carelon

2024 Provider Incentive Program Measures

Measure	Weight	Method
Breast Cancer Screening-ECDS*	1	Clinical
Care of Older Adults - Medication Review	1	Clinical | Pharmacy
Care of Older Adults - Pain Assessment	1	Clinical
Colorectal Cancer Screening-ECDS*	1	Clinical
Controlling Blood Pressure	3	Clinical
Glycemic Status Assessment for Patients with Diabetes (Formerly known as: Diabetes Care - Blood Sugar Controlled)	3	Clinical
Diabetes Care - Eye Exam	1	Clinical
Kidney Health Evaluation for Patients with Diabetes	1	Clinical
Medication Adherence for Cholesterol	3	Clinical | Pharmacy
Medication Adherence for Diabetes Medications	3	Clinical | Pharmacy
Medication Adherence for Hypertension	3	Clinical | Pharmacy
Osteoporosis Mgmt. in Women w/ Fracture	1	Clinical
Plan All-Cause Readmissions	1.5	Clinical
Statin Therapy for Patients w/ Cardiovascular Disease	1	Clinical | Pharmacy
Statin Use in Persons with Diabetes	1	Clinical | Pharmacy
TRC-Med Reconciliation Post-Discharge	1	Clinical | Pharmacy
TRC-Patient Engagement after Inpatient Discharge	0.25	Clinical

Requirement: 25-patient panel minimum per year

2024 rewards:
✰ 5 stars: $200/patient
✰ 4.5 stars: $80/patient
✰ 4 stars: $50/patient

*ECDS (Electronic Clinical Data Systems): Reporting standard that includes, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

Carelon Health Medicare STAR Reference Guide

HEDIS Measurement Year 2024
January 2024

Table of Contents

What is expected from you? 3
HEDIS (Healthcare Effectiveness Data & Information Set) 3
Medicare Advantage Measure Weight 4
Medicare HEDIS and SNP Measures 4
Advanced Illness and Frailty - HEDIS Exclusions 13
CAHPS (Consumer Assessment of Healthcare Providers and Systems) 14
Measuring the Patient Experience and Patient Satisfaction 18
Patient Post-Visit Survey Guidelines 18
HOS (Health Outcome Survey) 21
Pharmacy Measures (Part D) 25
CMS Admin, CMS Contractors 26
Provider Incentive 27
Standard Supplemental Data 28
Non Standard Supplemental Data 29
HEDIS Reporting 30
Organizational Structure 30

Medicare Star Measure Data Sources Overview

What is expected from you?

Please review the different segments and cohorts of STARS measures to understand the makeup of each measure to clearly explain to your membership the eligibility criteria and how to close the care gaps. During the course of the year, our provider partners are expected to work closely with their membership to address their attributed HEDIS care gaps with establishing a comprehensive care plan that the patient can follow.

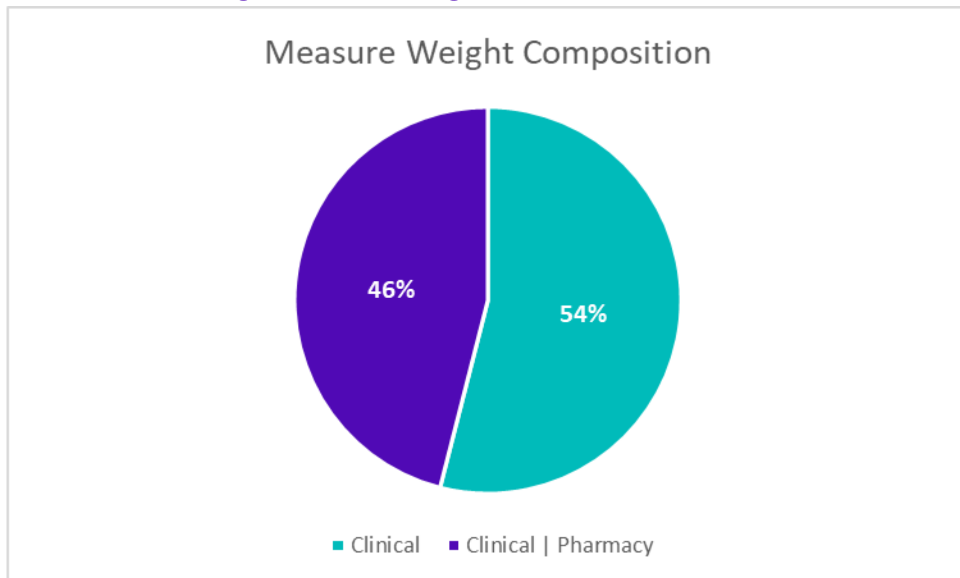
Please reach out to the Carelon STARS team or Network Management team with any questions or concerns that you may have in regards to STARS.

HEDIS (Healthcare Effectiveness Data & Information Set)

Overview

A tool developed and maintained by the National Committee of Quality Assurance (NCQA) used to measure the clinical quality performance of health plans through the collection and analysis of data documenting the clinical care received by Plan members from their providers.

Medicare Advantage Measure Weight:



Medicare HEDIS and SNP Measures:

- Medicare HEDIS and SNP Measures Included with individual details:

Quality Measure – Part C	Eligibility Criteria	How to Close Care Gaps	Value Set Codes
Breast Cancer Screening (BCS) - ECDS*	Percentage of women age 50-74 who had a mammogram to screen for breast cancer. One or more mammograms anytime on or between Oct. 1, two years prior to the measurement year and Dec. 31 of the measurement year.	Female Medicare Advantage (MA) enrollees 50 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years (numerator). **Best practices** Document:	Exclusion: Z90.13 - code if patient had two unilateral mastectomies or bilateral mastectomy

		- Date of last screening mammogram in yearly wellness visit or other office encounter. - Bilateral or unilateral mastectomy (both RT and LT) in history. - Counseling and patient refusals for screening mammograms does not count towards gaps in care closure. - Scan mammography report from radiologist into EMR. - Refer and schedule patient to complete a mammogram.	
Care for Older Adults (COA) – Medication Review	Percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review.	Doctor or clinical pharmacist review a list of everything the patient takes (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) during the measurement year and the presence of a medication list in the medical record.	**Medication Review** - 1160F – Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record - 99483 – Assessment of and care planning for a person with cognitive impairment - 99605 – Medication management by pharmacist (new patient) - 99606 – Medication management by pharmacist (existing patient) - 90863 – Pharmacologic management performed with psychotherapy services **Medication List** - 1159F – Medication list documented in medical record - G8427 – Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed **Medication Review and List**

			- 99495 – Transitional Care Management Services moderate complexity - 99496 - Transitional Care Management Services severe complexity
Care for Older Adults (COA) – Pain Assessment	Percent of members who had a pain screening at least once during the year. Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator)	Medicare Advantage Special Needs Plan enrollees who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).	**Pain Assessment** - 1125F – Pain severity quantified, Pain present - 1126F – Pain severity quantified, no pain present

Colorectal Cancer Screening (COL) - ECDS*	Percent of members aged 50-75 who had appropriate screening for colon cancer.	MA enrollees aged 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).
		
		Document
		- Date of last screening (must indicate type of screening - FOBT, colonoscopy, CT colonoscopy, etc.).
		  ○ **Note**: Documentation using the verbiage colorectal CA screening without specific type of test and date does not count.
		- Counseling and/or patient refusals on colorectal cancer screening (does not count towards gaps in care closures).
		- Maintain scanned copy of colonoscopy report from GI physician in EMR.
			Need date/type test/results for one of the following:
			- Colonoscopy — within past 10 years (2014-2024)
			- Flexible sigmoidoscopy — within past five years (2020 – 2024)
			- FOBT — done within measure year (2024)
			  ○ Guaiac – need three
			  ○ Immunochemical — need one (fecal immunochemical tests [FIT] or HIGH fecal occult blood testing [FOBT])
			- Cologuard (FIT-DNA) — within last three years (2022 – 2024)
			- CT Colonography – within last five years (2020 – 2024)

Controlling Blood Pressure (CBP)	Percent of members with high blood pressure who got treatment and were able to maintain a healthy pressure.	MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90 mm Hg) (numerator). - The member is compliant if the BP is <140/90 mm Hg. - The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). - Digital blood pressure readings taken by the member and documented in the member's medical record are eligible for use in reporting. - Blood Pressure readings are based on most recent results captured.	3078F - Diastolic <80 3079F - Diastolic 80-89 3080F - Diastolic ≥ to 90 3074F - Systolic < 130 3075F - Systolic 130-139 3077F - Systolic ≥ to 140
Osteoporosis Management in Women who had a Fracture (OMW)	Percent of female members who broke a bone and got screening or treatment for osteoporosis within 6 months.	Female MA enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator). Note: Includes all fractures except face, skull, fingers or toes. Biphosphonates - Alendronate Alendronate-cholecalciferol Ibandronate, Risedronate Zoledronic acid Other agents - Albandronate Calcitonin Denosumab, Raloxifene Teriparatide	**Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:** - A BMD test (Bone Mineral Density Tests Value Set), in any setting, on the IESD or in the 180-day (6-month) period after the IESD. - If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay. - Osteoporosis therapy (Osteoporosis Medication Therapy Value Set) on the IESD or in the 180-day (6-month) period after the IESD. - If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-

			Acting Osteoporosis Medications Value Set) during the inpatient stay. - A dispensed prescription to treat osteoporosis (Osteoporosis Medications List) on the IESD or in the 180-day (6-month) period after the IESD.
Diabetes Care – Eye Exam (EED)	Percent of members with diabetes who had an eye exam to check for damage from diabetes during the year.	Diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator). - Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. - Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. - Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.	**Eye Exam without Evidence of Retinopathy** - 2023F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy - 2025F – 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy - 2033F – Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed, without evidence of retinopathy **Eye Exam with Evidence of Retinopathy** - 2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, with evidence of retinopathy - 2024F – 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, with evidence of retinopathy - 2026F – Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results

			documented and reviewed, with evidence of retinopathy Diabetic Retinal Screening Negative - 3072F – Low risk for retinopathy (no evidence in prior year)
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions(FMC)	Percent of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. 365 days prior to the ED visit through 7 days after the ED visit.	A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up: - An outpatient visit (Outpatient Value Set) - A telephone visit (Telephone Visits Value Set) - An e-visit or virtual check-in (Online Assessments Value Set) - Transitional care management services (Transitional Care Management Services Value Set) - Case management visits (Case Management Encounter Value Set) - Complex Care Management Services (Complex Care Management Services Value Set) - An outpatient or telehealth behavioral health visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) - An outpatient or telehealth behavioral health visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)	

		- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) - An observation visit (Observation Value Set) - A substance use disorder service (Substance Use Disorder Services Value Set)	
Glycemic Status Assessment for Patients with Diabetes (GSD) (Formerly known as: Diabetes Care – Blood Sugar Controlled (HBD))	Percent of members with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c]) or glucose management indicator (GMI) was under control. Based on most recent result captured.	Diabetic MA enrollees age 18-75 (denominator) whose most recent Glycemic status is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.	Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; glucose management indicator: LOINC code 97506-0) to identify the most recent glycemic status assessment during the measurement year. 3044F HbA1c < 7% 3051F HbA1c > 7% and less than 8% 3052F HbA1c > 8% and < 9% 3046F HbA1c > 9%

Kidney Health Evaluation for Patients With Diabetes (KED)	Percentage of 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.	Members who received both an eGFR and a uACR during the measurement year on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set) • At least one uACR identified by either of the following: – Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year. – A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).	**eGFR (estimated Glomerular filtration Rate)** - 80047, 80048, 80050, 80053, 80069, 82565 - Creatinine lab test or BMP or CMP or Renal function panel test (panel tests include creatinine) **Quantitative urine albumin lab test** - 82043 - Albumin; urine (eg, microalbumin), quantitative **Urine creatinine lab test** - 82570 - Creatinine; other source
Plan All Cause Readmissions (PCR)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. The denominator for this measure is based on discharges, not members. Include all acute inpatient or	Ensuring Medicare Advantage patients recently discharged receive appropriate care coordination to prevent unexpected readmission to the hospital. Provider support: - Provide education and recommendations to your patients recently discharged of what to do if not feeling well. - Review the hospital discharge summaries and see that all diagnoses are documented. - Encourage provider offices to maintain frequent communications across the whole care team.	

	observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year.	- Provide case management planning to assist and identify high-risk patients through a risk.	
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD).	Percent of plan members with heart disease and were dispensed at least one high or moderate-intensity statin medication during the measurement year. Health plans can help make sure their members are prescribed medications that are more effective for them. This gap will close by the patient picking up one moderate or high intensity statin at anytime in the year.	
Transition of Care (TRC) ○ Patient Engagement After Inpatient Discharge ○ Medication Reconciliation Post-Discharge	18 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18–64 years. • 65 years and older. • Total. An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges:	- 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).	**Patient Engagement After Inpatient Discharge** Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement: - An outpatient visit (Outpatient Value Set) - A telephone visit (Telephone Visits Value Set) - Transitional care management services (Transitional Care Management Services Value Set) - An e-visit or virtual check-in (Online Assessments Value Set) **Medication Reconciliation Post-Discharge**

	1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.		Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days).

*ECDS - (Electronic Clinical Data Systems): Reporting standard that includes, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

- Advanced illness and frailty exclusions allowed for HEDIS measures

Advanced Illness and Frailty - HEDIS Exclusions

Measures	Patients receiving palliative care	Patients 66 years old and older with frailty and advanced illness	Patients 66–80 years old with frailty and advanced illness, as well as those 81 years old and older with frailty only	Patients 67–80 years old with frailty and advanced illness, as well as those 81 years old and older with frailty only
Breast Cancer Screening (BCS)	X	X		
Colorectal Cancer Screening (COL)	X	X		
Controlling High Blood Pressure (CBP)	X		X	
Eye Exam for Patients with Diabetes (EED)	X	X		
Glycemic Status Assessment for Patients With Diabetes (GSD)	X	X		
Kidney Health Evaluation for Patients with Diabetes (KED)	X			X
Osteoporosis Management in Women who had a Fracture (OMW)	X	X		

Statin Therapy for Patients with Cardiovascular Disease (SPC)	X	X		
Statin Therapy for Patients with Diabetes (SPD)	X	X		

- Data Collection Methods & Criteria
  - Administrative data – The plan's claims database
    - As claims are submitted from our Carelon clinics, network providers, and any other specialists, claims are captured and recorded in our HEDIS engine.
  - Hybrid data – Claims database and review of medical records, supplemental data
- Critical Timeline
  - Part C measures are monitored and completed by claims and/or supplemental data throughout the calendar year.
    - Claims can be submitted until March 1st of the following year for the current measurement year.
    - The final HEDIS run is completed in March to allow for claims runout.

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

Overview

Annual survey asking members about their experiences with their health care providers and plans. CMS publicly reports the results of its patient experience surveys. Your care provided as the provider has a direct impact on patient experience and perception. Below are listed different categories that are being measured.

WEIGHT	MEASURE DOMAIN	
4X	• **Getting needed care** • **Getting Appointments & care quickly** • Customer Service (Health Plan) • **Rating of health care quality** • Rating of health plan • Rating of drug plan • Getting needed prescriptions • **Care coordination**	

2024

1X	• Annual Flu Shot

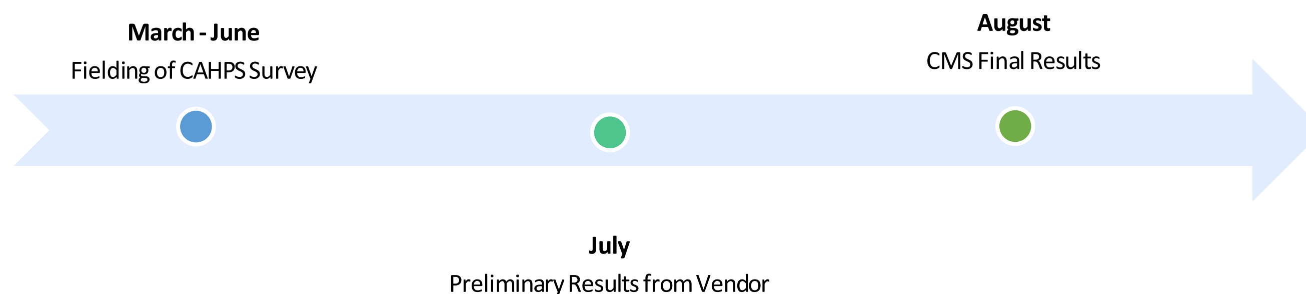
The following measure domains are most impactful on patient perceptions and satisfaction of their care experience.

Measure	Questions Asked
Rating of HealthCare Quality	• Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Care Coordination	• In the last 6 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 6 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 6 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 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 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 6 months, how often did your personal doctor seem informed and up to-date about the care you got from specialists?

Getting Care Quickly	• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 month, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Getting Needed Care	• In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?

- Data Collection Methods & Criteria
  - Survey administered by 3rd party vendor through mailers and by phone
  - Sample size = 800 members enrolled in the plan at least 6 months
  - Who Qualifies for this survey?
    - Medicare beneficiaries at least 18 years or older who are currently enrolled in a Medicare Advantage contract for at least 6 months are eligible to participate.

- Critical Timeline



- How to improve CAHPS Performance:
  In summary, when patients can navigate their healthcare with ease and feel that they are getting support needed to make their healthcare journey easier – it will reflect in the CAHPS measures that capture care coordination, getting care quickly, and getting care needed. The following tips can improve CAHPS performance as they can improve a patient's perception and satisfaction of their care experience:

TIPS	BENEFITS
Provide excellent customer service.	Builds a quality experience for patient / member.
Develop a trusting doctor-patient relationship by using active listening skills, asking patients to list key concerns at the start of the visit, and openly reviewing all treatment options with patient for shared decision-making.	Establishes trust by demonstrating empathy. Patient also feels provider listens to them to help better meet their needs.
Review all medications to ensure understanding why each medicine is needed, how it should be taken, and the importance of taking medicine as prescribed.	Improves medication adherence and health outcomes.
Educate on the importance of getting yearly preventive screenings, address gaps in care, and ensure patient receives their yearly flu shot.	Improves health outcomes, addresses staying healthy screenings / tests / vaccines and helps effectively manage chronic conditions.
Assess patient's emotional and mental health needs. Anxiety, depression and other psycho-social issues are common in patients with multiple chronic conditions.	Builds relationship, shows patients that provider cares about them, and improves / maintains mental health outcomes.
Offer resources, such as health education materials or interpretive services, and/or refer patient to applicable CareMore programs, like Nifty after Fifty® fitness program, Behavioral Health or other disease management programs.	Patient feels sufficient time was spent with them, that resources are available to help them stay happy, healthy and independent, and that their care is being effectively coordinated.
Set expectations with patients on when they will receive follow-up of blood tests, x-ray or other test results. Communicate both normal and abnormal results.	Improves coordination of care, effectiveness of care, and patient safety.
Provide end of visit summary and ask patient if all questions and concerns were addressed.	Patient feels provider communicated effectively and explained in easily understandable terms. Provides final opportunity to share any concerns or questions before ending visit.

Measuring the Patient Experience and Patient Satisfaction

The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered to evaluate patient experience and patient satisfaction. It aims to measure how well physicians and plans meet patient /members expectations and goals. It is best practice for healthcare organizations to continually measure their patient experience and patient satisfaction performance by administering a post-visit survey. Surveying patients will allow organizations to monitor and improve how patients experience their care and gauge how they may respond to the CAHPS survey.

Patient Post-Visit Survey Guidelines

Here are some basic tips for creating and disseminating a post-visit survey to patients:

1. **Keep it short and simple:** Make sure the survey is brief and to the point, with only a few key questions that are easy to understand and answer.
2. **Ask relevant questions:** Focus on the most important aspects of the patient experience, such as the quality of the visit, provider communication skills, and the overall satisfaction with the care received.
3. **Make it accessible:** Ensure that the survey is easy to access, whether it is sent via email, text message, or made available online.
4. **Response scale:** Provide patients with a range of response options, such as rating scales or multiple-choice questions, to help them express their opinions more easily. Align survey methodology with CMS CAHPS as much as possible to gauge how patients may respond to the real CAHPS survey.
5. **Provide anonymity:** Consider offering patients the option to remain anonymous when responding to the survey, which can encourage more honest feedback.
6. **Analyze results:** Once you have collected the survey results, analyze the data to monitor performance and identify any trends or opportunities to improve the patient experience.
7. **Be proactive:** Use the survey results to inform changes and improvements to the delivery of care, and communicate these changes to patients to show that their feedback is valued.

SURVEY MODE

There are several options for formatting a post-visit survey. Offering a mix of formats can be an effective strategy for yielding a higher response rate:

- Paper-based survey
- Online form
- Online survey platform (i.e., Survey Monkey or Qualtrics)
- A mix of the options

SURVEY DISSEMINATION

Patients can be invited to participate in the post-visit survey through various outreach methods.

- SMS text message
- E-mail invitation
- URL link via kiosk in clinic during visit checkout
- IVR calls

Ensure that outreach is HIPAA compliant. Outreach should occur within 1 to 2 weeks' post-visit. Offering a mix of outreach methods in sequence can yield a higher response rate. For example: 1st attempt via e-mail following by another invite via text message two days after initial invite followed by a third attempt via text message.

SURVEY QUESTIONS

The table below lists the CAHPS domains and their metrics that you can include in your organization's post-visit survey.

DOMAIN	RESPONSE SCALE
Getting Needed Care	
How often was it easy to get the care, test, or treatment you needed?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did you get an appointment with a specialist as soon as you needed?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
Getting Appointments & Care Quickly	
When you needed care right away, how often did you get it as soon as you needed it?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did you get an appointment for a check-up or routine care as soon as you needed?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
Care Coordination	
How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	4-Point Scale (i.e., Never, Sometimes, Often, Always)

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?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
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?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did your personal doctor talk about all prescription drugs you are taking?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
In the last 6 months, how often was your personal doctor up-to-date about your visit with the specialist you saw most often?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
In the last 6 months, how often did your personal doctor have medical records or other information about your care at your appointment?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
Doctor Communication	
How often did your personal doctor explain things in a way that was easy to understand?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did your personal doctor listen carefully to you?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did your personal doctor show respect for what you had to say?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
How often did your personal doctor spend enough time with you?	4-Point Scale (i.e., Never, Sometimes, Often, Always)
Flu Shot	
Have you had a flu shot in the last 18 months?	Yes – or – No
Have you had a flu shot since July 1, 2020?	Yes – or – No
Overall Satisfaction on Rating of Personal Doctor and Rating of Health care Quality	
Using any number from 0 to 10, where O is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	11-point scale (0 to 10; 0 = worst; 10 = Best)

Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	11-point scale (0 to 10; 0 = worst; 10 = Best)
Net Promoter Score	
How likely would you recommend <Medical Group or Healthcare Provider Organization Name> to family and friends?	11-point scale (0 to 10; 0 = worst; 10 = Best)

SURVEY DATABASE AND ANALYSIS

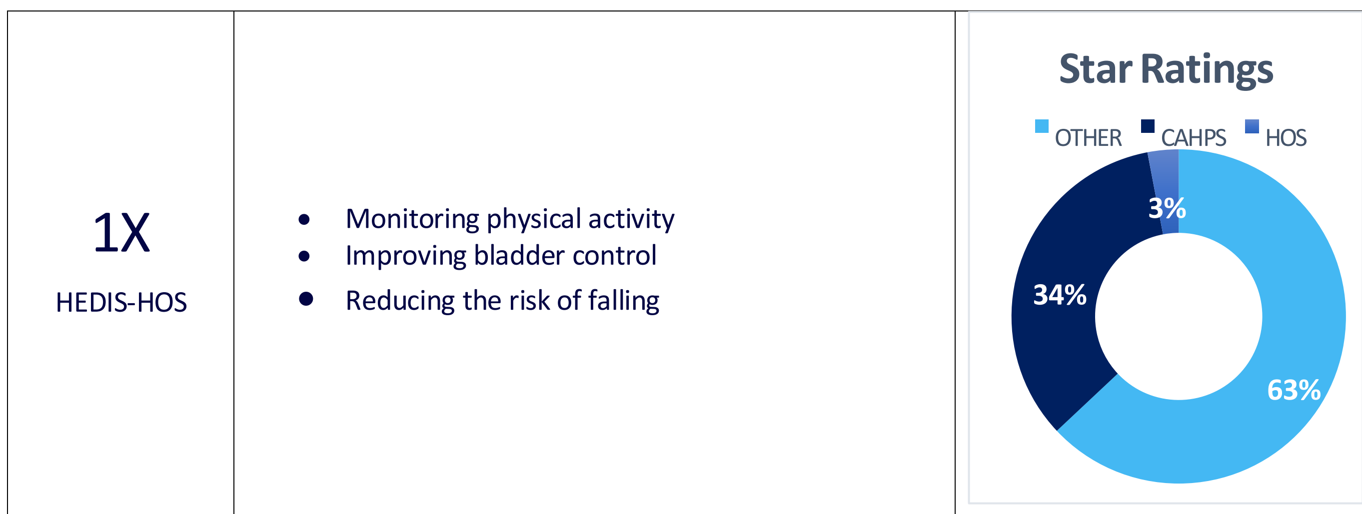
Once survey data is collected, data should be stored in a secure database with login access to key staff responsible for maintaining the database. There are various software options to store data such as excel, MS Access, etc. If an online survey platform is used – these platforms have a built-in database.

HOS (Health Outcome Survey)

Overview

The Health Outcome Survey (HOS), established by NCQA (National Committee for Quality Assurance), measures physical status and assesses ability to maintain or improve health based on self-reported data from Medicare Advantage patients. This survey is administered annually between August through November to a random sample. Patients who participate become eligible again after a 2-year cycle. These measures are currently weighted at a 1.

WEIGHT	MEASURE DOMAIN	



1X HEDIS-HOS	• Monitoring physical activity • Improving bladder control • Reducing the risk of falling

- Types of HOS Related Questions:

Monitoring phsycial activity

- In the past 12 months, did you talk with your provider about your level of exercise or physical activity? For example, did you provider ask if you exercise regaularly?
- Has your provider advised you to start, increase or maintain your current exercise program?

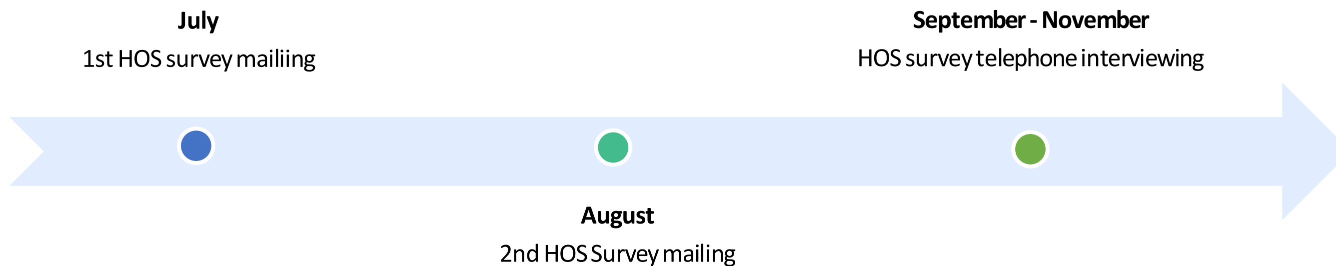
Improving bladder control

- Have you talked with your provider about urine leakage?
- There are many ways to control leaking or urine, including bladder training exercises, medication and surgery. Have you ever talked with your provider about any of these approaches?

Reducing fall risk

- In the past 12 months, did you talk with your provider about falling or problems with balance or walking?
- Has your provider done anything to help prevent falls or treat problems with balance or walking? Some things that they might advise is to use a cane or a walker.

- Data Collection Methods & Criteria
  - Survey administered by 3rd party vendor through mailers and by phone
  - Baseline survey administered to a new cohort each year. Two years later, these same respondents are surveyed again (follow-up)
- Critical Timeline



- HOS Provider Tips:

Monitoring Physical Activity

- Talk about the importance of physical activity and exercise.
- Discuss how to start, maintain or increase phsycial activity.
- Refer patients with limited mobility or difficulty wit walking/balance to physical therapy so that they may learn safe and effective exercises.

Improving Bladder Control

- Ask patient is bladder control is a problem and discuss when it has been a problem and othe rsymptoms that may be accompanying it.
- Discuss treatments for bladded conrtol issues that may arise as patient ages, such as behavioral therapy, exercises, medications, medical devices, or surgery.
- Provide educational materials such as brochures and other materials, which are good coversation starters.

Reduce Fall Risk

- Discuss balance problems, difficulty walking and other fall risks.
- Suggest a cane or walker.
- Perform bone-density screening for high-risk patients.
- Suggest a hearing / vision test.
- Suggest exercise and otehr phsycial activity.
- Check blood pressure with patient standing, sitting, and reclining.

Pharmacy Measures (Part D)

Overview

Pharmacy measure data sources include Prescription Drug Event Data and Part D Plan Reporting. Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans approved by the federal government.

- Measures Included:

Quality Measure – Part D	Eligibility Criteria	How to Close Care Gaps
Medication Adherence for Diabetes Medications	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who have two prescription claims on different dates of service for any qualifying diabetic medications.	Percent of plan members with a prescription for non-insulin diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Patients are excluded if they pick up one prescription fill for insulin at anytime in the year.
Medication Adherence for Hypertension (RAS antagonists)	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who have two prescription claims on different dates of service for any qualifying hypertension medications.	Percent of plan members with a prescription for a hypertension medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Patients are excluded if they pick up one prescription fill for Entresto at anytime in the year.
Medication Adherence for Cholesterol (Statins)	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who have two prescription claims on different dates of service for any qualifying cholesterol (statin) medications.	Percent of plan members with diabetes who were dispensed any intensity of a statin medication. Plans can help make sure their members get these prescriptions filled.
Statin Use in Persons with Diabetes (SUPD)	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period.	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of members with diabetes who take any intensity of a cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled. This gap will close by the patient picking up one prescription claim for a statin at anytime in the year.

  - Data Collection Methods & Criteria
    - Prescription Drug Event Data (PDE): Member prescription fill data submitted by drug plans to Medicare for the reporting period.
    - Part D Plan Reporting: Data is reported by Plans to CMS per the Part D Reporting Requirements for MTM.
  - Critical Timeline
  - Data collection takes place year-round

CMS Admin, CMS Contractors

Overview

Additional Star measure data sources include:

- Complaints and appeals tracking
- Data collected by CMS contractors

  - Measures Included:
    - Complaints about the Health/Drug Plan (4)
    - Members Choosing to Leave the Plan (Part C & D) (4)
    - Call Center – Foreign Language Interpreter and TTY Availability (Part C and D) (4)
    - Plan Makes Timely Decisions about Appeals (4)
    - Reviewing Appeals Decisions (4)
  - Data Collection Methods & Criteria
    - Data collection methods include:
      - Complaints Tracking Module (CTMs): Data based on the contract entry date (the date that complaints are assigned or re-assigned to contracts) for the reporting period specified.
      - Medicare beneficiary Database Suite of Systems (MBDS): A collection of individual applications/services that access a single, enterprise-wide authoritative source for Medicare beneficiary demographic data.
      - CMS Audit: Call center data collected by CMS.
      - Independent Review Entity (IRE): An independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations.
  - Critical Timeline
    - Data collection takes place year-round with the exception of Call Center/TTY audit (conducted Feb – June)

- *Improvement*
  - Overview
    - Two composite measures that evaluate how much a health plan improved year-over-year.

- Measures Included:
  - Part C - 30 measures (5)
  - Part D - 12 measures (5)
- Data Collection Methods & Criteria
  - Based on performance significant improvement, significant decline or no change on all rated measures.
- Critical Timeline
  - Data collection takes place year-round

Provider Incentive

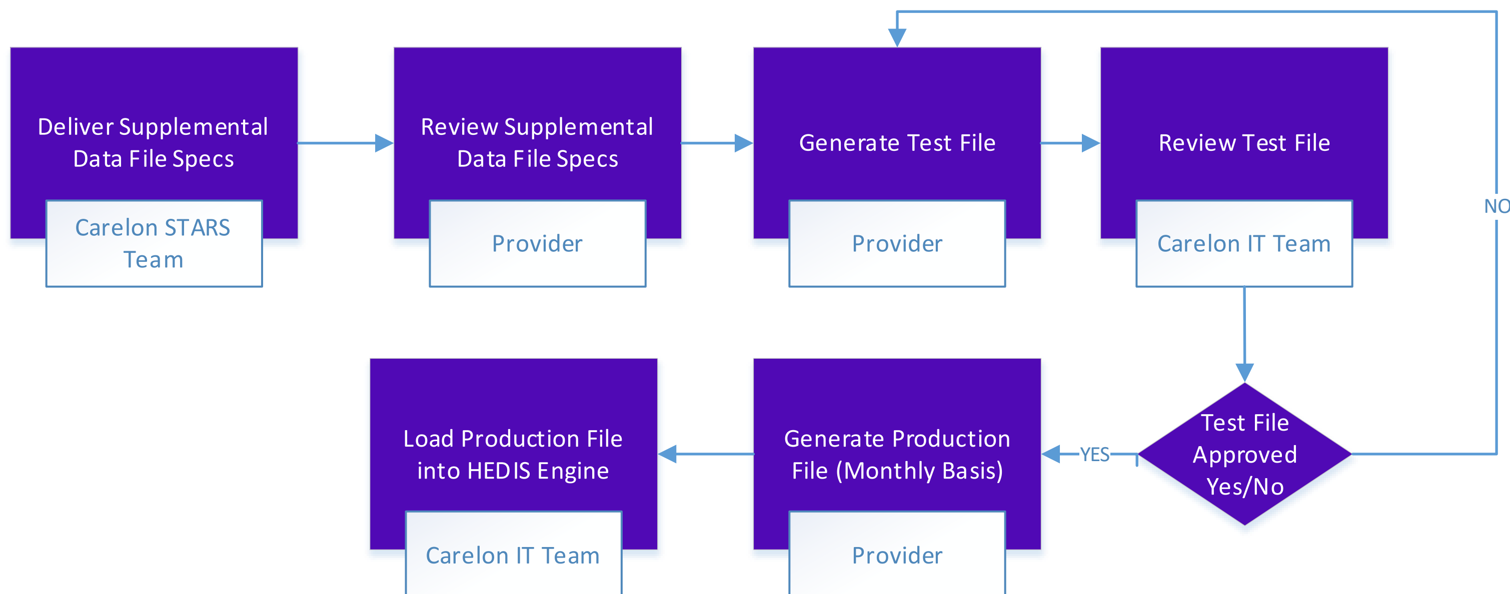
- **Program overview:** Carelon Health is now offering a new 3 year provider incentive that involves Risk Condition Assessments, STARS Performance, and Patient Experience Surveys. Each portion of the incentive structure offers different payouts depending on performance. Payouts would occur each year for DOS for prior year, but allow for 3 years of payouts. For example, 2023 DOS would equal a payout in October 2024.
  - **PAHAF:** Up to $300 will be offered as an incentive based on the PAHAF's completed through the portal or paper submission during the calendar year (payments go out monthly). An additional $10 bonus will be applied for 85% or greater return rate with 85% or greater accuracy of the PAHAFS, this additional $10 bonus will be paid in April 2025.
  - **STARS Performance:** Providers can earn up to $200 PMPY if 5 STARS are achieved. However, providers can earn $50 for 4 STAR or $80 for 4.5 STAR. Pharmacy bonuses will be applied if mail order rates and extended day supply goals are met.
    - Achieve a 12% or above on your mail order rate for STAR related medications and achieve an additional $5 PMPY. If 20% or greater is achieved, $10 PMPY can be earned.
    - Achieve 85% or above on your 90-day supply prescribed rate for STAR related medications and achieve an additional $5 PMPY. If 15% or greater is also achieved on your 100-day prescribed rate, $10 PMPY can be earned.
  - **Patient Experience:** Network providers will be incentivized to implement their own post visit survey and demonstrate improvement in year-over-year overall satisfaction and CAHPS-like metrics.
- **For additional information on the Provider Incentive Program, you can reach out directly to your network manager or the Carelon STARS team.**
  - **Carelon STARS Team - BusinessPerformance@carelon.com**

Standard Supplemental Data

Definition

- HEDIS data files generated by a provider group from an EMR that is securely passed to Carelon to load into the HEDIS engine. The data files contain empaneled patients and HEDIS gap data that allows Carelon to close care gaps as numerator hits, identify possible exclusions, and update appropriate denominators. The supplemental data files generation is a collaborative process with Carelon, but the files must meet the agreed upon specs to ensure a successful load.
- Electronically generated files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.

Workflow

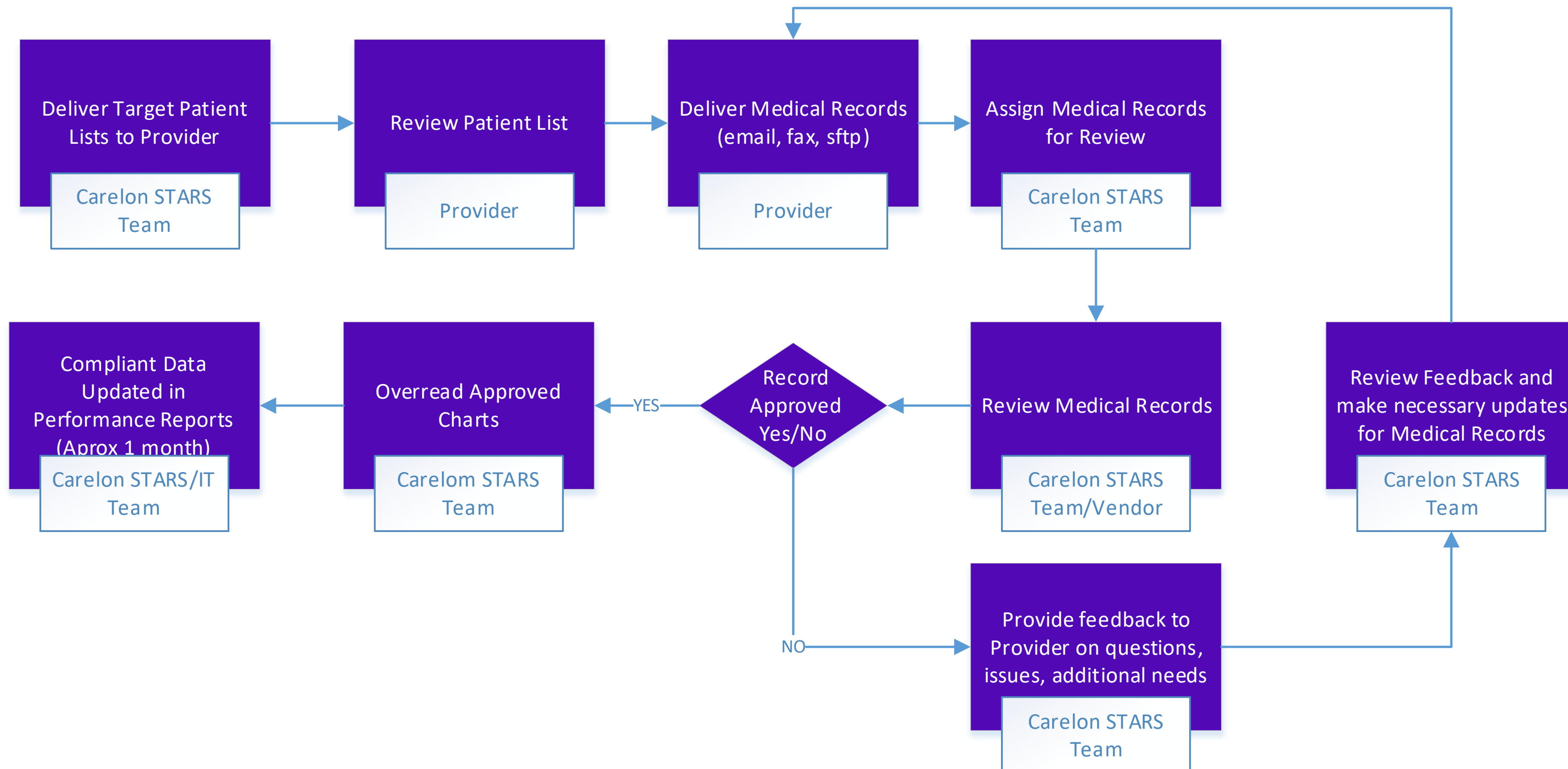


Non Standard Supplemental Data

Definition

- Nonstandard supplemental data allows for Carelon to capture any missing service data that may not be included in standard claims. This is commonly known as a medical record or chart chase review. Similar to standard supplemental data, data identified in medical records can be used for numerator hits, exclusions, and denominator identification.
- Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above, whether collected by a plan, an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.

Workflow



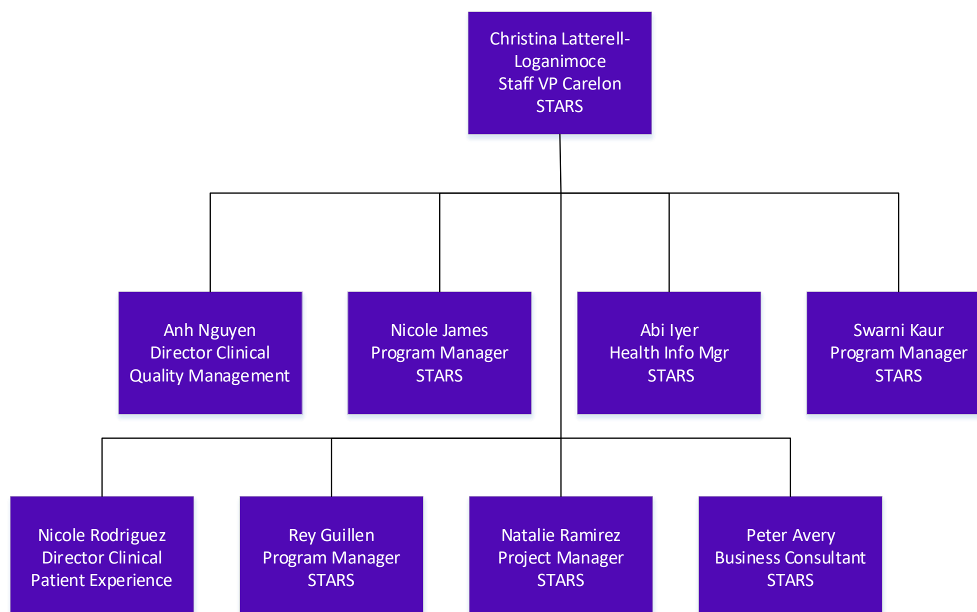
HEDIS Reporting

Provider HEDIS Scorecard

- The HEDIS Tableau Dashboard and scorecard is updated on a daily basis to provide an overview of our core markets, PODS, Health Plans and contracts on their current STAR performance. For providers, they are distributed during JOC meetings.
  - The data in the scorecard provides a real time snapshot of the provider's HEDIS performance
  - The membership and gap data is pulled directly from the Carelon HEDIS reports. All enrollment, claims, supplemental data, and any other critical HEDIS data is ingested into Carelon's semantic layer and gaps in care.

Organizational Structure

- **Carelon STARS Team Organization**
  - **STARS Contact Email: BusinessPerformance@carelon.com**



2024

Document Updates

Initial Draft – Swarnpreet Kaur	1/12/24
2nd Draft – MRARC	1/23/24
Final Draft – Compliance	1/29/24

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