosis Two rates are reported: an observed score and a risk-adjusted expected score Note that a lower rate indicates a better score Note: Observation stays are included in the numerator. Members leaving the hospital against medical advice are not included in the numerator.	■ Members who died during the inpatient stay ■ Female members with a principal diagnosis of pregnancy on the discharge claim ■ A principal diagnosis of a condition originating in the perinatal period on the discharge claim ■ Planned readmissions defined as: ● Principal diagnosis of maintenance chemotherapy or rehabilitation ● Organ transplant ● Potentially planned procedure without a principal acute diagnosis	■ Medicare ■ Medicaid ■ EP ■ QHP ■ HARP

Based on HEDIS® 2021. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Patient Satisfaction

You can improve your patients' experience by achieving several key measures. Ensuring your patients' satisfaction will also help improve your performance in the Healthfirst Quality Incentive Program (HQIP).

Access to Care and Appointment Availability (ACAA)

Description: Members scheduling an appointment should be offered visits within the following time frames:

- Routine visit appointments within four weeks for primary care providers or obstetrician-gynecologist (Ob/Gyns) and within six weeks for specialists
- Non-urgent "sick" visit appointments within 72 hours

> **TIP:** Train your office staff on the ACAA standards. Perform your own secret shopper calls to prepare for the ACAA audit.

How to Achieve This Measure and Pass the ACAA Audit

Healthfirst conducts ACAA audits using a "secret shopper" approach. Healthfirst staff will call and attempt to schedule a new patient appointment as if they were a member. At the end of the call, the auditor will identify themselves as Healthfirst staff to ensure a formal appointment is not scheduled.
Please note that audits have been placed on hold due to the continuing surge in COVID cases.
Each quarter, Healthfirst will assess the feasibility of re-starting audits for 2021. If/when audits begin, Healthfirst will notify all provider partners.

To pass this audit, during the audit call providers are required to:

- Acknowledge participation with Healthfirst for Medicare and/or Medicaid lines of business
- Give Healthfirst the correct phone number for making appointments, and make sure the phone is answered by a person during normal business hours.
- Provide the caller with a routine appointment within four weeks (six weeks for specialists) or a non-urgent "sick" visit appointment within 72 hours
- Make sure there are no restrictive barriers before scheduling an appointment

Reasons for audit failure:

- Wrong telephone number or number is not in service
- Unanswered phone calls or persistent busy signals
- Hold times longer than five minutes
- Answering service picks up during normal business hours

Barriers to pay attention to:

- Saying you do not accept Healthfirst insurance
- Requiring members to complete a questionnaire or full registration forms before providing appointment availability

The Healthfirst access and availability standards are outlined in the **Appointment Availability and 24-Hour Access Standards Appendix of the Healthfirst Provider Manual**. If you would like to dispute the results of the ACAA audit, please contact **HFProvider_Audits@Healthfirst.org** within the time frames.

Measure Definition for Access to Care and Appointment Availability			
Denominator	Numerator	Exclusions	Product Lines
Number of provider locations that qualify for the audit Note: Healthfirst uses a statistical methodology to determine sample sizes for the number of calls for each provider's ACAA audit. The sample considers both the type of specialty being audited and location in the provider directory at the time the sample is pulled.	Based on the number of provider locations pulled from the sample and audited for compliance The audited appointment time frames are: ■ Routine visit within four weeks (PCP or Ob/Gyn) or within six weeks (specialist) ■ Non-urgent "sick" visit within 72 hours	■ Providers who are not listed in the directory at the time the sample is pulled ■ PCPs who have a closed panel	■ Medicare ■ Medicaid

Based on **Healthfirst Provider Manual, Appointment Availability and 24-Hour Access Standards Appendix.**

CAHPS® Measures

Your patient's experience is often measured by using a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Patients receive this survey annually between March and June. The survey assesses patients' experiences with access to care, prescription medications, and care coordination.

Annual Flu Vaccine

CAHPS Survey Question to Patient: Have you had a flu shot since July 1?

Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death. Some people, such as older people, young children, and people with certain health conditions, are at high risk of serious flu complications.

The best available protection is an annual influenza vaccination for all patients six months old and older. It is recommended that patients are vaccinated each year.

Best Practices and Tips

- Administer flu shot as soon as it's available each fall
- Recommend flu vaccine where clinically appropriate
- Eliminate barriers to accessing flu shots and offer multiple options for patients to get their shot (walk-in appointments, flu shot clinics, making flu shots available at every appointment)
- Recommended flu vaccination period: Annually, August–December

Products: All lines of business

Resources

- **CDC Flu Vaccine Information**

Getting Needed Care

CAHPS Survey Questions to Patient:

- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often was it easy to get the care, tests, or treatment you needed?

Products: All lines of business

Getting Care Quickly

CAHPS Survey Questions to Patient:

- In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
- In the last six months, how often did you get an appointment for a checkup or routine care at a doctor's office or clinic as soon as you needed?

Products: All lines of business

Care Coordination

CAHPS Survey Questions to Patient:

- 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?
- In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them?
- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Product: Medicare

Best Practices and Tips to Improve CAHPS Measures

Checklist for CAHPS Success

Here are ways you can improve your patients' experience and help with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Actions To Take	
 **Before Appointments**	☐ Offer convenient appointment times by keeping blocks of time open for same-day, weekend, and early morning/evening slots.
	☐ Consider offering telehealth service (by phone or video chat) as an alternative to in-person appointments.
	☐ Confirm appointments with patients one day prior to visit by text message, a live call, or an automated call messaging system.
	☐ Provide options for registering in advance either by a patient portal or set up an online scheduling system so patients can provide their information before coming in.
	☐ Have patients' records ready and reviewed, and obtain any prior authorizations ahead of visit to expedite care.
	☐ Notify patients early if long wait times are expected or if there are any last-minute requests for lab work.
 **During Appointments**	☐ Do your best to see patients within 15 minutes of their appointment time.
	☐ Recommend flu vaccination for patients six months old and older to protect against the flu season (August to December) each year
	☐ Address patient questions and concerns about the flu vaccine, including side effects, safety, and vaccine effectiveness, in plain and easy-to-understand language
	☐ Review patients' prescriptions, make sure they understand the importance of their medications, and alert them to any possible adverse drug interactions.
	☐ Communicate when patients' test results will be available and set reminders to review results with patients in a timely manner.
	☐ Ask patients if they have any questions or concerns regarding their care.
 **End of Appointments**	☐ Immediately schedule patients' follow-up appointments to ensure continuous care.
	☐ Account for specialist care by making sure specialist appointments were made or help patients schedule appointments if needed.
	☐ Encourage patients to use the patient portal, which lets them access their health records and ask providers questions.
	☐ Share health records with patients' other providers to keep everyone up-to-date.

Healthfirst After-Visit Survey

Healthfirst relies on our providers to ensure our members receive top-quality care. In December 2020 Healthfirst launched the Healthfirst After-Visit Survey to obtain visit and provider-specific feedback from our members about their experience, including their experience with appointment scheduling, wait time, and coordination of care. Ensuring your patients' satisfaction in these areas will help improve Healthfirst's performance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Surveys are triggered by daily claims data received by Healthfirst. Only claims ≤ 60 days from date of service are considered. An individual will be outreached only three times per year. All adult (18+) members, except for CHP and SHP enrollees, are eligible to receive a telephonic survey after they visit a primary care provider (PCP) or specialist in the office, urgent care center, clinic, home, or via telehealth. Below are details of each After-Visit Survey question and associated best practices.

Measure Name: Likelihood to Recommend (Net Promoter Score)

- Question: how likely is it that you would recommend this healthcare provider to a friend or family member?
  - 1 to 5, where '1' is not at all likely and '5' is extremely likely
- Scoring Methodology: (Number of Promoters — Number of Detractors) / (Number of Respondents) x 100; where:
  - 1 to 3 = Detractors
  - 4 = Passives
  - 5 = Promoters

  Example: If you received 100 responses to your survey:
  10 responses were in the 1 to 3 range (Detractors)
  20 responses were in the 4 range (Passives)
  70 responses were in the 5 range (Promoters)

  Subtract 10 (Detractors) from 70 (Promoters), which equals 60. Then divide 60 by 100, which equals 0.6. Finally, multiply 0.6 by 100, which equals 60%. Since an example Net Promoter Score is always shown as just an integer and not a percentage, your NPS is simply 60. (And yes, you can have a negative NPS, as your score can range from -100 to +100.)
- Products: Medicaid, Medicare, Essential Plan, Qualified Health Plan, and HFIC
- Provider Type: PCP and Specialists
- Best practices:
  - Offer convenient appointment times by keeping blocks of time open for same-day, weekend, and early morning/evening slots.
  - Consider offering telemedicine service (by phone or video chat) as an alternative to in-person appointments.
  - Immediately schedule patients' follow-up appointments to ensure continuous care.
  - Do your best to see patients within 15 minutes of their appointment time.

- Have patients' records ready and reviewed and obtain any prior authorizations ahead of visit to expedite care.
- Confirm appointments with patients one day prior to visit by text message, a live call, or an automated call messaging system.
- Provide options for registering in advance either by a patient portal or set up an online scheduling system so patients can provide their information before coming in.
- Notify patients early if long wait times are expected.
- Review patients' prescriptions; make sure they understand the importance of their medications, and alert them to any possible adverse drug interactions.
- Communicate when patients' test results will be available and set reminders to review results with patients in a timely manner.
- Account for specialist care by making sure specialist appointments were made or help patients schedule appointments if needed.
- Share health records with patients' other providers to keep everyone up to date.
- Ask patients if they have any questions or concerns regarding their care.

Measure Name: Ease of scheduling appointment

- Question: how easy or difficult was it to schedule your appointment?
  - 1 to 5, where '1' is very difficult and '5' is very easy
- Scoring Methodology: (Sum of Responses) / (Number of Respondents)
- Products: Medicaid, Medicare, Essential Plan, Qualified Health Plan, and HFIC
- Provider Type: PCPs and Specialists
- Best practices:
  - Offer convenient appointment times by keeping blocks of time open for same-day, weekend, and early morning/evening slots.
  - Consider offering telemedicine service (by phone or video chat) as an alternative to in-person appointments.
  - Immediately schedule patients' follow-up appointments to ensure continuous care.

Measure Name: Appointment convenience

- Question: Was your appointment time convenient for you?
  - Yes
  - No
  - I do not know

- Scoring Methodology:
  - Numerator: # Respondents answering "Yes"
  - Denominator: # Respondents answering "Yes" or "No"
  - Denominator Exclusions: Respondents answering "I do not know"
- Products: Medicaid, Medicare, Essential Plan, Qualified Health Plan, and HFIC
- Provider Type: PCPs and Specialists
- Best practices:
  - Offer convenient appointment times by keeping blocks of time open for same-day, weekend, and early morning/evening slots.
  - Consider offering telemedicine service (by phone or video chat) as an alternative to in-person appointments.
  - Immediately schedule patients' follow-up appointments to ensure continuous care.

Measure Name: Wait time

- Description: How long did you wait to see your healthcare provider after your scheduled appointment time?
  - Under 15 minutes
  - Over 15 minutes
  - I do not know
- Scoring Methodology
  - Numerator: # Respondents answering "Under 15 Minutes"
  - Denominator: # Respondents answering "Under 15 Minutes" or "Over 15 Minutes"
  - Denominator Exclusions: Respondents answering "I do not know"
- Products: Medicaid, Medicare, Essential Plan, Qualified Health Plan, and HFIC
- Provider Type: PCPs and Specialists
- Best practices:
  - Do your best to see patients within 15 minutes of their appointment time.
  - Have patients' records ready and reviewed; obtain any prior authorizations ahead of visit to expedite care.
  - Confirm appointments with patients one day prior to visit by text message, a live call, or an automated call messaging system.
  - Provide options for registering in advance either by a patient portal or set up an online scheduling system so patients can provide their information before coming in.
  - Notify patients early if long wait times are expected.

Measure Name: Coordination of care

- Description: Was your healthcare provider aware of your test results, medications, and information about other provider visits?
  - Yes
  - No
  - I do not know
  - Not applicable
- Scoring Methodology
  - Numerator: # Respondents answering "Yes"
  - Denominator: # Respondents answering "Yes" or "No"
  - Denominator Exclusions: Respondents answering "I do not know" or "Not Applicable"
- Products: Medicaid, Medicare, Essential Plan, Qualified Health Plan, and HFIC
- Provider Type: PCPs
- Best practices:
  - Have patients' records ready and reviewed ahead of visit to expedite care.
  - Review patients' prescriptions; make sure they understand the importance of their medications, and alert them to any possible adverse drug interactions.
  - Communicate when patients' test results will be available and set reminders to review results with patients in a timely manner.
  - Ask patients if they have any questions or concerns regarding their care.
  - Account for specialist care by making sure specialist appointments were made or help patients schedule appointments if needed.
  - Share health records with patients' other providers to keep everyone up-to-date.

Health Outcomes Survey (HOS)

The Health Outcomes Survey (HOS) is a patient-satisfaction survey that is used by CMS to assess a plan's quality of service and care. The HOS will be administered this year between July and November. Many of the following HOS measures can be improved through telehealth visits and consultations:

- Improving Bladder Control
- Monitoring Physical Activity
- Reducing the Risk of Falling
- Improving and Maintaining Mental Health
- Improving and Maintaining Physical Health

See **Appendix 5** for questions from the HOS.

Improving Bladder Control

This measure assesses whether patients who have had urinary incontinence in the last six (6) months have discussed treatment options with their provider.

Best Practices and Tips

Assess/Discuss	Advise
Broach the subject of urinary incontinence. Patients are often too embarrassed to bring it up themselves. For instance… Ask if the patient currently has, or has had, urine leakage or "accidents" in the past six months. Ask the patient how often the problem occurs. Ask the patient if they're currently receiving any treatment.	Explain that **treatment can improve bladder control and reduce urinary incontinence**. If the patient isn't receiving treatment, **explain their options**, which include many ways to control or manage symptoms, such as bladder training exercises, medicine, or surgery. When necessary, recommend appropriate treatment.

Monitoring Physical Activity

This measure assesses whether a patient has discussed physical activity with their primary care provider (PCP) and whether the PCP gave advice about the patient's level of physical activity.

Best Practices and Tips

Assess/Discuss	Advise
Ask the patient about their level of exercise and physical activity, including: ■ jogging, walking, or swimming. ■ bodyweight exercises or chair exercises. ■ household tasks that require physical exertion.	**Recommend starting, increasing, or maintaining** patient's level of physical activity. Explain the importance of physical activity for ■ muscle strength and balance. ■ reduced risk of falls. ■ mental well-being. ■ healthy aging. **Recommend patient utilize:** ■ SilverSneakers® fitness benefits and features ■ Physical activity programs at local senior. centers/ other community settings

Resources

SilverSneakers is a fitness program benefit for Medicare Advantage plan members, giving them access to more than 16,000 fitness centers and helping them remain active and socially connected. Support is free, and members don't need a referral. For more information, call toll-free: **1-866-584-7389** (TTY 711), Monday to Friday, 8am–8pm EST.

Reducing the Risk of Falling

This measures whether the patient has a problem with falling, walking, or balancing and has discussed it with their PCP and received treatment for it.

Best Practices and Tips

Assess/Discuss	Advise
Assess your patient's risk of falling. Please consider factors related to the patient's: ■ history of falls ■ muscular system issues ■ nervous system issues ■ balance ■ gait ■ vision	If a patient is at **risk of falling**, recommend a preventive course of action, such as: ■ proper use of a cane or walker. ■ exercise or a physical therapy program to improve leg strength and balance. ■ modification of home to make it safer. ■ review of medications. ■ annual vision or hearing tests. **Recommend patient utilize:** ■ NationsHearing benefits and features ■ SilverSneakers benefits and features ■ Physical activity programs at local senior centers/ other community settings

Resources

Hearing loss affects physical health, putting people at risk for falls and disability. Members have access to quality hearing coverage, including no-cost routine hearing exams and hearing aids as low as $0 through NationsHearing. Call **1-877-438-7251**, (TTY 711), Monday to Friday, 8am–8pm, or visit **nationshearing.com/healthfirst** for more information.

See above for more information about SilverSneakers.

Improving or Maintaining Mental Health

This measures whether a patient's mental well-being has declined over a two-year period. Note: data for this measure is collected from patients at two points in time, two years apart.

Best Practices and Tips

Assess/Discuss	Advise
■ Assess patients using a Patient Health Questionnaire-2 (PHQ-2) and, if appropriate, a PHQ-9. ■ Conduct a reconciliation of medication at every visit to ensure the patient is taking medications correctly.	■ For patients experiencing depression or anxiety, talk with them about how they can get help. Consider referring them to a specialist. ■ Discuss and address issues of substance abuse and illegal drug use.

Improving or Maintaining Physical Health

This measures whether a patient's physical health has declined over a two-year period. Note: data for this measure is collected from patients at two points in time, two years apart.

Best Practices and Tips

Assess/Discuss	Advise
■ Assess patients' physical activity level before seeing the PCP (many practices have medical assistants complete this). ■ Use the annual wellness visit to talk with patients about their health, and document changes that have occurred in the past year.	■ Recommend relevant physical activity, and provide educational materials, suggested exercises. and information on fitness programs such as SilverSneakers and other community resources. ■ Refer patients with limited mobility to physical therapy, if appropriate. ■ Assess and address pain issues that patients may be experiencing

Resources

Visit the following websites for more resources on best practices for preventive care for older adults:

- **National Institute on Aging**, nia.nih.gov.
- **National Council on Aging**, ncoa.org.

Appendices

Appendix 1: Glossary of Terms

Term	Description
Care Opportunity	Members in a denominator for an HQIP measure who show in Healthfirst's records as not yet meeting the measure's numerator criteria. For most measures, providers may close a care opportunity by completing a service related to preventive care, chronic care, or care transitions and submitting claims or supplemental data with billing codes that meet the numerator's criteria.
CMS	Centers for Medicare & Medicaid Services (CMS), the federal regulator of Medicare and Medicaid
Denominator	The number of members who meet the criteria for the measure based on the HQIP measure specifications.
Exclusions	Members are excluded from measure denominator if required or optional according to the HQIP measure specifications.
HEDIS®	The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used sets of healthcare performance measures in the United States. HEDIS is a registered trademark of the National Committee for Quality Assurance ("NCQA"). HEDIS is one of healthcare's most widely used performance improvement tools – 184 million people are enrolled in plans that report HEDIS results. HEDIS includes more than 90 measures across six domains of care: ■ Effectiveness of Care, with subsections for: ● Prevention and Screening ● Respiratory and Cardiovascular ● Diabetes, Musculoskeletal, Behavioral ● Medication Management and Care Coordination ● Overuse and Appropriateness ■ Access to/Availability of Care ■ Experience of Care ■ Utilization and Risk Adjusted Utilization ■ Health Plan Descriptive Information ■ Measures Collected Using Electronic Clinical Data Systems ■ See **ncqa.org/hedis/measures/** for more information.
Healthfirst Quality Incentive Program (HQIP)	Since 2010, Healthfirst has used quality incentive programs to align providers and healthcare professionals with the standards of care that will help us reach that shared quality-of-care goal. The HQIP focuses attention on the areas that will improve member health outcomes and elevate our performance as a health plan. By achieving or surpassing the performance goals set in the HQIP, hospitals can earn incentive payments while delivering the superior healthcare and satisfaction to members for which we all strive.
Measurement Year	Unless stated otherwise within the measure description, the measurement year is January 1 through December 31. This 12-month time frame is where data is collected for submission during the reporting year. As an example, for HQIP measures based on HEDIS 2021 specifications, the measurement year is 2019.

Term	Description
National Committee for Quality Assurance (NCQA)	**NCQA** is a private, not-for-profit organization dedicated to improving healthcare quality. NCQA accredits health plans, creates HEDIS performance measures, and coordinates data submissions.
Numerator	The number of members in the denominator who completed a care opportunity based on the HQIP measure specifications.
Performance Measure	An evidence-based, nationally vetted method to measure how good a health plan is at getting its patients good care in certain targeted areas.
Preventable Admissions and Readmissions	Measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions and Readmissions for which Healthfirst is measured by NYSDOH and CMS.
Quality Assurance Reporting Requirements (QARR)	QARR are New York state tools used to measure the performance of health plans and practitioners on important aspects of care and service.
Supplemental Data	Throughout the year, this data could be standard submissions to the plan such as lab files. Supplemental data could also be nonstandard, such as health risk assessment data submitted to the plan.

Appendix 2: Supplemental Data Submissions

Healthfirst accepts supplemental encounter and lab data to help close care opportunities. Supplemental data submissions are accepted in Excel format as well as delimited files. The supplemental encounter and lab data reference guides are available via request to **datasubmit@healthfirst.org**.

Please note that any lab/encounter data submitted is subject to internal Healthfirst audit, in which case supporting medical record documentation must be provided upon request.

Claims and Encounter Submission Deadlines

The deadline to set up a SFTP account for submitting supplemental data is **December 31, 2021**.

For the 2021 HQIP, **February 28, 2022** is the deadline for new claims and lab/encounter data. Claims and lab/encounter data submitted after this date will not be considered when calculating incentive payments.

The deadline for the submission of corrected claims is **February 1, 2022**, which is earlier than the regular claims deadline. Please keep this in mind when submitting claims for correcting previously submitted claims information.

Any claims and lab/encounter data submitted before the deadline not in the file format outlined in the encounter and lab data reference guide will also not be considered. Additionally, Healthfirst will not accept data in the following formats:

- Encounter files for services that need to be submitted/billed to one of our delegated vendors, including DentaQuest and Davis Vision
- Chart documentation or registry (e.g., Citywide Immunization Registry [CIR]) data as proof of service

Appendix 3: Exclusions Reference

<table>
<tr><th>Measure</th><th colspan="2">Exclusion Description</th></tr>
<tr><td rowspan="5">Multiple Measures</td><td colspan="2">Advanced Illness and Frailty Exclusions
Members 66 years of age and older as of December 31 of the measurement year with claims indicating both an advanced illness condition and a frailty condition within the measurement year. Applies to these measures:</td></tr>
<tr><td>■ ART
■ BCS
■ CBP
■ CDC</td><td>■ COL
■ KED
■ OMW
■ SPC</td></tr>
<tr><td colspan="2">Frailty Exclusions
Members 81 years of age and older as of December 31 of the measurement year with claims indicating a frailty condition within the measurement year. Applies to these measures:</td></tr>
<tr><td>■ ART
■ CBP
■ OMW</td><td>■ KED</td></tr>
<tr><td colspan="2">Note that supplemental data may not be used to identify exclusions due to advanced illness or frailty.</td></tr>
<tr><td>Multiple Measures</td><td>Advanced Illness Conditions Include:
■ Alzheimer's disease
■ Chronic kidney disease, stage 5
■ Creutzfeldt-Jakob disease
■ Dementia
■ Emphysema
■ End stage renal disease (ESRD)
■ Heart failure
■ Leukemia that has relapsed or is not in remission
■ Liver failure
■ Liver cirrhosis
■ Pancreatic cancer
■ Parkinson's disease
■ Pulmonary fibrosis
■ Respiratory failure (acute and chronic)
■ Many secondary cancers (that spread from the primary site)</td><td>Frailty Conditions Include:
■ Age-related cognitive decline or physical debility
■ Bed confinement
■ Dependence on ventilator or other life-support machines
■ Falls or a history of falling
■ Need for home nursing care, personal care assistance, or constant supervision
■ Pressure ulcers (bed sores)
■ Use of certain medical supplies or equipment such as:
● Cane
● Commode chair
● Hospital bed
● Supplemental oxygen
● Walker
● Wheelchair
■ Walking difficulties or gait abnormalities</td></tr>
</table>

Measure	Exclusion Description
Multiple measures	**Hospice Exclusion** Most HEDIS measures exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, or claims/encounter data. The hospice exclusion applies to these measures
	■ AAB ■ ABA ■ AMR ■ AWC ■ ADV ■ ART ■ BCS ■ CBP ■ CCS ■ CDC ■ CHL ■ CIS ■ COA ■ COL ■ CWP ■ KED ■ PPC ■ SPC ■ SPR ■ SSD ■ WCC ■ WCV ■ W30
AAB	■ Members in hospice care any time during the measurement year ■ Acute bronchitis episodes are excluded when the member has a diagnosis for a comorbid condition (including HIV, cancer, COPD, cystic fibrosis, emphysema, and immune system disorders) during the 12 months prior to or on the acute bronchitis diagnosis date
ABA	■ Optional exclusion for members pregnant within the measurement year or the year prior
ART	■ Advanced illness and frailty ■ Members with a diagnosis of HIV ■ Female members pregnant during the measurement year
AMR	■ Members diagnosed with other chronic respiratory conditions (including emphysema, COPD, cystic fibrosis, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors) ■ Members diagnosed with acute respiratory failure
BCS	■ Members in hospice care any time during the measurement year ■ Members 66–75 years of age with both frailty and advanced illness ■ Members 66–75 years of age who live long term in an institution or facility ■ Members with absence of both the right and left breasts prior to December 31 (mastectomy)
CBP	■ Members in hospice care any time during the measurement year ■ Members 66–75 years of age with both frailty and advanced illness ■ Members 66–75 years of age who live long term in an institution or facility ■ All members with evidence of ESRD or kidney transplant or receiving dialysis ■ Female members with a diagnosis of pregnancy during the measurement year
CCS	■ Members in hospice care any time during the measurement year ■ Members who had a hysterectomy with no residual cervix any time prior to December 31 of the measurement year
CDC	■ Members in hospice care any time during the measurement year ■ Members 66–75 years of age with both frailty and advanced illness ■ Members 66–75 years of age who live long term in an institution or facility ■ Members who have only gestational or steroid-induced diabetes
CHL	■ Members in hospice care any time during the measurement year ■ A pregnancy test and a prescription for isotretinoin ■ A pregnancy test and an X-ray

Measure	Exclusion Description
CIS	■ Members in hospice care any time during the measurement year ■ Members who had a contraindication for a specific vaccine
COA	■ Members in hospice care any time during the measurement year
COL	■ Members in hospice care any time during the measurement year ■ Members 66–75 years of age with both frailty and advanced illness ■ Members 66–75 years of age who live long term in an institution or facility ■ Members with either colorectal cancer or a total colectomy any time on or prior to December 31 of the measurement year
CWP	■ Members in hospice care any time during the measurement year
IMA	■ Members in hospice care any time during the measurement year ■ Members who had a contraindication for a specific vaccine
KED	■ Members in hospice care any time during the measurement year ■ Members with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year ■ Members receiving palliative care during the measurement year ■ Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: ● Enrolled in an Institutional SNP any time during the measurement year ● Living long-term in an institution any time during the measurement year ■ Members with frailty and advanced illness
Medication Adherence measures	■ Members who have one or more prescriptions for insulin are excluded from the Diabetes Adherence denominator ■ Members with an ESRD diagnosis during the measurement period are excluded from the Diabetes and Hypertension (RAS Antagonists) Adherence denominators ■ Members with a first fill of medication 90 days before the end of the measurement period
MRP	■ Members in hospice care any time during the measurement year
OMW	■ Members in hospice care any time during the measurement year ■ Members 66–80 years of age with both frailty and advanced illness ■ Members 66 years of age and older who live long term in an institution or facility ■ Members 81 years of age and older with frailty ■ Members who had a BMD test within 24 months prior to the fracture ■ Members who were dispensed a drug to treat or prevent osteoporosis within 12 months prior to the fracture ■ Members who are receiving palliative care
PCR	■ Members who died during the inpatient stay ■ Discharges for female members with a principal pregnancy discharge diagnosis ■ Discharges with a perinatal-related principal diagnosis ■ Planned readmissions defined as: ● Principal diagnosis of maintenance chemotherapy or rehabilitation ● Organ transplant ● Potentially planned procedure without a principal acute diagnosis
PDI	■ Obstetric admissions ■ Transfers from other inpatient facilities Condition-specific exclusions: ■ Asthma = with cystic fibrosis and respiratory anomalies ■ Gastroenteritis = with gastrointestinal abnormalities or with bacterial gastroenteritis ■ UTI = with kidney/urinary tract disorder, or with high or intermediate immuno-compromised state, or with transplant, or with hepatic failure or cirrhosis

Measure	Exclusion Description
PQI	■ Obstetric admissions ■ Transfers from other inpatient facilities Condition-specific exclusions: ■ COPD/Asthma = with cystic fibrosis and respiratory anomalies ■ Hypertension = with cardiac procedure or with dialysis access procedure with Stage I–IV kidney disease ■ Heart Failure = with cardiac procedure ■ Pneumonia = with sickle cell anemia or with immuno-compromised state ■ UTI = with kidney/urinary tract disorder or with immuno-compromised state ■ LE Amputation = with traumatic amputation of lower extremity
PPC	■ Members in hospice care any time during the measurement year
SPC	■ Members in hospice care any time during the measurement year ■ Members 66–75 years of age with both frailty and advanced illness ■ Members 66–75 years of age who live long term in an institution or facility ■ Female members with a diagnosis of pregnancy or undergoing in vitro fertilization in the measurement year or the year prior ■ Dispensed a prescription for clomiphene in the measurement year or year prior ■ ESRD or cirrhosis in the measurement year or year prior ■ Myalgia, myositis, myopathy, or rhabdomyolysis in the measurement year
SPR	■ Members in hospice care any time during the measurement year
SSD	■ Members in hospice care any time during the measurement year ■ Members with diabetes
SUPD	■ Members enrolled in hospice during the measurement year ■ Members with ESRD in the measurement year
WCC	■ Members in hospice care any time during the measurement year ■ Female members who have a diagnosis of pregnancy during the measurement year
W30	■ Members in hospice care any time during the measurement year

Appendix 4: Medication Reference

Measure	Medication	Prescription Details
AMR	Asthma Controller Medications	**Antiasthmatic combinations** ■ Dyphylline-guaifenesin **Antibody inhibitors** ■ Omalizumab **Anti-interleukin-5** ■ Benralizumab ■ Mepolizumab ■ Reslizumab **Inhaled steroid combinations** ■ Budesonide-formoterol ■ Fluticasone-salmeterol ■ Fluticasone-vilanterol ■ Mometasone-formoterol ■ Inhaled corticosteroids **Leukotriene modifiers** ■ Montelukast ■ Zafirlukast ■ Zileuton **Methylxanthines** ■ Theophylline
AMR	Asthma Reliever Medications	■ Albuterol ■ Levalbuterol

Measure	Medication	Prescription Details
ART	DMARD Medications	**5-Aminosalicylates** ■ Sulfasalazine **Alkylating agents** ■ Cyclophosphamide **Aminoquinolines** ■ Hydroxychloroquine **Anti-rheumatics** ■ Auranofin ■ Leflunomide ■ Methotrexate ■ Penicillamine **Immunomodulators** ■ Abatacept ■ Adalimumab ■ Anakinra ■ Certolizumab ■ Certolizumab pegol ■ Etanercept ■ Golimumab ■ Infliximab ■ Rituximab ■ Sarilumab ■ Tocilizumab **Immunosuppressive agents** ■ Azathioprine ■ Cyclosporine ■ Mycophenolate **Janus kinase (JAK) inhibitor** ■ Baricitnib ■ Tofacitinib **Tetracyclines** ■ Minocycline

Measure	Medication	Prescription Details
Medication Adherence – Diabetes Medications	Non-Insulin Diabetes Medications	**Biguanides** ■ metformin **Sulfonylureas** ■ chlorpropamide ■ glimepiride (+/- pioglitazone) ■ glipizide (+/- metformin) ■ glyburide (+/- metformin) ■ tolazamide ■ tolbutamide **Thiazolidinediones** ■ pioglitazone (+/- alogliptin, glimepiride, metformin) ■ rosiglitazone (+/- metformin) **DPP-4 Inhibitors** ■ alogliptin (+/- metformin, pioglitazone) ■ linagliptin (+/- empagliflozin, metformin) ■ saxagliptin (+/- metformin, dapagliflozin) ■ sitagliptin (+/- metformin, simvastatin) **Incretin Mimetics** ■ albiglutide ■ dulaglutide ■ exenatide ■ liraglutide ■ lixisenatide ■ semaglutide **Meglitinides** ■ nateglinide ■ repaglinide (+/--metformin) **Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors** ■ canagliflozin (+/-- metformin) ■ dapagliflozin (+/- metformin, saxagliptin) ■ empagliflozin (+/- metformin, linagliptin) ■ ertugliflozin (+/- sitagliptin, metformin)

Measure	Medication	Prescription Details
Medication Adherence – Hypertension Medications	RAS Antagonists	**ARBs** ■ azilsartan (+/- chlorthalidone) ■ candesartan (+/- hydrochlorothiazide) ■ eprosartan (+/- hydrochlorothiazide) ■ irbesartan (+/- hydrochlorothiazide) ■ losartan (+/- hydrochlorothiazide) ■ olmesartan (+/- amlodipine, hydrochlorothiazide) ■ telmisartan (+/- amlopdipine, hydrochlorothiazide) ■ valsartan (+/- amlodipine, hydrochlorothiazide nebivolol) **ACE Inhibitors** ■ benazepril (+/- amlodipine, hydrochlorothiazide) ■ captopril (+/- hydrochlorothiazide) ■ enalapril (+/- hydrochlorothiazide) ■ fosinopril (+/- hydrochlorothiazide) ■ lisinopril (+/- hydrochlorothiazide) ■ moexipril (+/- hydrochlorothiazide) ■ perindopril (+/- amlodipine) ■ quinapril (+/- hydrochlorothiazide) ■ ramipril ■ trandolapril (+/- verapamil) **Direct Renin Inhibitor** ■ aliskiren (+/- amlodipine, hydrochlorothiazide)
Medication Adherence – Cholesterol Medications	Statin Medications	■ atorvastatin (+/- amlodipine, ezetimibe) ■ fluvastatin ■ lovastatin (+/- niacin) ■ pitavastatin ■ pravastatin ■ rosuvastatin ■ simvastatin (+/-ezetimibe, niacin, sitagliptin)
OMW	Osteoporosis Medications	**Biphosphonates**: ■ Alendronate ■ Alendronate-cholecalciferol ■ Ibandronate ■ Risedronate ■ Zoledronic acid **Other agents:** ■ Abaloparatide ■ AIbandronate ■ Denosumab ■ Raloxifene ■ Teriparatide
SPC	High-Intensity Statin	■ Atorvastatin 40-80 mg ■ Amlodipine-atorvastatin 40-80 mg ■ Ezetimibe-simvastatin 80 mg ■ Rosuvastatin 20-40 mg ■ Simvastatin 80 mg

Measure	Medication	Prescription Details
SPC	Moderate-Intensity Statin	■ Atorvastatin 10-20 mg ■ Amlodipine-atorvastatin 10-20 mg ■ Ezetimibe-simvastatin 20-40 mg ■ Fluvastatin XL 80 mg ■ Fluvastatin 40 mg bid ■ Lovastatin 40 mg ■ Pitavastatin 2–4 mg ■ Pravastatin 40-80 mg ■ Rosuvastatin 5-10 mg ■ Simvastatin 20-40 mg
SUPD	Statin Medications	■ Atorvastatin (+/- amlodipine, ezetimibe) ■ Fluvastatin ■ Lovastatin (+/- niacin) ■ Pitavastatin ■ Pravastatin ■ Rosuvastatin ■ Simvastatin (+/-ezetimibe, niacin, sitagliptin)

Appendix 5: Health Outcomes Survey Questions

HOS: Improving Bladder Control	Yes	No
Many people experience urine leakage, also called urinary incontinence. In the past six months, have you experienced urine leakage?		
Have you ever talked with a doctor, nurse, or other healthcare provider about urine leakage?		
There are many ways to control or manage urine leakage, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other healthcare provider about any of these approaches?		

HOS: Monitoring Physical Activity	Yes	No
In the past 12 months, did you talk with a doctor or other healthcare provider about your level of exercise or physical activity? For example, a doctor or other healthcare provider may ask if you exercise regularly or take part in physical exercise.		
In the past 12 months, did a doctor or other healthcare provider advise you to start, increase, or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other healthcare provider may advise you to start taking the stairs, to increase walking time from 10 to 20 minutes every day, or to maintain your current exercise program.		

HOS: Reducing the Risk of Falling	Yes	No
A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other healthcare provider about falling or problems with balance or walking?		
Has your doctor or other healthcare provider done anything to help prevent falls or treat problems with balance or walking? Some things they might recommend are ■ using a cane or walker. ■ checking your blood pressure lying down or standing. ■ suggesting an exercise or physical therapy program. ■ suggesting a vision or hearing test.		
Did you fall in the past 12 months?		
In the past 12 months, have you had a problem with balance or walking?		

HOS: Improving or Maintaining Mental Health		
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious): ■ Accomplished less than you would like as a result of any emotional problems ■ Didn't do work or other activities as carefully as usual		No, none of the time
		Yes, a little of the time
		Yes, some of the time
		Yes, most of the time
		Yes, all of the time
How much of the time during the past 4 weeks: ■ Have you felt calm and peaceful? ■ Did you have a lot of energy? ■ Have you felt downhearted and blue?		All of the time
		Most of the time
		A good bit of the time
		Some of the time
		A little of the time
		None of the time
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?		All of the time
		Most of the time
		A good bit of the time
		Some of the time
		A little of the time
		None of the time

HOS: Improving or Maintaining Physical Health		
In general, would you say your health is:		Excellent
		Very good
		Good
		Fair
		Poor
Does your health now limit you in these activities? If so, how much? ■ Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf ■ Climbing several flights of stairs		Yes, limited a lot
		Yes, limited a little
		No, not limited at all
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? ■ Accomplished less than you would like as a result of your physical health? ■ Were limited in the kind of work or other activities as a result of your physical health?		No, none of the time
		Yes, a little of the time
		Yes, some of the time
		Yes, most of the time
		Yes, all of the time
During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?		Not at all
		A little bit
		Moderately
		Quite a bit
		Extremely

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst"). Plans contain exclusions and limitations.

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