Access/Availability of Care

Specific Guidelines for Access/Availability of Care Measures

Continuous Enrollment

For some Access/Availability of Care measures, the eligible population includes individuals who were continuously enrolled for some period of time (e.g., during the measurement year). For these measures, follow the guidelines on continuous enrollment described in the *General Guidelines.*

Which Services Count

Report all services for Access/Availability of Care measures, whether or not the MCO paid for them (e.g., report services paid for by a third party such as a community center, or services for which payment was denied because they were not properly authorized). The MCO must include all paid, suspended, pending and denied claims. The MCO is ultimately responsible for the quality of care it provides to its members and for ensuring that certain services have been provided, even if another community practitioner provides the services.

To count services in the medical record, documentation in the medical record must indicate the date the procedure was performed and the result (when applicable). For the *Prenatal and Postpartum Care* measure, services provided prior to enrollment in the MCO cannot be counted.

Hybrid Methodology

An MCO that uses the hybrid method for *Prenatal and Postpartum Care* should follow the guidelines pertaining to the hybrid methodology and substitution of medical records in the *Guidelines for Calculations and Sampling.*

Adults' Access to Preventive/Ambulatory Health Services (AAP)

Summary of Changes to HEDIS 2007

- Added CPT codes 99304–99310, 99318, 99324–99328, 99334–99337 to Table AAP-A.
- Added HCPCS codes to Table AAP-A.
- Added ICD-9-CM Diagnosis codes V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 to Table AAP-A.
- Deleted mental health and chemical dependency services exclusions.

Description

The percentage of enrollees 20–44, 45–64 and 65 years and older who had an ambulatory or preventive care visit. Nine separate rates are calculated, one for each of the three product lines for each of the three age groups. The MCO reports the percentage of:

- Medicaid and Medicare enrollees who had an ambulatory or preventive care visit during the measurement year
- Commercial enrollees who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 20–44, 45–64, 65 years and older as of December 31 of the measurement year (report each age stratification separately).

Continuous enrollment *Medicaid and Medicare:* The measurement year.

Commercial: The measurement year and the two years prior to the measurement year.

Allowable gap No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Diagnosis/Event None.

Administrative Specification

Denominator The eligible population (report each age stratification separately).

Numerator *Medicaid and Medicare:* One or more ambulatory or preventive care visits during the measurement year.

Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

To identify visits, count each member with an occurrence of one of the CPT codes or UB-92 Revenue codes listed in Table AAP-A.

Exclude inpatient stays and emergency department (ED) visits.

Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB-92 Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			
Home services	99341-99350			
Nursing facility care	99301-99303, 99304-99310, 99311-99313, 99318			
Domiciliary, rest home or custodial care services	99321-99323, 99324-99328, 99331-99333, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429	G0344		0770, 0771, 0779
Ophthalmology and optometry	92002, 92004, 92012, 92014			
Clinic				051x
Freestanding clinic				052x
Professional fees, outpatient services				0982
Professional fees, clinic				0983
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Note

- *In the rare situation that the MCO's CMS-approved benefit package does not include some preventive services, the MCO does not need to report this measure for its Medicare product line.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table AAP-1/2/3: Data Elements for Adults' Access to Preventive/Ambulatory Health Services

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification*
Numerator events by administrative data	*For each age stratification*
Reported rate	*For each age stratification*
Lower 95% confidence interval	*For each age stratification*
Upper 95% confidence interval	*For each age stratification*

Children and Adolescents' Access to Primary Care Practitioners (CAP)

SUMMARY OF CHANGES TO HEDIS 2007

- Deleted mental health and chemical dependency services exclusions.

Description

The percentage of enrollees 12–24 months, 25 months–6 years, 7–11 years and 12–19 years who had a visit with an MCO primary care practitioner. The MCO reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with an MCO primary care practitioner during the measurement year.
- Children 7–11 and adolescents 12–19 years who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year.

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages

Age stratification 1: 12–24 months as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 31, 2005, and December 1, 2004).

Age stratification 2: 25 months–6 years as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between November 30, 2004, and January 1, 2000).

Age stratification 3: 7–11 years as of December 31 of the measurement year. Include all children who are 7 years old but not older than 11 during the measurement year (i.e., born on or between December 31, 1999, and January 1, 1995).

Age stratification 4: 12–19 years as of December 31 of the measurement year. Include all adolescents who are 12 years but not older than 19 during the measurement year (i.e., born on or between December 31, 1994, and January 1, 1987).

Continuous enrollment

Age stratifications 1 and 2: The measurement year.

Age stratifications 3 and 4: The measurement year and the year prior to the measurement year.

Allowable gap *Age stratifications 1 and 2:* No more than 1 gap in enrollment of up to 45 days during the measurement year.

Age stratifications 3 and 4: No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment.

To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.

Anchor date December 31 of the measurement year.

Benefit Medical.

Diagnosis/event None.

Administrative Specification

Denominator The eligible population.

Numerator *Age stratifications 1 and 2:* One or more visits with an MCO primary care practitioner during the measurement year. *Age stratifications 3 and 4:* One or more visits with an MCO primary care practitioner during the measurement year or the year prior to the measurement year.

The MCO should count all members who had a visit to *any* primary care practitioner, as defined by the MCO, with an occurrence of one of the CPT of ICD-9-CM codes listed in Table CAP-A. Exclude inpatient stays and ED and specialist visits.

Note: *Refer to Appendix 3 for the definition of* primary care practitioner.

Table CAP-A: Codes to Identify Ambulatory or Preventive Care Visits

Description	CPT	ICD-9-CM Diagnosis
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	
Home services	99341-99350	
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429	
General medical examination		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Note

- *The MCO must use its internal directory or provider database to identify primary care practitioners. The directory or database should be current (i.e., updated at least every year).*
- *The MCO may count visits to physician assistants and nurse practitioners in primary care practitioner offices as long as the practitioner provided any service in Table CAP-A, even if the practitioner is not listed as a primary care practitioner in the MCO directory.*
- *An MCO with internal codes or transaction data not cited above that denote a Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well-child visit may use these codes as long as it provides the state with documentation of its method for tracking these visits.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CAP-1/2: Data Elements for Children and Adolescents' Access to Primary Care Practitioners

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification*
Numerator events by administrative data	*For each age stratification*
Reported rate	*For each age stratification*
Lower 95% confidence interval	*For each age stratification*
Upper 95% confidence interval	*For each age stratification*

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS 2007

- Added LOINC codes 41763-4, 42337-6, 42338-4, 42949-8, 43028-0, 43030-6, 43031-4, 43111-4 to Table PPC-C under Decision Rule 2 and Decision Rule 3.
- Deleted Occurrence code 10 from Tables PPC-C and PPC-D.
- Deleted CPT Category II code 0501F from Tables PPC-C and PPC-D.
- Added HCPCS codes to Table PPC-E.
- Added ICD-9 Procedure code 89.26 to Table PPC-E.
- Revised requirements for Decision Rule 3; the visit to a family practitioner or other primary care practitioner must be in conjunction with a pregnancy-related diagnosis code.

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester *or* within 42 days of enrollment in the MCO.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Definitions

Preterm*: Any neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.

Post-term*: Any neonate whose birth occurs from the beginning of the first day (295th day) of the 43rd week following the onset of the last menstrual period.

Start date of the last enrollment segment: For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

Refer to *Medicaid Continuous Enrollment* in *General Guidelines* for information about handling administrative one-day enrollment gaps.

*These definitions are from the *Guidelines for Perinatal Care, Fifth Edition.* American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Age None specified.

Continuous enrollment 43 days prior to delivery through 56 days after delivery.

Allowable gap No allowable gap during the continuous enrollment period.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis *Delivered a* live *birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Women who delivered in a birthing center should be included in this measure. Refer to Tables PPC-A and PPC-B to identify live births.

Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.

Administrative Specification

Denominator The MCO should follow the first two steps below to identify the eligible population. This population is the denominator for both rates.

Step 1 *Identify live births.* Identify all women with a live birth between November 6, 2005, and November 5, 2006, using Method A and Method B below.

Method A The codes listed in Table PPC-A both identify a delivery and indicate that the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no further verification of the outcome.

Table PPC-A: Codes to Identify Live Births

Description	ICD-9-CM Diagnosis
Identify live births	650, V27.0, V27.2, V27.3, V27.5, V27.6, V30-V37*, V39*

*These codes are assigned to the infant and should only be used if the MCO is able to link infant and mother records.

Method B *Identify deliveries and verify live births.* The codes in Table PPC-B, step A, identify deliveries but do not indicate the outcome. The MCO must use step B to eliminate deliveries that did not result in a live birth.

Table PPC-B: Codes to Identify Deliveries and Verify Live Births

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure	DRG
Step A: Identify deliveries	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.11, 645.21, 646.x1, 646.12, 646.22, 646.42, 646.52, 646.62, 646.82, 647.x1, 647.x2, 648.x1, 648.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.02, 654.12, 654.32, 654.42, 654.52, 654.62, 654.72, 654.82, 654.92, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.01, 665.11, 665.22, 665.31, 665.41, 665.51, 665.61, 665.71, 665.72, 665.81, 665.82, 665.91, 665.92, 666.x2, 667.x2, 668.x1, 668.x2, 669.01, 669.02, 669.11, 669.12, 669.21, 669.22, 669.32, 669.41, 669.42, 669.51, 669.61, 669.71, 669.81, 669.82, 669.91, 669.92, 670.02, 671.01, 671.02, 671.11, 671.12, 671.21, 671.22, 671.31, 671.42, 671.51, 671.52, 671.81, 671.82, 671.91, 671.92, 672.02, 673.x1, 673.x2, 674.01, 674.51, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2	72.0-73.99, 74.0-74.2, 74.4, 74.99	370-375
Step B: Exclude deliveries not resulting in a live birth		630-637, 639, 656.4, 768.0, 768.1, V27.1, V27.4, V27.7		

Step 2 Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Numerator

Timeliness of prenatal care A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the MCO and any gaps in enrollment during the pregnancy. Includes only visits that occur while the member was enrolled.

Step 3 Determine enrollment status during the first trimester. Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 6.

Step 4 Determine continuous enrollment for the first trimester. Determine if women identified in step 3 were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]) with no gaps in enrollment. For these women, use one of the four decision rules in Table PPC-C to determine if there was a prenatal visit during the first trimester.[1] For women who were not continuously enrolled during the first trimester, proceed to the next step.

Step 5 For women who had a gap between 176 and 280 days prior to delivery, proceed to step 6.

[1] If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days prior to delivery with no gaps during this period), the MCO has sufficient opportunity to provide prenatal care in the first trimester. The MCO must use the Table PPC-C. Any enrollment gaps in the second and third trimesters are incidental.

Step 6 For women identified in step 3 and step 5, determine the start date of the last enrollment segment.[5] For women not enrolled in the MCO on or before 280 days prior to delivery (or EDD) and for women who had a gap between 176 and 280 days prior to delivery (step 5), determine the start date of the last enrollment segment.

For women whose last enrollment started on or between 219 and 279 days prior to delivery, proceed to step 7. For women whose last enrollment started less than 219 days prior to delivery proceed to step 8.

Step 7 Determine if enrollment started on or between 219 and 279 days prior to delivery. If the last enrollment segment started on or between 219 and 279 days prior to delivery, determine numerator compliance using the numerator criteria in Table PPC-D and find a visit between the last enrollment start-date and 176 days prior to delivery.[6]

Step 8 Determine if enrollment started less than 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery). If the last enrollment segment started less than 219 days prior to delivery, determine numerator compliance using Table PPC-D numerator criteria for a visit within 42 days after enrollment.

Table PPC-C: Markers for Early Prenatal Care Obtainable from Administrative Data

Decision Rule 1
Marker Event
Any prenatal care visit to an OB practitioner, a midwife or family practitioner or other primary care practitioner with documentation of when prenatal care was initiated.
Administrative
Any one code:
• **CPT:** 59400*, 59510*, 59610*, 59618*, 59425*, 59426* • **CPT Category II:** 0500F, 0502F

*Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

[5] See definition of **last enrollment segment**.

[6] The 176 days prior to delivery includes the 42-day period after enrollment. For example, a member who had a last enrollment segment 225 days prior to delivery would have until the end of the first trimester (176 days prior to delivery) instead of the 183 days prior to delivery under the 42-day criteria. Table PPC-D allows more flexibility for identifying prenatal care visits occurring later in the pregnancy.

Decision Rule 2

Marker Event

Any visit to an OB practitioner or midwife with one of the following:

- Obstetric panel
- TORCH antibody panel
- Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)
- Ultrasound (echocardiography) of pregnant uterus
- Pregnancy-related diagnosis code
- ICD-9-CM Diagnosis for prenatal care

Administrative

The member must meet criteria in Part A ***and*** (Part B ***or*** Part C).

Part A: *Any one code.*

- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99271-99275
- **UB-92 Revenue:** 514

Part B: *Any one code.*

- **CPT:** 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 80055
- **ICD-9-CM Diagnosis:** 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, V22-V23, V28
- **LOINC:** 24314-7, 24364-2

Part C: *One of the following.*

TORCH: A code for each of the four infections must be present for this component	Cytomegalovirus	• **CPT:** 86644 • **LOINC:** 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6
	Herpes simplex	• **CPT:** 86694, 86695, 86696 • **LOINC:** 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4
	Rubella	• **CPT:** 86762 • **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 34952-2, 41763-4
	Toxoplasma	• **CPT:** 86777 • **LOINC:** 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 15396-5, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23484-9, 23485-6, 23486-4, 23784-2, 24242-0, 24398-0, 24399-8, 25300-5, 25542-2, 33336-9, 33337-7, 34422-6, 35281-5, 35282-3, 40676-9, 40677-7, 40678-5, 40785-8, 40786-6, 42949-8

Decision Rule 2

Marker Event		
Rubella/ABO/Rh: A code for Rubella ***and*** (ABO ***or*** Rh) must be present for this component	Rubella	• **CPT:** 86762 • **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 34952-2, 41763-4
	ABO	• **CPT:** 86900 • **LOINC:** 883-9
	Rh	• **CPT:** 86901 • **LOINC:** 10331-7, 34961-3
	ABO and Rh	• **LOINC:** 34530-6, 882-1, 884-7

Decision Rule 3

Marker Event

*Any visit to a family practitioner or other primary care practitioner** with a pregnancy related ICD-9-CM Diagnosis code* ***AND*** *one of the following:*

- Obstetric panel
- TORCH antibody panel
- Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)
- Ultrasound of the pregnant uterus

** When using a visit to a family practitioner or other primary care practitioner, it is necessary to determine that prenatal care was rendered and that the member was not merely diagnosed as pregnant and referred to another practitioner for prenatal care.

Administrative

The member must meet criteria in Part A ***and*** (Part B ***or*** Part C).

Part A: *Any CPT or UB-92 Revenue code* ***with*** *any ICD-9-CM Diagnosis code; [(CPT with ICD-9-CM) or (UB-92 with ICD-9-CM)]; the ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB-92 Revenue code.*

- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99271-99275
- **UB-92 Revenue:** 514
- **ICD-9-CM Diagnosis:** 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, V22-V23, V28

Part B: *Any one code.*

- **CPT:** 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 80055
- **LOINC:** 24314-7, 24364-2

Part C: *One of the following.*

TORCH: A code for each of the four infections must be present for this component	Cytomegalovirus	• **CPT:** 86644 • **LOINC:** 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6
	Herpes simplex	• **CPT:** 86694, 86695, 86696 • **LOINC:** 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4

Decision Rule 3 (continued)		
Administrative (continued)		
TORCH: A code for each of the four infections must be present for this component	Rubella	• **CPT:** 86762 • **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 34952-2, 41763-4
	Toxoplasma	• **CPT:** 86777 • **LOINC:** 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 15396-5, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23484-9, 23485-6, 23486-4, 23784-2, 24242-0, 24398-0, 24399-8, 25300-5, 25542-2, 33336-9, 33337-7, 34422-6, 35281-5, 35282-3, 40676-9, 40677-7, 40678-5, 40785-8, 40786-6, 42949-8
Rubella/ABO/Rh: A code for Rubella ***and*** (ABO ***or*** Rh) must be present for this component	Rubella	• **CPT:** 86762 • **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 34952-2, 41763-4
	ABO	• **CPT:** 86900 • **LOINC:** 883-9
	Rh	• **CPT:** 86901 • **LOINC:** 10331-7, 34961-3
	ABO and Rh	• **LOINC:** 34530-6, 882-1, 884-7

Decision Rule 4
Marker Event
Any visit to a family practitioner or other primary care practitioner with diagnosis-based evidence of prenatal care in the form of a documented LMP or EDD with either a completed obstetric history or risk assessment and counseling/education.
Administrative
The member must meet criteria in Part A ***and*** Part B. ***Part A:*** *Any code.* • **CPT:** 99201-99205, 99211-99215, 99241-99245, 99271-99275 • **UB-92 Revenue:** 514 ***Part B:*** • Any internal MCO code for LMP or EDD with an obstetrical history • Any internal MCO code for LMP or EDD with risk assessment and counseling/education

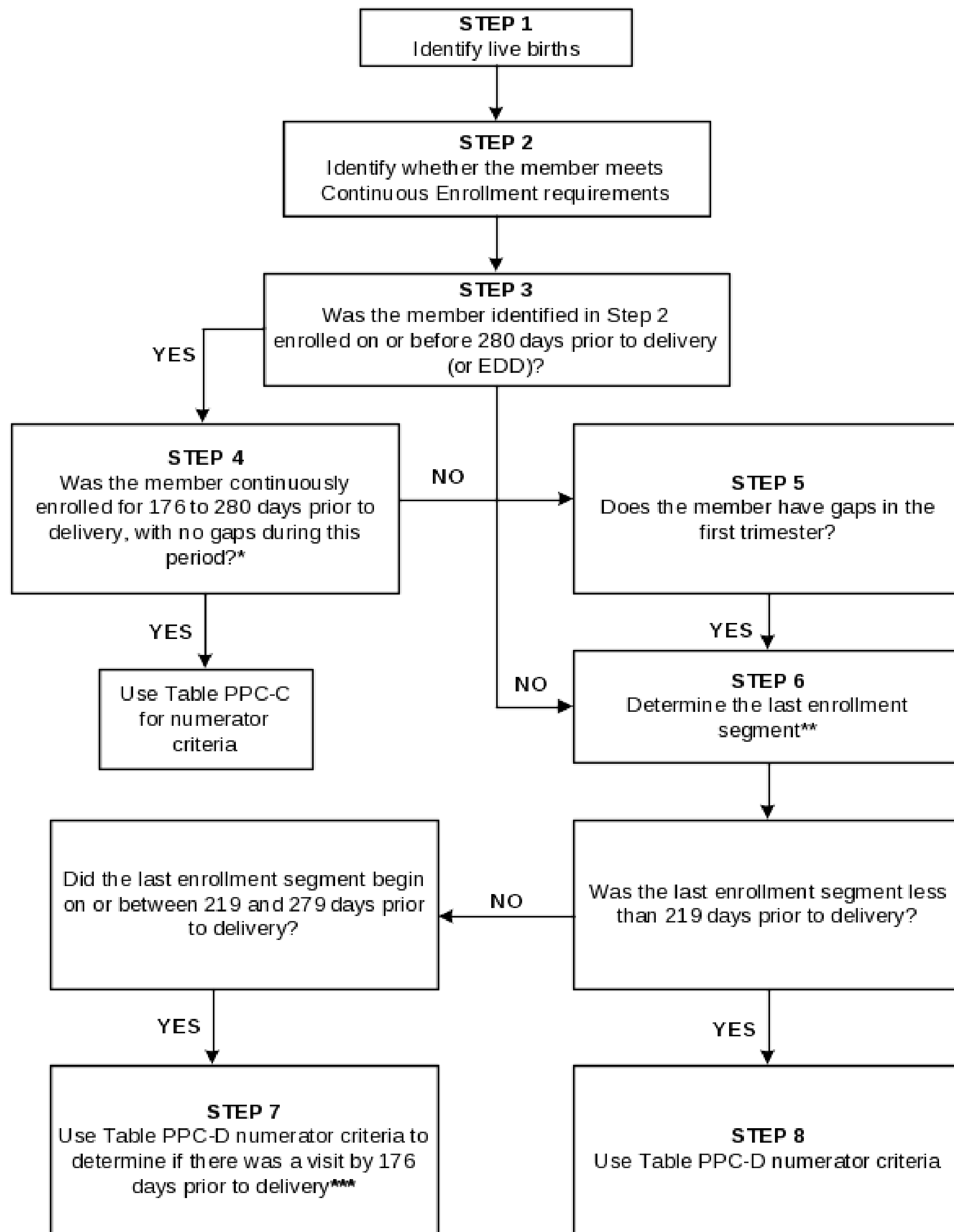
Table PPC-D: Markers for Prenatal Care Obtainable from Administrative Data

Marker Event
Any visit to an OB/GYN, family practitioner or other primary care practitioner with either an ultrasound or a principal diagnosis of pregnancy.
Administrative
The member must meet criteria in Part A ***or*** (Part B ***and*** Part C). ***Part A:*** *Any one code.* • **CPT:** 59400*, 59510*, 59610*, 59618*, 59425*, 59426* • **CPT Category II:** 0500F, 0502F ***Part B:*** *Any one code.* • **CPT:** 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818 • **ICD-9-CM Diagnosis**: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, V22-V23, V28 ***Part C:*** *Any one code.* • **CPT:** 99201-99205, 99211-99215, 99241-99245, 99271-99275 • **UB-92 Revenue:** 514

***** Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

Prenatal and Postpartum Care
Timeliness of Prenatal Care Numerator



* If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days prior to delivery), there is no need to look for gaps occurring during other times in the pregnancy. Use the criteria in Table PPC-C to determine numerator compliance. For example, if a member was enrolled during the first trimester, 176–280 days prior to delivery with a gap between the 125–150 days prior to delivery, the MCO must still meet the PPC-C first trimester criteria for numerator compliance. The gap and last enrollment segment are incidental because the member meets the first trimester enrollment test.

** See the definition of **last enrollment segment.**

*** The 176 days prior to delivery includes the 42-day period following enrollment. For example, a member who had a last enrollment segment 225 days prior to delivery has until the end of the first trimester (176 days prior to delivery), instead of the 183 days prior to delivery under the 42-day criteria. Table PPC-D also has greater flexibility to identify a prenatal care visit.

Postpartum care A postpartum visit (Table PPC-E) for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Table PPC-E: Codes to Identify Postpartum Visits

CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB-92 Revenue	LOINC
57170, 58300, 59400*, 59410*, 59430, 59510*, 59515*, 59610*, 59614*, 59618*, 59622*, 88141-88145, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0

* Generally, these codes are used on the date of delivery, not on the date of the postpartum visit, so this code may be used only if the claim form indicates when postpartum care was rendered.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from Frequency of Ongoing Prenatal Care or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from Frequency of Ongoing Prenatal Care.

Numerator

Timeliness of prenatal care A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the MCO and any gaps in enrollment during the pregnancy. Includes only visits that occur while the member was enrolled.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation in medical record must identify one of the following:

Prenatal care visits to an OB/GYN practitioner or midwife. Documentation in the medical record must include a note indicating the date on which the prenatal care visits occurred, and evidence of *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal OB form may be used), ***or***
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing)
  - TORCH antibody panel alone or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing
  - Echography of a pregnant uterus, ***or***

- Documentation of LMP or EDD in conjunction with *either:*
  - Prenatal risk assessment and counseling/education
  - Complete obstetrical history, ***or***
- For members whose last enrollment segment was after 219 days prior to delivery:
  - Any visit to an OB/GYN, family practitioner or other primary care practitioner with a principal diagnosis of pregnancy.

Prenatal care visits to a family practitioner or other primary care practitioner. Documentation in the medical record must include a note indicating the date on which the prenatal care visits occurred, with diagnosis of pregnancy and evidence of *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, *or* pelvic exam with obstetric observations *or* measurement of fundus height (a standardized prenatal OB form may be used), ***or***
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel
  - Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing
  - TORCH antibody panel
  - Echography of a pregnant uterus, ***or***
- Evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDD in conjunction with *either:*
  - Complete obstetrical history
  - Prenatal risk assessment and counseling/education, ***or***
- For members whose last enrollment segment was after 219 days prior to delivery:
  - Any visit to an OB/GYN, family practitioner, or other primary care practitioner with a principal diagnosis of pregnancy.

Postpartum care A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

Administrative Refer to the A*dministrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include a note indicating the date on which a postpartum visit occurred and *one* of the following.

- Pelvic exam, ***or***
- Evaluation of weight, blood pressure, breasts and abdomen, ***or***
- Notation of “postpartum care”

Note

- *When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses, provided that a cosignature by a physician is present, if required by state law.*
- *The use of an EDD date is optional and requires medical record review. It allows increased compliance for preterm deliveries.*
- *The MCO may count services that occur over multiple visits toward this measure as long as all services occur within the time frame established in the measure.*
- *The MCO should refer to Appendix 3 for the definition of primary care practitioner and OB/GYN practitioner.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table PPC-1/2: Data Elements for Prenatal and Postpartum Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Annual Dental Visit (ADV)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of enrolled members 2–21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Eligible Population

Product line Medicaid.

Ages 2–21 years as of December 31 of the measurement year. The measure is reported for each of the following age stratifications and as a combined rate.

- 2–3-years
- 4–6-years
- 7–10-years
- 11–14-years
- 15–18-years
- 19–21-years
- Total

Continuous enrollment The measurement year.

Allowable gap No more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Dental.

Event/diagnosis None.

Note: *Visits for many 1-year-olds will be counted because the specification includes children whose second birthday occurs any time during the measurement year.*

Administrative Specification

Denominator The eligible population for each age group and the combined total.

Numerator One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any of the codes in Table ADV-A.

Table ADV-A: Codes to Identify Annual Dental Visits

CPT	HCPCS/CDT-3	ICD-9-CM Procedure
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97

Note: *Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table ADV-1: Data Elements for Annual Dental Visit

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

SUMMARY OF CHANGES TO HEDIS 2007

- Added HCPCS to Tables IET-A and IET-B.
- Added UB-92 Revenue code 0456 to Table IET-B.
- Revised ICD-9-CM Diagnosis codes in Table IET-C to be consistent with those listed in Table IET-A.

Description

This measure calculates two rates for adult members and two rates for adolescent members with Alcohol and Other Drug (AOD) dependence.

- Initiation of AOD Dependence Treatment. The percentage of adolescent and adult members diagnosed with AOD dependence who initiate treatment through either:
  - An inpatient AOD admission, ***or***
  - An outpatient service, for AOD dependence *and* an additional AOD service within 14 days.
- *Engagement of AOD Treatment*. An intermediate step between initially accessing care (initiation treatment) and completing a full course of treatment. This measure is designed to assess the degree to which members engage in treatment with two additional AOD services within 30 days after initiation.

Definitions

Index Episode Start Date — Either the discharge date of the earliest inpatient encounter or the service date of the earliest intermediate, ED or outpatient encounter between January 1 and November 15 of the measurement year with a qualifying diagnosis of AOD dependence.

Intake Period — January 1 through November 15 of the measurement year. To ensure adequate opportunities for care are initiated within 14 days of a new episode of care, and two subsequent visits occur within an additional 30 days after initiation (inclusive), the last 45 days of the measurement year are not included in the Intake Period.

Negative Diagnosis History — A period of 60 days prior to the Index Episode Start Date, during which the member had no claims/encounters with any diagnosis of AOD dependence (Tables IET-A through IET-C). If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day Negative Diagnosis History.

New Episode — To qualify as a New Episode, the following criterion must be met: a 60-day Negative Diagnosis History prior to the Index Episode Start Date. If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day negative diagnosis history.

Inpatient Facility Code — The MCO's place of service or facility code, indicating that care was provided at an inpatient facility.

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Age 13 years and older as of the December 31 of the measurement year.

- 13–17-years
- 18–25 years
- 26–34 years
- 35–64 years
- 65+ years
- Total

Continuous enrollment 60 days prior through 44 days after the Index Episode Start Date.

Allowable gap None.

Anchor date None.

Benefits Medical and chemical dependency (inpatient and ambulatory).

Note: *Members with detoxification-only chemical dependency benefits do not meet this criterion.*

Event/diagnosis New episode of alcohol or other drug dependence diagnosis identified through:

- An outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year, ***or***
- A detoxification or emergency department visit between January 1 and November 15 of the measurement year, ***or***
- An inpatient discharge between January 1 and November 15 of the measurement year.

The MCO should follow the steps below to identify the eligible population, which is the denominator for both rates for this measure.

Step 1 Identify all members who meet the specified age criteria.

- Members who had an outpatient claim for AOD services between January 1 and November 15 of the measurement year, ***or***
- Members who had a detoxification or emergency department claim between January 1 and November 15 of the measurement year, ***or***
- Members who had an inpatient claim with a discharge date between January 1 and November 15 of the measurement year.

Outpatient visits: Use Table IET-A to identify outpatient services with any diagnosis of AOD dependence.

Detoxification and ED visits: Use Table IET-B to identify detoxification and emergency department visits with any diagnosis of AOD dependence. If the emergency department visit resulted in an inpatient stay, include the member in the inpatient category below.

Inpatient services: Use Table IET-C to determine inpatient services with any diagnosis of AOD dependence.

Table IET-A: Codes to Identify Intermediate Care and Outpatient Visits

CPT		HCPCS
90801-90802, 90804-90815, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99420	***OR***	G0155, G0176, G0177, H0001, H0002, H0004-H0007, H0015, H0016, H0020, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S9480, S9484, S9485, T1006, T1012

WITH

ICD-9-CM Diagnosis
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

Table IET-B: Codes to Identify Detoxification and Emergency Department Services

CPT		HCPCS		ICD-9-CM Procedure		UB-92 Revenue
99281-99285 ***WITH*** An ICD-9 diagnosis code from IET-A	***OR***	H0008-H0014, S9475 ***WITH*** An ICD-9 diagnosis code from IET-A	***OR***	94.62, 94.63, 94.65, 94.66, 94.68, 94.69 (ICD-9 procedure codes do not require a diagnosis of chemical dependency)	***OR***	045x ***WITH*** An ICD-9 diagnosis code from IET-A

Table IET-C: Codes to Identify Inpatient Services

ICD-9-CM Diagnosis		DRG
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1 ***WITH*** An inpatient facility code	***OR***	433, 521-523

Step 2 Determine the Index Episode Start Date. For each member identified in step 1, determine the Index Episode Start Date by identifying the date of the member's earliest encounter during the measurement year (e.g., outpatient, detoxification or emergency department visit date; inpatient discharge date) with any qualifying AOD dependence diagnosis (Tables IET-A–IET-C).

Step 3 Determine if the Index Episode Start Date is a New Episode. Members with a New Episode of AOD dependence have a Negative Diagnosis History. For members with an inpatient visit, use the admission date to determine negative diagnosis history.

Step 4 Calculate continuous enrollment. The member must be continuously enrolled without any gaps for 60 days prior through 44 days after the Index Episode Start Date.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD treatment Initiation of AOD treatment can occur in the following circumstances.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment, ***or***
- If the Index Episode was a detoxification ED visit or outpatient visit, the member must have a subsequent service within 14 days of the Index Episode Start Date to be considered initiated.

ED and detoxification visits count only toward the denominator and should not be included as the initiation visit.

Step 5 Identify all members in the denominator population whose Index Episode Start Date was an inpatient discharge with any AOD diagnosis. This visit counts as the initiation event.

Step 6 Identify all members in the denominator population whose Index Episode Start Date was an outpatient visit, detoxification visit or emergency department visit.

Step 7 Use Table IET-A or Table IET-C to determine if the members in step 6 had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the Index Episode Start Date (inclusive).

- To determine if the 14-day criterion is met for inpatient stays, use the admission date, not the discharge date.

Step 8 Exclude from the denominator members whose initiation service was an inpatient stay with a discharge date after December 1.

Engagement of AOD treatment Identify members who had an initiation of AOD treatment visit and two or more services with an AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). Use Table IET-A or Table IET-C to identify engagement treatment.

- For members who initiated treatment via an inpatient stay, 30 days starts at the member's inpatient discharge date.
- To determine if the 30-day criterion is met for engagement inpatient stays, use the admission date of the subsequent inpatient stay, not the discharge date.
  - ED and detoxification visits count only toward the denominator and should not be included as an engagement visit.

Note

- *An inpatient visit that included detoxification services should not be counted toward Initiation or Engagement numerators. Detoxification services may be identified using the codes in Table IET-B.*
- *If two engagement visits occur on the same day with different providers, both visits are included in the measure.*
- *If the member is directly transferred to another acute facility, the MCO should use the discharge date from the second facility when calculating the measure.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Call Answer Timeliness (CAT)

Summary of Changes to HEDIS 2007

- No changes to this measure.

Description

The percentage of calls received by the MCO's Member Services call centers (during Member Services operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Definitions

Call	Telephone contact initiated by an external caller connects with the MCO Member Services call center. For calls transferred from other parts of the MCO telephone system, measure time from after the call is transferred into the Member Services call center and the member chooses the option to speak to a Member Services representative and is placed in the call queue.
Member services operating hours	Hours of live call center operation indicated by membership materials (e.g., ID card, summary plan descriptions, enrollment materials).
Member services representative	An employee at the MCO Member Services call centers responsible for answering Member Services calls regarding enrollment, benefits and claims processing.
MCO Member Services call center	An entity within the MCO or under contract with the MCO that is responsible for handling MCO network member service inquiries regarding enrollment, benefits and claims processing.
Queue	A sequence of calls waiting to be handled by the Member Services representative. The wait time on a queued call is calculated by Automatic Call Distribution (ACD), which tracks incoming calls.

Calculation

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Note: *An MCO that uses the same systems, policies and procedures and staff to answer calls for all product lines may report the same rate for all product lines if it is not possible for it to report data by individual product line.*

Denominator

The number of calls received by the MCO Member Services call centers (during hours of operation) during the measurement year, where the member called directly into Member Services or selected a Member Services option and was put in the call queue. Exclude calls to an MCO benefits contractor (mental health, dental, vision, pharmacy) that uses its own call center.

Numerator

The number of calls answered by a live voice within 30 seconds.

Note: *Time measured begins when the member is placed in the call queue and is waiting to speak to a Member Services representative.*

Formulas *For an MCO with one call center that answers all the MCO's calls and has the MCO as its only client:*

- Report the measure as specified.

For an MCO with one call center that answers all the MCO's calls and also has multiple clients:

- If the call center is unable to report timeliness data for the specific MCO, the MCO reports timeliness for the entire volume of calls the center handles.

For an MCO with multiple call centers, each of which answers a portion of the total calls for the MCO, and has the MCO as its only client:

- Report the measure as a weighted average (see the formula below):

Definitions Let N_1 = The total number of Member Services calls received by call center 1

Let N_2 = The total number of Member Services calls received by call center 2

Let P_{CAT1} = The rate for the *Call Answer Timeliness* HEDIS measure for call center 1

Let P_{CAT2} = The rate for the *Call Answer Timeliness* HEDIS measure for call center 2

Set-up calculations Let W_1 = The weight assigned to call center 1. This result is calculated by the formula $W_1 = N_1/(N_1+N_2)$

Let W_2 = The weight assigned to call center 2. This result is calculated by the formula $W_2 = N_2/(N_1+N_2)$

Pooled analysis The pooled result from the two rates is calculated as:

$$P_{CAT\ pooled} = W_1 * P_{CAT1} + W_2 * P_{CAT2}$$

Note

- *Calls abandoned within 30 seconds remain in the measure and are noncompliant for the numerator.*
- *If during peak call periods (or any regular business hours), the plan blocks calls by immediately giving members a busy signal and keeping the calls from reaching the call queue, the auditor assesses the percentage of blocked calls and its impact on the measure.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CAT-1/2/3: Data Elements for Call Answer Timeliness

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Call Abandonment (CAB)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of calls received by the MCO's Member Services call centers (during Member Services operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice.

Definitions

Abandonment	The caller dials directly into the MCO Member Services call center or selects the Member Services option, is placed in the call queue and hangs up the phone, disconnecting from the call center before being answered by a Member Services representative.
Call	Telephone contact initiated by an external caller that connects to the MCO Member Services call center. For calls transferred from other parts of the MCO telephone system, measure time from after the call is transferred into the Member Services call center, the member chooses the option to speak to a Member Services representative and is placed in the call queue.
Member services operating hours	Hours of live call center operation indicated by membership materials (e.g., ID card, summary plan descriptions, enrollment materials).
Member services representative	An employee at the MCO Member Services call centers responsible for answering Member Services calls regarding enrollment, benefits and claims processing.
MCO Member Services call center	An entity within the MCO or under contract with the MCO that is responsible for handling MCO network member service inquiries regarding enrollment, benefits and claims processing.
Queue	A sequence of calls waiting to be handled by the Member Services representative. The wait time on a queued call is calculated by Automatic Call Distribution (ACD), which tracks incoming calls.

Calculation

Product lines	Commercial, Medicaid, Medicare (report each product line separately). ***Note:*** *An MCO that uses the same systems, policies and procedures and staff to answer calls for all product lines may report the same rate for all product lines if it is not possible for it to report data by individual product line.*
Denominator	The number of calls received by the MCO Member Services call centers (during hours of operation) during the measurement year where the member called directly into Member Services or selected a Member Services option and was put in the call queue. Exclude calls to the MCO's benefits contractor (mental health, dental, vision, pharmacy) when the contractor has its own call center.

Numerator The number of calls abandoned by the caller or the system before being answered by a live voice.

Formulas *For an MCO with one call center that answers all the MCO's calls and has the MCO as its only client:*

- Report the measure as specified.

For an MCO with one call center that answers all the MCO's calls and also has multiple clients:

- If the call center is unable to report abandonment data for the MCO, report abandonment for the entire volume of calls the center handles.

For an MCO with multiple call centers, each of which answers a portion of the total amount of calls for the MCO and has the MCO as its only client:

- Report the measure as a weighted average (see the formula below):

Definitions

Let N_1 = The total number of Member Services calls received by call center 1.

Let N_2 = The total number of Member Services calls received by call center 2.

Let P_{CAB1} = The rate for the *Call Abandonment* HEDIS measure for call center 1.

Let P_{CAB2} = The rate for the *Call Abandonment* HEDIS measure for call center 2.

Set-up calculations

Let W_1 = The weight assigned to call center 1. This result is calculated by the formula $W_1 = N_1/(N_1+N_2)$.

Let W_2 = The weight assigned to call center 2. This result is calculated by the formula $W_2 = N_2/(N_1+N_2)$.

Pooled analysis The pooled result from the two rates is calculated as:

$$P_{CA\ pooled} = W_1{*}P_{CAB1} + W_2{*}P_{CAB2}.$$

Note

- *Calls abandoned within 30 seconds remain in the measure and are noncompliant for the numerator.*
- *If during peak call periods (or any regular business hours), the plan blocks calls by immediately giving members a busy signal and keeping the calls from reaching the call queue, the auditor assesses the percentage of blocked calls and its impact on the measure.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CAB-1/2/3: Data Elements for Call Abandonment

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓