Bamboo Health

Explaining HEDIS Measures:

TRANSITIONS OF CARE AND FOLLOW-UP AFTER ED VISIT FOR PEOPLE WITH MULTIPLE CHRONIC CONDITIONS

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Star Ratings Program Overview

In February 2020, the Centers for Medicare and Medicaid Services (CMS) released Part II of its 2021 Medicare Advantage and Part D Advance Notice, and the Medicare Advantage and Part D Program Technical Changes proposed rule, which included several updates to the Medicare Advantage Star Ratings program. As a result, two additional HEDIS measures are included for scoring for health plans' Star Ratings: 1) *Transitions of Care*, and 2) *Follow-up after Emergency Department (ED) Visit for People with Multiple Chronic Conditions.*

STAR RATINGS ARE INTENDED TO RATE THE QUALITY OF PATIENT CARE AND PATIENT EXPERIENCE PROVIDED BY A MEDICARE ADVANTAGE PLAN.

Scored at the Medicare contract level, the 5-star system includes over 30 quality measures, typically derived by the following measure sets:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcome Survey (HOS)

MEASURES ARE ORGANIZED INTO 5 DOMAINS:

- Staying Healthy: Screenings, Test, Vaccines
- Managing Chronic (Long-Term) Conditions
- Member Experience
- Member Complaints and Changes in Plan Performance
- Health Plan Customer Service

Impact of Star Ratings

Star Ratings directly impact health plan revenue in the form of Quality Bonus payments and Rebates for plans bidding below the Medicare Advantage county benchmark. Star Ratings also impact member enrollment, marketing activities, and market share.

Understanding these Two HEDIS Measures

Two additional HEDIS measures are now included for health plans' Star Ratings scoring: Transitions of Care and Follow-up after ED Visit for People with Multiple Chronic Conditions. Both measures will be worth one point of health plans' performances in the Managing Chronic (Long-Term) Conditions domain and will impact their overall ratings on the 5-star quality scale. With these new measures, and especially as the Transitions of Care measure is expected to be weighted more heavily in the future, it's critical that health plans have the tools and resources needed to efficiently monitor members' care transitions and ensure timely follow-up care.

NEW STAR RATINGS MEASURES IN THE MANAGING CHRONIC CONDITIONS DOMAIN:

TRANSITION OF CARE

FOLLOW-UP AFTER ED VISIT FOR PEOPLE WITH MULTIPLE CHRONIC CONDITIONS

INTENT OF THE MEASURES

CMS recognizes that a patient's care journey immediately post-discharge has a significant impact on patient outcomes.

Ensuring smooth transitions of care after any acute encounter can lead to reduced readmissions, reduced ED recidivism, and increased continuity of patient care.

MEASURE FAQS

- Measures will be weighted one point each.
- Measures are existing National Committee for Quality Assurance (NCQA) HEDIS measures.
- Measures were included as display (unscored) measures in 2020.

Transition of Care Measure Overview

Coordinating care for members following hospital or ED discharges is critical for health plans in order to avoid unnecessary readmissions and ensure proper care delivery. However, transitions from acute care settings are often subject to poor care collaboration. To overcome these challenges, the Transitions of Care measure will rate health plans on the percentage of Medicare beneficiaries 18 years and older where the following criteria were satisfied after a discharge from an inpatient facility:

MEASURES: Percent of all discharges for which each of the 4 measure components occurred

POPULATION: All beneficiaries age 18 or older with continuous enrollment from the date of discharge through 30 days after discharge

ELIGIBLE EVENTS (MEASURE DENOMINATOR): Acute and non-acute discharges on or between January 1 and December 1 of the measurement year

4 COMPONENTS OF THE TRANSITIONS OF CARE MEASURES

Notification of Inpatient Admission

- Documentation in the medical record of receipt of notification of inpatient admission on the day of admission, or within the following two calendar days
- Notification may include an admission, discharge, and transfer (ADT) notification, electronic health record (EHR) notification, email, phone, or fax

Receipt of Discharge Information

- Documentation in the medical record of receipt of discharge information on the day of discharge, or within the following two calendar days
- Discharge information includes: treating provider, procedures or treatment, diagnosis at discharge, current medication list, testing results, instructions for patient care

Patient Engagement after Inpatient Discharge

- Evidence of patient engagement provided within 30 days after discharge
- Patient engagement may include outpatient visits (in office or home), telehealth visits, or telephone visits

Medication Reconciliation Post-Discharge

- Medication reconciliation performed within 30 days after discharge
- Performed by a prescribing practitioner, clinical pharmacist, or registered nurse

Follow-Up after ED Visit Measure Overview

With high-risk patients and those faced with multiple chronic conditions often being at risk for readmission, health plans need to ensure timely and proper follow-up post-discharge from the ED or hospital. To further support these efforts, health plans will now be measured on the percentage of ED visits for members 18 years and older who have multiple high-risk, chronic conditions, where the members had a follow-up service within 7 days of their ED visit.

MEASURES: Percent of all ED visits for which the member had a follow up service within 7 days of the ED visit

POPULATION: All beneficiaries age 18 or older within at least 2 different chronic conditions prior to the ED visit, and no more than one enrollment gap of up to 45 days in the 365 days prior to the ED visit

ELIGIBLE EVENTS (MEASURE DENOMINATOR): All ED visits

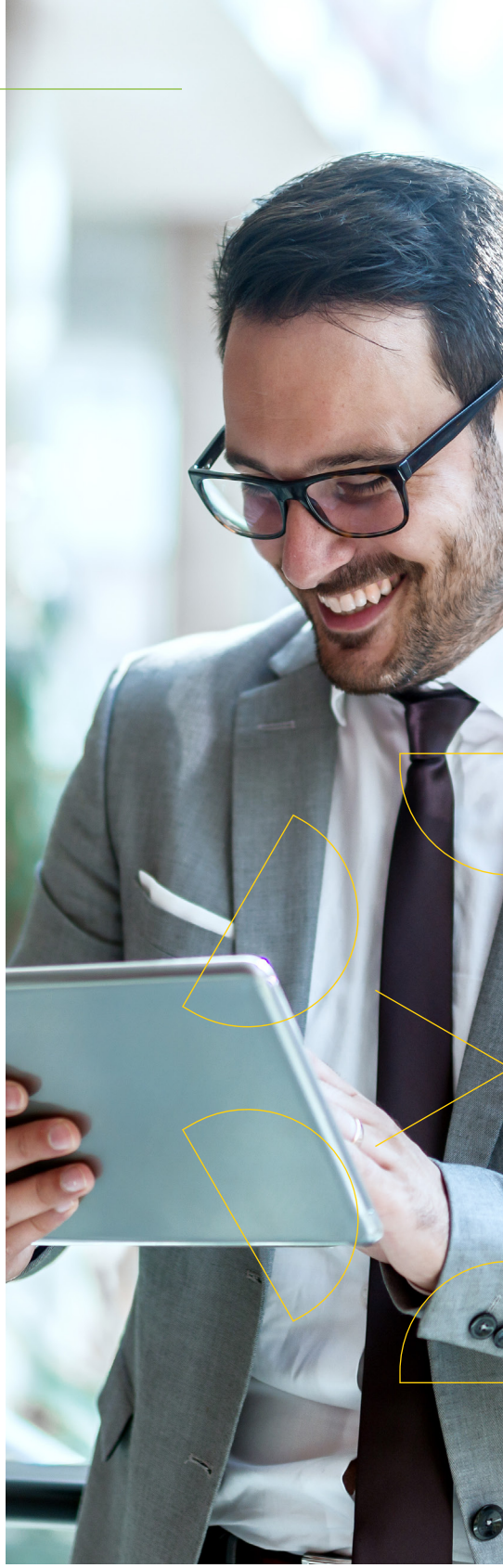
Member Eligibility Criteria:

Eligible members must have two or more of the following conditions: Chronic obstructive pulmonary disease (COPD), and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, and stroke and transient ischemic attack.

Follow-Up Services Criteria:

Follow-up services can include outpatient visits and encounters, telehealth and telephonic visits, transitional or complex care management services, case management visits, and behavioral health visits.

Key Considerations for Health Plans



With these two measures come key considerations for how health plans currently operate and can potentially operate in the future. In regards to quality measures, health plans should consider:

- Performance in these HEDIS measures and measures with similar requirements (i.e. display measures)
- Current benchmarks for timely follow-up care and member engagement
- Data and tools available providing timely and actionable insights allowing health plans to meet measure timeliness requirements (i.e. consider real-time data solutions)
- Current care management functions and processes to ensure coordinated care
- Relationships with providers who manage members' care

We help health plans achieve higher scores on these HEDIS measures. Connect with us to learn how.
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