Humana Updates and Resources

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Provider Consultants

September 28th 2018
Agenda

• Medicare CMS Stars
• HEDIS Stars Measures
• Patient Safety Part D Measures
• Member Experience CAHPS/HOS
• Preventative Screen
• Claims
• Credentialing
• Resources
Medicare CMS Stars: General framework

Stars has been created by the Centers for Medicare & Medicaid Services (CMS) to raise the quality of care for Medicare enrollees and reduce federal health care expenditures. The program holds health plans accountable for the care provided to enrollees by physicians, hospitals and other health care providers.

• CMS developed the Stars program for Medicare Advantage consumers with two objectives:
  – Drive health plans toward higher quality and more efficient care
  – Influence consumer plan choices during open enrollment

• Star ratings are calculated at an overall contract level (ratings combine Part C and D measures)
  – Based on 40-plus weighted measures (measure set reviewed by CMS each year)
  – Ratings published annually (1 Star to 5 Stars)
  – Consensus-building entities (e.g., NCQA and PQA) consult with CMS for measure concept development, specifications and endorsement
Measures physicians can impact

HEDIS – Healthcare Effectiveness Data and Information Set

CAHPS – Consumer Assessment of Healthcare Providers and Systems

HOS – Healthcare Outcomes Survey

CMS (Centers for Medicare & Medicaid Services) – Administrative data on plan quality/member satisfaction

IRE – Independent review entity

Physicians directly influence 80 percent of the Stars rating
## Stars BY2021 Measures and Weights

<table>
<thead>
<tr>
<th>HEDIS (measured Jan – Dec)</th>
<th>ABBR</th>
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<tbody>
<tr>
<td>Rheumatoid Arthritis Management</td>
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<td>Osteoporosis Management</td>
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<td>Plan All-Cause Readmissions</td>
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<td>Colorectal Cancer Screening</td>
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<td>COA^2 – Functional Status Assessment</td>
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<td>Statin Therapy for Cardiovascular Disease</td>
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<table>
<thead>
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<th>CAHPS (measured Feb – Jun)</th>
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<td>Getting Appointments and Care Quickly</td>
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<td>Overall Rating of Health Plan</td>
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<td>Care Coordination</td>
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<tr>
<td>Improving or Maintaining Mental Health</td>
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<td>Monitoring Physical Activity</td>
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<tr>
<td>Improving Bladder Control</td>
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<tr>
<td>Reducing the Risk of Falls</td>
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<td>Appeals Upheld (drug plan)</td>
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<tr>
<td>Reviewing Appeals Decisions</td>
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<table>
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<th>CMS (measured Jan – Dec)</th>
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<tr>
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<td>Complaints about the Health Plan</td>
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<td>Members Choosing to Leave the Plan</td>
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<td>Medicare Plan Finder Accuracy</td>
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<tr>
<td>Special Needs Plan Care Management</td>
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<td>Call Center - Foreign Language Interpreter &amp; TTY/TDD - Part C</td>
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<tr>
<td>Call center - Foreign Language Interpreter &amp; TTY/TDD - Part D</td>
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<table>
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<td>Part C Improvement</td>
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<tr>
<td>Part D Improvement</td>
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<table>
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<tr>
<th>Display Measures (2018)</th>
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<tr>
<td>High Risk Medications</td>
<td>HRM</td>
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<tr>
<td>Opioid Overutilization</td>
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<td>Antipsychotic Use in Persons with Dementia</td>
<td>APD</td>
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<tr>
<td>Formulary Administration Analysis</td>
<td>FAA</td>
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<tr>
<td>Beneficiary Access and Performance Problems</td>
<td>BAPC</td>
</tr>
<tr>
<td>Hospitalization for Potentially Preventable Complications</td>
<td>HPC</td>
</tr>
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</table>

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1. Proposed measures and weights reflect latest CMS Call Letter (4/2/2018). Note HPC will be a display measure for BY20 and Reducing the Risk of Falls will be a Stars Measure for BY20.
2. Measures apply only to Special Needs Plans (SNP).
3. Per CMS Advanced Notice guidelines, medication adherence measures for Puerto Rico are 0-weight.
4. Display measures are not part of Star ratings. 2018 Display measures reflect MY2017 services, displayed on CMS.gov in 2018.

Updated: April 9, 2018
CMS Stars measure thresholds

- CMS grades on a curve; therefore, Stars thresholds are based on the top performers. Because of this, CMS always is raising the bar, and every gap in care is an improvement opportunity.
- Provider performance may improve from month to month, but physicians may notice Stars ratings decline due to the grading curve; consequently, Humana associates seek to close all available gaps in care.
- Humana’s objective is to be the leader in the industry by improving quality of care by focusing on closing every member gap.

Key call-to-action items:
- Close HEDIS gaps based on current Stars Quality Report
- Data submission (obtain evidence of care)
- CAHPS/HOS comment scorecards
- Part D (adherence and patient safety) “impactables”
How Humana supports quality improvement

Humana conducts outreaches to physicians and their patients with Humana coverage to do the following:

• Provide Star Quality Reports highlighting patients needing preventive services
• Facilitate quality visits/relationships (provider engagement representatives)
• Promote physician Star rewards
• Encourage use of electronic medical records (EMRs) and lab connections
• Assist with data collection
• Execute clinical and incentive programs to support patient well-being
Methods for submitting supplemental data

1. **Claims/encounters** - Most preferred method for gap closure
   - Lessen the need for submission of data by ensuring proper codes are included on claims.

2. **Medical records connectivity**
   - Allow Humana to connect electronically with provider electronic medical records and exchange clinical data.
   - Send your Humana-covered patient’s medical records automatically to Humana after each episode of care.

3. **Data feeds**
   - Enable providers to extract data from their electronic medical record into a standardized layout and provide it on a regular basis to Humana via secure email or FTP.
   - Extract data from EMRs to create the file for submission.

4. **Attestations**
   - Ensure open gaps reports have been completed.
   - Verify that completed reports are signed by a practitioner with approved credentials (M.D., N.P., P.A., D.O., R.P.H.).

5. **Copies of medical records**
   - Submit medical records to close gaps in care. Be sure to include two patient identifiers and the minimal information required by the measures.
   - Provide medical records to Humana via upload, fax or mail.
HEDIS Stars measures
HEDIS Stars measures

- HEDIS Stars measures have an assigned weight.

- The weight is indicative of the measure’s value within the Stars rating scale. Generally, outcome measures are triple-weighted, compared to screenings measures that are single-weighted.

- The combined rates of the HEDIS Stars measures constitute 27 percent of the Stars score.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>1</td>
</tr>
<tr>
<td>Adult BMI assessment</td>
<td>1</td>
</tr>
<tr>
<td>Care for older adults – medication review</td>
<td>1</td>
</tr>
<tr>
<td>Care for older adults – functional status assessment</td>
<td>1</td>
</tr>
<tr>
<td>Care for older adults – pain assessment</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis management</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes care – eye exam</td>
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<tr>
<td>Diabetes care – kidney disease monitoring</td>
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</tr>
<tr>
<td>Diabetes care – blood sugar controlled</td>
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<tr>
<td>Controlling blood pressure</td>
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<tr>
<td>Rheumatoid arthritis management</td>
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<tr>
<td>Plan all-cause readmissions</td>
<td>3</td>
</tr>
<tr>
<td>Medication reconciliation post-discharge</td>
<td>1</td>
</tr>
<tr>
<td>Statin therapy for patients with cardiovascular disease</td>
<td>1</td>
</tr>
</tbody>
</table>
Osteoporosis management in women who had a fracture (OMW)

• Percentage of women 67 to 85 years old who suffered a fracture and had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Notes:

• A patient who had a BMD test 24 months before the fracture or a prescription to treat or prevent osteoporosis within 12 months before the fracture is excluded from the denominator.
• A copy of the radiology report should be obtained and filed in the patient’s medical record.
Comprehensive diabetes care (CDC)

- Percentage of patients 18 to 75 years old with diabetes (Type 1 or Type 2) who had each of the following:
  - **Blood sugar controlled (CDC-HbA1c) measure**
    - Result must be recorded and 9 percent or less for Medicare Advantage Star reporting for compliance.
    - The last reading/result of the measurement year will be used for HEDIS reporting, and performance rating for a care opportunity may reopen with a noncompliant or missing result.
  
  - **Eye exam (dilated or retinal) (CDC-eye)**
    - A comprehensive eye exam by an eye care professional should be performed and read during the measurement year for compliance.
    - A negative eye exam by an eye care professional in the year prior to the measurement year can close the care opportunity (ICD-10 code submission required).

  - **Diabetic nephropathy screening (CDC-neph)**
    - To be compliant, a patient must have had a nephropathy screening, nephrology consult or dispensed prescription for angiotensin-converting enzyme (ACE) inhibitor/angiotensin receptor blocker (ARB) therapy.
How to address the HbA1c care opportunity

- Ensure the patient has taken the test
- Ensure correct coding for HbA1c result on a claim (CPT II)
- Work with the patient to achieve an HbA1c within acceptable limits
- Accurately document the result in the medical record, including date of service
- Use lab and supplemental data feeds
Best practices for CDC-eye measure

- Review and use appropriate CPT II codes to indicate review of eye exam results.
- Refer patients to covered eye care professionals and schedule appointments for patients, if necessary.
- Ensure use of proper diagnosis codes to report negative test results for retinopathy.
- Utilize mobile eye exam units using fundus photography to capture image of the retina.
Best practices for diabetic nephropathy screening

Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with patient.

Review diabetes services needed at each office visit.

Order labs prior to appointments for diabetic patients.

Provide a test option in office.

Send reminders to patients with either Type 1 or Type 2 diabetes regarding required testing.

Connect patients to community and/or health plan resources.
Controlling blood pressure (CBP)

• Percentage of patients diagnosed with hypertension whose blood pressure (BP) was adequately controlled during the measurement year:
  - Patients 18-59 years old whose BP was less than 140/90 mmHg
  - Patients 60-85 years old with a diagnosis of diabetes whose BP was less than 140/90 mmHg
  - Patients 60-85 years old without a diagnosis of diabetes whose BP was less than 150/90 mmHg

The last reading/result of the measurement year will be used for HEDIS reporting and performance rating.

Notes:
• CBP is a “chart chase” measure (“chart chase” is the term used for records collection season); therefore, the following medical record documentation is required:
  - Hypertension diagnosis documented on or before June 30 of the measurement year
  - Actual blood pressure reading (to pass, the most recent adequately controlled blood pressure reading of the year must be documented)
Medication reconciliation post-discharge (MRP)

• Percentage of discharges from Jan. 1 – Dec. 1 of the measurement year for patients 18 years old and older for whom medications were reconciled from the date of discharge through 30 days.

Notes:
• Medication reconciliation is the process of reviewing medications given in the hospital with those taken regularly to prevent duplication or interactions.
• Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review.
• Ensure documentation on the encounter includes some mention of the inpatient/SNF stay and/or that they were recently discharged.
Methods to address the MRP clinical care opportunity

- 99496 (days 1-7 post-discharge)
- 99495 (days 8-14 post-discharge)
- 1111F (within 30 days post-discharge); Include National Provider Identifier (NPI)

Complete an electronic attestation form and/or Star Quality Report.

Ensure medical record is submitted showing completion.

* A medical coder reviews the patient’s medical record and assigns the pertinent code based on qualifying documentation of medication reconciliation. These codes are transmitted to Humana via supplemental data feed by uploading electronic medical records directly to Humana’s secure portal or faxed to Humana Record Retrieval. If the clinical opportunity remains open by the end of the year, Humana will conduct a chart review to identify MRP completion.
Plan all-cause readmission (PCR)

• Percentage of patients 65 years old and older discharged from a hospital stay and readmitted to a hospital within 30 days, either for the same condition or a different reason

Notes:
• Efforts from the plan and physicians supporting coordination of care and prevention of readmissions improve this rate.
• This is a highly leveraged measure and one of the most difficult to control.
Best practices for addressing the PCR measure

• Promote health plan services (e.g., transition of care, care coordination, home health, etc.).

• Be aware of the daily discharge census.

• Manage scheduling capacity to be able to see patients who have been discharged from a hospital stay within seven days.

• Conduct medication reconciliation during first post-discharge visit with patient.

• Discuss with patients if they have issues accessing the resources necessary to prevent a readmission (e.g., transportation for follow-up appointments and necessary medications).

• Connect patient to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.
Statin therapy for patients with cardiovascular disease (SPC)

• Percentage of men 21-75 years old and women 40-75 years old, identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and dispensed at least one high- or moderate-intensity statin medication during the measurement year.

Notes:

• A patient is excluded if there is a diagnosis of:
  - Pregnancy
  - Drugs administered for in vitro fertilization or dispensed with clomiphene medication
  - End-stage renal disease
  - Myositis
  - Myalgia
  - Cirrhosis
  - Myopathy
  - Rhabdomyolysis

• Patients are identified for the eligible population in two ways:
  - Event (during prior year): Myocardial infarction (inpatient), coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), other revascularization
  - Diagnosis: At least one acute inpatient or outpatient visit with ischemic vascular disease (IVD) diagnosis in current and previous year
Patient safety Stars measures
Patient safety measures

- Patient safety Stars measures have an assigned weight.
- The weight is indicative of the measure’s value within the Stars rating scale.
- Because medication adherence measures heavily influence patient outcomes, most are triple-weighted.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Medication adherence: diabetes medication</td>
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<tr>
<td>Medication adherence: hypertension (ACE/ARB)</td>
<td>3</td>
</tr>
<tr>
<td>Medication adherence: cholesterol (statins)</td>
<td>3</td>
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<tr>
<td>Comprehensive medication review (CMR)</td>
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<tr>
<td>Statin use in persons with diabetes (SUPD)</td>
<td>3*</td>
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</table>

* SUPD was single-weighted as an introductory measure, but will now be triple-weighted.

The combined rates of the patient safety Stars measures constitute 13 percent of the Stars score.
Medication adherence (Part D) measures

Percentage of patients 18 years old or older who fill a prescription 80 percent or more of the time for the following:

• Diabetes:
  - Biguanides
  - Thiazolidinediones
  - Incretin mimetics
  - Sulfonylureas
  - DPP-IV inhibitors
  - Meglitinides

Note: Patients who take insulin are not included.

• Blood pressure:
  - ACE inhibitor
  - ARB drug
  - Direct renin inhibitor drug

• Cholesterol
  - Statin drugs
Medication therapy management (MTM)

• Completion rate for comprehensive medication review (CMR)
  - Measures the percent of Medicare Part D beneficiaries 18 years old or older enrolled in the MTM program for at least 60 days who received a CMR

• MTM eligibility criteria:
  - Patients have three of the following five chronic diseases: congestive heart failure (CHF), diabetes mellitus, dyslipidemia, hypertension or bone disease arthritis – osteoporosis
  - Minimum of eight Part D medications
  - Anticipated Part D drug cost of more than $3,967
Statin use in persons with diabetes (SUPD)

- Percentage of Medicare Part D beneficiaries 40 to 75 years old dispensed medication for diabetes who receive a statin medication

**Notes:**
- A patient is excluded if in hospice.
- Prescription claims data are used as a proxy for diabetes diagnosis in this measure.
- This measure uses only prescription claims as a source of data.
Member experience overview
### CAHPS and HOS survey timelines

<table>
<thead>
<tr>
<th>Month</th>
<th>CAHPS survey</th>
<th>HOS survey</th>
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<tbody>
<tr>
<td>January 2018</td>
<td>Prenotification letter</td>
<td>HOS baseline cohort survey begins</td>
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<tr>
<td></td>
<td>First paper questionnaire mails</td>
<td>HOS follow-up cohort survey begins</td>
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<tr>
<td>February</td>
<td>Second paper questionnaire mails</td>
<td>HOS baseline cohort survey ends</td>
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<tr>
<td>March</td>
<td>Telephonic outreach begins</td>
<td>HOS follow-up cohort survey ends</td>
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<tr>
<td>April</td>
<td>Follow-up calls end</td>
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<tr>
<td>May</td>
<td>Cutoff date for phone and mail surveys</td>
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</tr>
<tr>
<td>June</td>
<td>Final data files due to CMS</td>
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**Blackout period:** Late February through June. Health plans are prohibited from asking their members any CAHPS-related question that could influence official survey responses. Physicians, however, may discuss CAHPS and HOS quality topics with patients during this period.
Why are CAHPS and HOS important?

- At **27 percent**, CAHPS and HOS make up the second largest combined slice of the overall CMS Star rating.
- At a **4-Star level** or above, each plan is eligible for a bonus based on membership.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

• Survey assesses consumers’ experiences with the quality of their health care and other plan services.

• Medicare Advantage and prescription drug plan version of the survey asks 68 questions.

• 800 members are randomly selected from each health plan annually.

• Five attempts are made to survey the health plan member: two by paper and three telephonically.

Humana
### CAHPS survey question domains

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<thead>
<tr>
<th>Weight</th>
<th>Measure</th>
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<tr>
<td>1.5</td>
<td>Getting care quickly</td>
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<tr>
<td>1.5</td>
<td>Getting needed care</td>
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<tr>
<td>1.5</td>
<td>Care coordination</td>
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<td>1.5</td>
<td>Customer service</td>
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<td>1.5</td>
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<td>Rating the health plan</td>
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<tr>
<td>1.5</td>
<td>Rating the drug plan</td>
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</tbody>
</table>

**Composite** | **Single item** | **Overall**
Health Outcomes Survey (HOS)

• This tool assesses the ability of a Medicare Advantage Organization to maintain or improve its patients’ physical and mental health.

• Survey asks 68 questions.

• Between 1,200 and 2,000 members are randomly selected from each plan annually.

• Patients are selected to receive a baseline survey and a follow-up survey two years apart.

• Up to 11 attempts are made to survey the member: two by paper and six to nine telephonically.
# HOS measure domains

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<th>Measure</th>
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<td>3</td>
<td>Mental health</td>
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<td>1</td>
<td>Bladder control*</td>
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<td>1</td>
<td>Fall risk</td>
</tr>
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<td>1</td>
<td>Physical activity</td>
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</table>

*Bladder control is included in overall HOS scoring as of Feb. 1, 2017, according to direction from the Centers for Medicare & Medicaid Services (CMS).*
Sources

- HEDIS 2018, Volume 2, Technical Specifications for Health Plans

The information in this presentation is not a complete or comprehensive description of HEDIS or the Stars program. The presentation serves as an introduction to HEDIS, Stars and corresponding clinical measures.
CAHPS/HOS materials

The materials below can assist with improving your CAHPS and HOS scores.

<table>
<thead>
<tr>
<th>CAHPS/HOS measures</th>
<th>CAHPS/HOS guide</th>
<th>CAHPS/HOS one-pager</th>
<th>Let’s Talk pads</th>
<th>Physical activity prescription pads</th>
<th>Specialist appointment reminder pads</th>
<th>Provider scorecard</th>
<th>Happy poster</th>
<th>Bladder/ falls poster</th>
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<td>Getting needed care</td>
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<tr>
<td>Getting care quickly</td>
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<td>Care coordination</td>
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<td>Overall rating of health care quality</td>
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<td>Overall rating of health plan</td>
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<td>Flu vaccine</td>
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<td>Physical health</td>
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<td>Mental health</td>
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<td>Physical activity</td>
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<td>Bladder control</td>
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<td>Risk of falling</td>
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Preventative Screen/Humana Programs
Annual Wellness Visit (AWV)

• Medicare Advantage Members are eligible for a “Welcome To Medicare” visit when they become Medicare eligible and then Annually there after
• The visit is an opportunity to have a sit down planning meeting to assess:
  o Brain health, memory and depression
  o Overall physical, joint and emotional health
  o B/P check
  o Body Mass Index calculation
  o Keep track of doctors
  o Keep track of medications
  o Manage chronic problems
  o Plan for screenings/shots
  o Review Medical History

**Frequency –**

  o Welcome to Medicare Visit – once per lifetime w/in first 12 months of Medicare Part B enrollment
  o Initial AWV – once per lifetime at least 12 months after Medicare Part B enrollment
  o Subsequent AWV – annually after the initial AWV
Annual Physical/In Home Wellness Assessment

Annual Physical

• Medicare Advantage Members are eligible for 1 physical every 12 months in the years following the Welcome to Medicare Visit

• Services assessed may include:
  o Reviewing medical history
  o Conducting a physical exam to identify risk status and manage any interventions as needed
  o B/P check
  o Counsel on diet, exercise, substance abuse, injury prevention
  o Recording height, weight and intervals according to provider’s clinical discretion
  o Screening vision at provider’s discretion
  o Screening hearing at provider’s discretion

The physical can be preformed in the same 12 months as the AWV and is reimbursable on the same day as an AWV
In Home Wellness Assessment

IHWA

- A licensed physician or nurse practitioner will perform a 45-90 min assessment in the patient’s home
- Services assessed may include:
  - Brief exam including vitals
  - Active/inactive/chronic medical conditions with associated medications
  - Functional status/Fall risk assessment
  - Personal/social history, drug/tobacco/alcohol screenings
  - Diabetes/cancer assessments
  - Depression screen/mental status exam
  - Preventative/chronic disease care recommendations

The IHWA does not take the place of a visit with the members Primary Care Provider. All IHWA are sent to the provider by the vendor once they are completed and processed.
### Clinical programs

#### Well-being and lifestyle
- Health and wellness education
- Member assistance program
- Smoking cessation
- Health coaching
- Humana fitness: SilverSneakers
- Go365

#### Acute, episodic events
- Utilization management
- Clinical review
  - Radiology review services
  - Therapeutic review services
  - Oncology quality management
- HumanaFirst: Urgent advice
- Senior case management
- Humana At Home Transitions
- Well Dine<sup>SM</sup>
- Transplant management

#### Long-term health
- Humana At Home Chronic Care Program (HCCP)
- Humana At Home Stay Healthy
- End-stage renal disease (ESRD)/chronic kidney disease (CKD) management
- Humana Behavioral Health

#### Across all levels of health
- HumanaFirst: Health Planning and Support
- Humana health alerts
- Humana guidance centers
  - Welvie shared decision-making tool
- Availity care profile
- Member Summary
- In-home health and well-being assessments

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1. **Member evaluation**
   - New member assessments
   - Predictive modeling
   - Transition of care

2. **Guidance and support**

3. **Analysis and feedback**
   - Retrospective
   - Current
   - Prospective
Claims

Provider Payment Integrity
- Humana has a process to address claims concerns
- Inquiries can be submitted by:
  o Calling 1-800-438-7885 or
  o contactPPI@humana.com
  o Customer Service will research the issue and respond within 3 business days
- Unsatisfactory resolution can be escalated by sending a secure email to helpPPI@humana.com
  o You will receive an acknowledgement of the submission but need to allow 7 business days for review/response to the inquiry

Coding Questions
- If you have specific coding questions they can be submitted through Availity if you have access or
  o Sign into Humana.com and go to “Claims Tool” and select “Code Edit Simulator”

Humana offers MRA Webinars Monthly/Quarterly free of charge for those interested in additional education
Credentialing

Provider Updates

• You can submit changes and terminations of providers via email/fax to:
  
  o EMAIL: NCRNETWORKOPS@humana.com
  
  o FAX: 312.601.0501
Resources
Resources Available

- MRP Flyer
- OMW Flyer
- Clinical Programs Flyer
- CAHPS/HOS Package
- Outcomes MTM Flyer for CMR Completion
- SPC Flyer
- SUPD Flyer
- Humana Pharmacy Flyer
- Cover My Meds Flyer
- Availity Flyer and Webinar Schedule
- Medicare Preventative Services Tip Sheet
- Well Dine Flyer
- Transitions of Care Flyer
- Claims Escalation Flyer
- MRA Webinar Schedule
- 2018 Provider HEDIS Guide