Health Plan Descriptive Information

Board Certification (BCR)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

The following changes will be included in HEDIS 2008.

- The percentage of the following physicians whose board certification is active as of December 31 of the measurement year. Reporting categories will also be changed.
  - Family medicine physicians
  - Internal medicine physicians
  - Pediatricians
  - OB/GYN physicians
  - Geriatricians
  - All other physician specialists and subspecialists

Description

The percentage of the following physicians whose board certification is active as of December 31 of the measurement year.

- Family medicine physicians
- Internal medicine physicians
- Pediatricians
- OB/GYN physicians
- Geriatricians
- All other physician specialists and subspecialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association. The MCO should report separately for each product as of December 31 of the measurement year.

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

Physicians This measure applies to independent physicians or group of physicians who provide care for MCO members.

MCO must include

- Physicians who have an independent relationship with the MCO. An **independent relationship** exists when the MCO selects and directs its members to see a specific physician or group of physicians. An *independent relationship* is not synonymous with an *independent contract.*
- Physicians who see members outside of the inpatient hospital setting or outside of freestanding facilities.
- Physicians who are hospital based and who see MCO members as a result of their independent relationship with the MCO. Examples of this type of physician may include, but are not limited to:
  - Anesthesiologists with pain management practices
  - Hospital-based cardiologists
  - Hospital-based faculty, provided that they meet these criteria.

MCO must exclude

- Physicians who practice exclusively within the inpatient hospital setting and who provide care for MCO members only as a result of members being directed to the hospital. Examples of this type of physician may include, but are not limited to:
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Neonatalogists
  - ED physicians.
- Physicians who practice exclusively within freestanding facilities and who provide care for MCO members only as a result of members being directed to the facility. Examples of this type of facility may include, but are not limited to:
  - Mammography centers
  - Urgent care centers
  - Surgicenters.
- Dentists who do not provide care under MCO medical benefits. Examples of this type of practitioner may include, but are not limited to:
  - Endodontists
  - Oral surgeons
  - Periodontists
  - Dentists who provide primary dental care under a dental plan or rider.

Categories The following specialties should be counted in the primary care and specialist categories for each of the product lines.

Table BCR-A: Identifying Primary Care and Physician Specialists

Product Line	Primary Care	Pediatric Physician Specialists	OB/ GYNs	Geriatricians	Physician Specialists
Medicaid and commercial	• General internal medicine • General practice • Family practice • General pediatrics	Pediatric physician specialists	OB/GYNs	Geriatricians	All others
Medicare	• General internal medicine • General practice • Family practice			Geriatricians	All others

Definitions

Primary care physician Refer to the practitioner definitions in the *Appendix 3* for the definition of **primary care physician**.

OB/GYN physician Refer to the practitioner definitions in Appendix 3 for the definition of **OB/GYN physician**. Physicians whose clinical area of practice is primary care in family practice, general practice or internal medicine should not be counted in this category, even if they perform OB/GYN services and have confirmed hospital privileges. These general physicians are excluded because no specialty certification exists to identify them in the OB/GYN specialty.

Pediatric physician specialists

Pediatric physician specialists include physicians whom the MCO has designated to provide the following services to its pediatric or adolescent product line.

- Adolescent medicine
- Cardiology
- Critical care medicine
- Emergency medicine
- Endocrinology
- Gastroenterology
- Hematology-Oncology
- Infectious disease
- Neonatology
- Nephrology
- Orthopedic surgery
- Pulmonology
- Rheumatology
- Sports medicine
- Pediatrics/Physical medicine and rehabilitation
- Neurology
- Psychiatry
- Surgery
- Otolaryngology

For pediatric specialty areas where a pediatric-focused specialty certificate can be earned under other general certificate areas, the physician must have a pediatric-focused specialty certificate (child and adolescent psychiatry, adolescent medicine, pediatric pathology, pediatric radiology, pediatric surgery, pediatric emergency medicine) to be counted.

For pediatric specialty areas in which no specialty certificate exists under pediatrics, the MCO must show evidence of either a general or specialty certificate with a focus in pediatric care.

Geriatricians

Internal medicine and family practice physician specialists in older adult care.

Other physician specialists

All areas of practice other than those listed under primary care and those to be reported separately should be included in the "other physician specialist" rate.

Calculation of Board Certification

Number of physicians in each practice area

For each product line, identify in the appropriate cells (refer to Table BCR-1/2/3) the number of physicians in each practice area by type and number of physicians in each practice area (board certified or not) with whom the MCO contracted in those practice areas as of December 31 of the measurement year.

Physicians are assumed to practice in the clinical area or areas in which they are listed in the MCO internal directory. Physicians listed under more than one category should be counted as many times as they are listed and should be included in each area of practice.

For example, a physician who is listed as both a general pediatrician and a pediatric gastroenterology specialist should be reported in the PCP category (for general pediatrics) and the pediatric physician specialist category (for gastroenterology); a family physician who also practices as a geriatrician should be reported in both the PCP category (for family practice) and the geriatricians category (for geriatrics).

Board certification number

Report the number of physicians from the number of physicians in each practice area who are board certified.

Pediatric specialist. To count a physician as a board-certified pediatric specialist, the MCO must document one of the following.

- If a specialty certificate exists under the general category of pediatrics, the physician must be board certified in the pediatric specialty area to be counted as a pediatric specialist. A general certificate in pediatrics is not sufficient.

- If a specific pediatric-focused specialty certificate can be earned under other general certificate areas, the physician must have a pediatric-focused specialty certificate (child and adolescent psychiatry, adolescent medicine, pediatric pathology, pediatric radiology, pediatric surgery, pediatric emergency medicine) to be counted as a pediatric specialist.
- For all other categories, the physician must have a board certification in the specialty area (e.g., plastic surgery) as well as a general pediatric board certification, ***or*** a pediatric-focused specialty certificate (i.e., a pediatric plastic surgeon must be board certified in plastic surgery and board certified in pediatrics, ***or*** board certified in pediatric surgery and board certified in plastic surgery).

Geriatrician. To be counted as a board-certified geriatrician, the physician must have a specialty certificate in geriatric medicine.

Board certification percentage

For each type of physician, calculate the percentage that is board certified by dividing the board certification number by the number of physicians in each practice area.

Other physician specialist. Calculating the physician specialist board-certification percentage is more complicated than calculating the other categories because some physicians are listed in the directory under more than one specialty and may be board certified in some specialties, but not all.

To count toward the board-certification numerator, a physician reported in a specialty area must be certified in that specialty. For example, a physician who practices cardiology must be certified in cardiology. A general certification (e.g., internal medicine) does not count toward the numerator for a physician specialist.

First, determine the number of areas of specialization and status of board certification for each physician; then determine how to count them in the denominator (i.e., number of physicians in each practice area) and numerator (i.e., number of board-certified physicians) of the calculation.

- A physician with only one specialty but who is not board certified in that specialty counts as 1 in the denominator and 0 in the numerator.
- A physician with only one specialty who is board certified in that specialty counts as 1 in the denominator and 1 in the numerator.
- A physician with more than one specialty is counted in the denominator once for each specialty. Count in the numerator the number of specialty areas in which the physician is board certified.

  For example, a physician listed under both hematology and medical oncology counts as 2 in the denominator. A physician who is board certified in both hematology and medical oncology counts as 2 in the numerator. A physician who is board certified in only one of these two areas counts as 1 in the numerator. A physician who is not board certified in either area counts as 0 in the numerator.

For each type of physician, calculate the percentage that is board certified by dividing the board certification number and the number of physicians in each practice area.

Note

- *Confirmation that the physician applied and has been accepted in a board-certification program by the appropriate certifying body may not be counted toward board certification.*
- *Confirmation that a newly formed board awarded physician who met its criteria for board certification without having completed a residency/fellowship may be counted toward board certification.*
- *The numbers in the column* Number of Physicians in Each Practice Area *will not be the same as the MCO's actual number of physicians because some physicians may practice in more than one area and will be counted in the denominators of several percentages.*
- *OB/GYN and pediatric practitioners should not be included in Medicare reporting.*

Table BCR-1/2/3: Board Certification

Type of Physician	Number of Physicians in Each Practice Area	Board Certification	
		Number	Percentage
Primary care physicians			
OB/GYN physicians			
Pediatric physician specialists			
Geriatricians			
Other physician specialists			

Enrollment by Product Line (ENP)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

This measure reports the total number of members enrolled for each product line stratified by age and sex.

Report Medicaid in number of member months contributed by enrollees during the measurement year and stratified by Medicaid eligibility category, age and sex. The MCO may report this information only if it is provided by the state Medicaid agency.

Report commercial and Medicare in number of member years contributed by enrollees during the measurement year, stratified by product line, age and sex.

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

Calculation of Member Months and Member Years

Member months A member's "contribution" to the total yearly membership.

Step 1 Determine member months using a prespecified day of each month (e.g., the 15th or the last day of the month), to be determined according to the MCO's administrative processes. The day selected must be consistent from month to month and from year to year. For example, if the MCO tallies membership on the 15th of the month and Ms. X is enrolled in the MCO on January 15, Ms. X contributes one member month in January.

Retroactive enrollment. The MCO may include in the member months any months in which members were enrolled retrospectively and for which the MCO received a retroactive capitation payment.

Step 2 Use the member's age on the prespecified day of each month to determine to which age group the member months will be contributed. For example, if an MCO tallies membership on the 15th of each month and Ms. X turns 25 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February and March) to the 20–24 age category and nine member months to the 25–29 age category.

Member years Member years serve as a proxy for annual membership and are calculated as:

X member months/12 months = Y member years.

Member Months of Enrollment by Age and Sex—Total Medicaid, Medicaid/Medicare Dual-Eligibles, Medicaid-Disabled, Other Low Income

The MCO assigns Medicaid members to beneficiary categories based on a state-provided list of all payment-rate categories used by that state and the MCO in their contract. The state should use the algorithm provided below (described in Categories A–D) to assign each payment-rate category it uses to one of the three beneficiary categories and provide this categorization of rate categories to the MCO. The MCO should then report Medicaid members using the state's categories. The state should classify beneficiaries according to the hierarchy below, beginning with Category A.

This algorithm addresses variables most likely to influence utilization patterns.

- The presence of a Medicare benefit
- The presence of a disability
- Whether or not there is a restricted benefit package
  - This last group is not reported separately because of its anticipated small numbers, but it is included in the total count of Medicaid members

Category A

Total Medicaid—Table ENP-1a Include all Medicaid members enrolled in the MCO who receive Medicaid benefits, including those who receive a restricted benefits package smaller in scope than the other Medicaid members enrolled in the same MCO. A **restricted benefits package** is either:

- Pregnant women whose Medicaid eligibility is based on poverty-related coverage and whose Medicaid benefits are restricted to services related to pregnancy and other conditions that may complicate pregnancy, ***or***
- Other individuals whose benefits are limited (for example, to emergency services).

The MCO should include individuals in either of these two groups in this category. Total Medicaid also includes the sum of Categories B–D. If a member does not meet either of the two criteria described above, go to Category B.

Category B

Medicaid/Medicare Eligible—Table ENP-1b Include all Medicaid members (including children) entitled to both the state's full Medicaid benefit for which the MCO has contracted and to Medicare Part A or B benefits.

Qualified Medicare Beneficiaries (QMB), other specified low-income Medicare beneficiaries, Qualified Disabled and Working Individuals (QDWI) and Qualified COBRA Continuation Beneficiaries whose Medicaid benefit is limited to the payment of a premium for Medicare or commercial coverage are not included in this category because these individuals do not receive the Medicaid benefit package.

If an individual does not meet the criteria for Category B, go to Category C.

Category C

Disabled—Table ENP-1c Include all Medicaid members who do not meet the criteria for Category B *and* who receive Medicaid benefits wholly or in part because of physical or mental disability. This category includes supplemental security income (SSI) beneficiaries, SSI-related beneficiaries and other disabled, medically needy beneficiaries.

If a Medicaid beneficiary does not meet the criteria for Category B and does not receive Medicaid on the basis of a disability (Category C), go to Category D.

Category D

Other Low Income—Table ENP-1d Include all non-disabled, non-Medicare, low-income Medicaid beneficiaries who do not meet the criteria for Category B or C.

Table instructions

Assign Medicaid beneficiaries to Categories A–D based on the definitions provided above.

Report by eligibility category the number of member months by age and sex, including subtotals.

Calculate the subtotal percentages within each eligibility category by dividing the total subtotal member months into total member months by sex (e.g., [X member months of enrolled Medicaid disabled males, 0–19/Y member months for all Medicaid disabled males, 0–90+ and age unknown] x 100 = Z percent of member months for Medicaid disabled males, 0–19 years of all male Medicaid disabled member months).

Note

- *NCQA recognizes that most MCOs do not serve Medicaid beneficiaries in all categories. Not many serve the few individuals with a restricted benefits package (see Category A).*
- *Membership and utilization data are reported on the basis of member months for Medicaid beneficiaries, acknowledging that Medicaid beneficiary enrollment in managed care is less stable than enrollment of the commercially insured.*

Member Years of Enrollment by Age and Sex—Commercial, by Product

Table ENP-2 provides information on the MCO's commercial enrollment by product for the most recent calendar year on the basis of member years.

Table instructions

Report by commercial product the number of member years by age and sex, including subtotals.

Calculate the subtotal percentages within each commercial product by dividing the total subtotal member years into total member years by sex (e.g., [X member months of enrolled commercial product males, 0–19/Y member years for all commercial product males, 0–90+ and age unknown] x 100 = Z percent of member years for commercial product males, 0–19 years of age of all male commercial product member years).

Member Years of Enrollment by Age and Sex—Commercial, Employer/Purchaser-Specific

Table ENP-2e provides information on MCO enrollment for a specific purchaser in the most recent calendar year, based on member years. Information is reported separately for "active employees" and "early retirees."

An **early retiree** is a former employee who has met the company definition of early retirement (usually 55 years of age with a minimum of 10 years of service) and who is not 65 or older. Employers frequently offer these individuals benefits consistent with their active employees; however, early retirees are often required to contribute a greater share of the cost.

NCQA recognizes that some MCOs do not classify early retirees separately and will be unable to report these data. The MCO should complete Table D3-2E at the request of employers or purchasers.

Table instructions

Report by employer or purchaser the number of member years by age and sex, including subtotals.

Calculate the subtotal percentages within each purchaser/employer group by dividing the total subtotal member years into total member years by sex (e.g., [X member months of enrolled employer group males, 0–19/Y member years for all employer group males, 0–90+ and age unknown] x 100 = Z percent of member years for employer group males, 0–19 years of age of all male employer group member years).

Member Years of Enrollment by Age and Sex—Medicare

Table ENP-3 provides information on MCO total Medicare enrollment for the most recent calendar year on the basis of member years.

Table instructions

Report by eligibility category the number of member years by age and sex, including subtotals.

Calculate the subtotal percentages within the Medicare product line by dividing the total subtotal member years into total member years by sex (e.g., [X member months of enrolled Medicare males, 0–19/Y member years for all Medicare males, 0–90+ and age unknown] x 100 = Z percent of member years for Medicare males, 0–19 years of age of all male Medicare member years).

Table ENP-1a: Member Months of Enrollment by Age and Sex—Total Medicaid

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
≥65 Subtotal:	_____	_____	_____
≥65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____	_____	_____

Table ENP-1b: Member Months of Enrollment by Age and Sex—Medicaid/Medicare Dual-Eligible

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
≥65 Subtotal:	_____	_____	_____
≥65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____	_____	_____

Table ENP-1c: Member Months of Enrollment by Age and Sex—Medicaid, Disabled

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
≥65 Subtotal:	_____	_____	_____
≥65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____	_____	_____

Table ENP-1d: Member Months of Enrollment by Age and Sex—Medicaid, Other Low Income

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
≥65 Subtotal:	_____	_____	_____
≥65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____%	_____%	_____%

Table ENP-2: Member Years of Enrollment by Age and Sex—Commercial, by Product

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
≥65 Subtotal:	_____	_____	_____
≥65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____	_____	_____

Table ENP-2e: Member Years of Enrollment by Age and Sex—Commercial, Employer/ Purchaser-Specific

Age	Active Employees			Early Retirees (Non-Medicare)		
	Male	Female	Total	Male	Female	Total
<1						
1-4						
5-9						
10-14						
15-17						
18-19						
0-19 Subtotal:						
0-19 Subtotal (%):	%	%	%	%	%	%
20-24						
25-29						
30-34						
35-39						
40-44						
20-44 Subtotal:						
20-44 Subtotal (%):	%	%	%	%	%	%
45-49						
50-54						
55-59						
60-64						
45-64 Subtotal:						
45-64 Subtotal (%):	%	%	%	%	%	%
65-69						
70-74						
75-79						
80-84						
85-89						
≥90						
≥ 65 Subtotal:						
≥ 65 Subtotal (%):	%	%	%	%	%	%
Age unknown						
Total:						

Table ENP-3: Member Years of Enrollment by Age and Sex—Medicare

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
0-19 Subtotal:	_____	_____	_____
0-19 Subtotal (%):	_____%	_____%	_____%
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
20-44 Subtotal:	_____	_____	_____
20-44 Subtotal (%):	_____%	_____%	_____%
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
45-64 Subtotal:	_____	_____	_____
45-64 Subtotal (%):	_____%	_____%	_____%
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥ 90	_____	_____	_____
≥ 65 Subtotal:	_____	_____	_____
≥ 65 Subtotal (%):	_____%	_____%	_____%
Age unknown	_____	_____	_____
Total:	_____	_____	_____

Enrollment by State (EBS)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The number of members enrolled as of December 31 of the measurement year, by state.

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

Anchor Date December 31 of the measurement year.

Calculation

Calculate enrollment by state using the address on record for members on December 31 of the measurement year, to be determined according to the MCO's administrative processes. Report by categories (states and territories) listed in Table EBS-1/2/3. If the member's address is unknown or does not match, report as "Other." If a child's address is not captured, the MCO may use the address of the policyholder, parent or caretaker.

Report on total unduplicated membership as of December 31 of the measurement year. If the MCO assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to prevent duplicate counts.

Table EBS-1/2/3: Member Enrollment by State

State	Number	State	Number	State	Number
Alabama	_____	Michigan	_____	Utah	_____
Alaska	_____	Minnesota	_____	Vermont	_____
Arizona	_____	Mississippi	_____	Virginia	_____
Arkansas	_____	Missouri	_____	Washington	_____
California	_____	Montana	_____	West Virginia	_____
Colorado	_____	Nebraska	_____	Wisconsin	_____
Connecticut	_____	Nevada	_____	Wyoming	_____
Delaware	_____	New Hampshire	_____	American Samoa	_____
District of Columbia	_____	New Jersey	_____	Fed. Sts. of Micronesia	_____
Florida	_____	New Mexico	_____	Guam	_____
Georgia	_____	New York	_____	Cmnwlth. of N. Marianas	_____
Hawaii	_____	North Carolina	_____	Puerto Rico	_____
Idaho	_____	North Dakota	_____	Virgin Islands	_____
Illinois	_____	Ohio	_____	Other	_____
Indiana	_____	Oklahoma	_____	***Total:***	_____
Iowa	_____	Oregon	_____		
Kansas	_____	Pennsylvania	_____		
Kentucky	_____	Rhode Island	_____		
Louisiana	_____	South Carolina	_____		
Maine	_____	South Dakota	_____		
Maryland	_____	Tennessee	_____		
Massachusetts	_____	Texas	_____		

Race/Ethnicity Diversity of Membership (RDM)

SUMMARY OF CHANGES TO HEDIS 2007

- Clarified race/ethnicity reporting categories using Table RDM-A.

Description

An unduplicated count and percentage of members enrolled any time during the measurement year by race and ethnicity.

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

Calculations

Table instructions Report the number and percentage of members by race/ethnicity stratified by gender for the product population. If a member's race or ethnicity is unknown or unavailable from the state agency or CMS, report as "Unknown."

Report on total unduplicated membership during the measurement year. If the MCO assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to prevent duplicate counts.

Data source Obtain race and ethnicity data from enrollment information furnished by state Medicaid agencies or by the Centers for Medicare & Medicaid Services (CMS), or supplemented through the MCO's own direct data collection from members (surveys, health risk assessments, disease management registries) or through other available indirect methods (surname analysis, geo-coding).

When using CMS as the data source, refer to Table RDM-A for a crosswalk of reporting categories for the RDM measure.

Definitions

Race reporting category

White refers to people having origins in any of the original peoples of Europe, the Middle East or North Africa. It includes people who indicated their race or races as "White" or wrote in entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab or Polish.

Black or African American refers to people having origins in any of the Black racial groups of Africa. It includes people who indicated their race or races as "Black, African Am., or Negro," or wrote in entries such as African American, Afro American, Nigerian or Haitian.

American Indian and Alaska Native refers to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicated their race or races by marking this category or writing in their principal or enrolled tribe, such as Rosebud, Sioux, Chippewa or Navajo.

Asian refers to people who are Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese and Other Asian. "Other Asian" may include people who are Burmese, Hmong, Pakistani, Thai or from two or more Asian subgroups.

Native Hawaiian and Other Pacific Islander refers to people whose origins are in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands. In addition this would include: Carolinian, Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese) and Yapese.

Some Other Race refers to people whose race information has been collected but does not fit into any of the other seven race categories. This category in the Census includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census race categories.

Two or More Races refers to people with any combination of races, including Some Other Race.

Ethnicity reporting category

Hispanic or Latino refers to people of Spanish, Mexican, Puerto Rican or Cuban origin.

Note: *NCQA encourages collecting and reporting race and Hispanic ethnicity based on categories adapted from the official U.S. census forms established by the U.S. Department of Commerce, Bureau of the Census and defined by the Office of Management and Budget (OMB). As CMS and other state agencies may have varying classifications schemes for race and ethnicity, use the following crosswalk for HEDIS reporting.*

Table RDM-A: CMS/HEDIS Crosswalk for Reporting Categories

CMS Category	HEDIS Race	HEDIS Ethnicity
0 = Unknown	Unknown	Unknown
1 = White not Hispanic	White	Not Hispanic
2 = Black not Hispanic	Black	Not Hispanic
3 = Other	Some Other Race	Unknown
4 = Asian	Asian	Unknown
5 = Hispanic	Unknown	Hispanic
6 = North American Native	American Indian/AN	Unknown

Table RDM-1/3: Race/Ethnicity Diversity of Membership

Data Source: _____

Values include NR, CMS, MCO direct, Surname analysis/geo-coding, Multiple sources, Other

Total unduplicated membership during the measurement year:

Number of members: _____

The total unduplicated count of members in the plan is the denominator for calculating the percentages. Each cell represents the proportion of members of a specific race/ethnicity combination of the total unduplicated count of members in the plan.

Percentage of plan members with known race information (sum all the race categories, except Unknown Race, and divide by the number of total unduplicated members during the measurement year): _____

Percentage of plan members with known ethnicity information (sum all the ethnicity categories, except Unknown Ethnicity, and divide by the number of total unduplicated members during the measurement year): _____

Table RDM-1/3: Race/Ethnicity Diversity of Membership *(continued)*

Race	Sex	Hispanic or Latino		Not Hispanic or Latino		Unknown Ethnicity		Total	
		Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Black or African-American	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
American-Indian and Alaska Native	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Asian	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Native Hawaiian and Other Pacific Islander	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Some other race	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Two or more races	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	100%

Language Diversity of Membership (LDM)

SUMMARY OF CHANGES TO HEDIS 2007

- Clarified the responses for Need/Want Interpreter data element.

Description

An unduplicated count and percentage of Medicaid and Medicare members enrolled at any time during the measurement year by demand for language interpreter services and spoken language.

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

Calculations

Table instructions Report the number and percentage of members by demand for language interpreter services and spoken language stratified by gender for each product population. If a member's interpreter service needs or spoken language is unknown or unavailable from the state agency or CMS, report as "Unknown."

Report on total unduplicated membership during the measurement year. If the MCO assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to prevent duplicate counts.

Data source Obtain interpretation service needs and language spoken from enrollment information furnished by state Medicaid agencies or supplemented through the MCO's own direct data collection from members (surveys, health risk assessments, disease management registries) or through other available indirect methods (surname analysis, geo-coding).

Need/Want Interpreter Identify individuals who need or want interpreter services; enter this information in Table LDM-1/3. This information should be reported by gender for the plan population.

Data collection guidance for plans and agencies. This information can be gathered through a two-part question to beneficiaries/members:

(Does the Medicaid or Medicare beneficiary) Do you need or want an interpreter to communicate with a doctor or health care practitioner?

- No
- Yes
- Unknown (if data is unavailable)

Spoken Language Indicate the language spoken by the member at home most of the time; enter this information in Table LDM-1/3.This information should be reported by gender for the plan population.

Data collection guidance for plans and agencies. This information may be gathered through the second part of a two-part question:

What language (does the beneficiary) do you speak most of the time at home?

Note

The U.S. Census asks Does this person speak a language other than English at home?

Table LDM-1/3: Language Diversity of Membership

Data Source: _____

Values include NR, CMS, MCO direct, Surname analysis/geo-coding, Multiple sources, Other

Total unduplicated membership during the measurement year:

Number of members _____

The total unduplicated count of members in the plan is the denominator for calculating the percentages. Each cell represents the proportion of members with identified demand for interpreter services and indicated spoken language of the total unduplicated count of members in the plan.

Demand for Language Interpretation Services		Sex	Number	Percentage
Need/Want an Interpreter	Yes	Male	_____	_____
		Female	_____	_____
		Total:	_____	_____
Need/Want an Interpreter	No	Male	_____	_____
		Female	_____	_____
		Total:	_____	_____
Need/Want an Interpreter	Unknown	Male	_____	_____
		Female	_____	_____
		Total:	_____	_____
Total: *(this should sum to 100%)*		_____	_____	_____
Percentage of members with known interpretation needs: *(sum the Yes/No categories and divide by the number of total unduplicated members during the measurement year)*		_____	_____	_____

Table LDM-1/3: Language Diversity of Membership (continued)

Spoken Language at Home	Sex	Number	Percentage
English	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Spanish (or Spanish Creole)	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Other Indo-European Languages (e.g., French or French Creole, Italian, Portuguese or Portuguese Creole, German, Yiddish, Scandinavian languages, Greek, Russian, Polish, Serbo-Croatian, Armenian, Persian, Gujarathi, Hindi, Urdu)	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Asian and Pacific Island Languages (e.g., Chinese, Japanese, Korean, Mon-Khmer, Cambodian, Miao, Hmong, Thai, Laotian, Vietnamese, Tagalog and Other Pacific Island languages)	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Other Languages (e.g., Navajo, Other Native North American languages, Hungarian, Arabic, Hebrew, African languages)	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Unknown	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Total: *(this should sum to 100%)*	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Percentage of members with known spoken language: *(sum all the language categories, except unknown and divide by the number of total unduplicated members during the measurement year)*		_____	_____

Note

- *CMS does not provide language information on its Medicare beneficiaries. Medicare plans should obtain language data through alternate sources, including surveys or case management and enrollment registries.*

Weeks of Pregnancy at Time of Enrollment in the MCO (WOP)

SUMMARY OF CHANGES TO HEDIS 2007

- Deleted ICD-9-CM Diagnosis code 644.20 from Table WOP-A.

Description

The percentage of all enrolled women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the MCO, according to the following categories.

- Prior to pregnancy (280 days or more prior to delivery)
- The first 12 weeks of pregnancy, including the end of the 12th week (279–196 days prior to delivery)
- The beginning of the 13th week through the end of the 27th week of pregnancy (195–91 days prior to delivery)
- The beginning of the 28th week of pregnancy or after (90 days or fewer prior to delivery)

Note: *Pregnancy is a condition of eligibility for Medicaid benefits; consequently, Medicaid purchasers are interested in the stage of pregnancy of Medicaid eligible women at their enrollment in order to interpret the pregnancy-related measures found in the Access/Availability of Care domain.*

Eligible Population

Product line	Medicaid.
Age	None specified.
Continuous enrollment	None.
Anchor date	Date of delivery.
Benefit	Medical.
Event	Delivered a *live* birth during the measurement year. Live births that occurred in a birthing center should be included in this measure. Refer to Tables PPC-A and PPC-B (Prenatal and Postpartum Care).

Administrative Specification

Denominator The eligible population. Report this number under “Total” in Table WOP-1.

Numerator The number of women who enrolled in the MCO at the following times.

- Prior to 0 weeks (280 days or more prior to delivery)
- 1–12 weeks (279–196 days prior to delivery)
- 13–27 weeks (195–91 days prior to delivery)
- 28 or more weeks of pregnancy (90 days or fewer prior to delivery)
- Unknown

The MCO uses enrollment and delivery data to determine the number of weeks prior to delivery that each woman enrolled.

Estimate the weeks of pregnancy at time of enrollment using administrative systems.

This can sometimes be estimated by using the delivery date. In other cases, either the last EDD noted in the patient's prenatal care record or the gestational age of the fetus obtained from the patient's delivery records must be used in following these steps:

Step 1 Prior to pregnancy. Identify all women, regardless of whether or not they had a premature birth, whose most recent date of enrollment in the MCO was more than 40 weeks (280 days or more prior to delivery) before the delivery date. These women will be included in the "≤0 weeks" row of Table WOP-1.

Step 2 Premature births. For women with a delivery date ≤40 weeks (fewer than 280 days prior to delivery) after enrollment in the MCO, use the codes listed in Table WOP-A to determine through discharge data whether the delivery resulted in a premature birth.

For women identified with codes in Table WOP-A, the MCO should use either the EDD or gestational age of the fetus recorded in delivery records or the last menstrual period noted in the patient's prenatal care record to estimate the weeks of pregnancy at enrollment in the MCO. If these are not available, then include these women in the unknown category.

Table WOP-A: Codes to Identify Premature Births

DRGs	ICD-9-CM Procedure
386, 387, 388	644.21

Step 3 Assume a full-term pregnancy for all remaining women (i.e., those not enrolled in the MCO more than 40 weeks prior to the delivery date, and for whom there is no indication of a premature birth). For these women, the weeks of pregnancy at enrollment may be determined by subtracting the number of weeks of enrollment in the MCO prior to delivery from 40 weeks. Calculate the number of women in each remaining category.

- 1–12 weeks of pregnancy (279–196 days prior to delivery)
- 13–27 weeks of pregnancy (195–91 days prior to delivery)
- 28 or more weeks of pregnancy (90 days or fewer prior to delivery)

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for Medicaid. The sample size serves as the total and the denominator for all percentage calculations in Table WOP-1.

Numerator The number of women who enrolled in the MCO at the following times.

- Prior to 0 weeks (280 days or more prior to delivery)
- 1–12 weeks (279–196 days prior to delivery)
- 13–27 weeks (195–91 days prior to delivery)
- 28 or more weeks of pregnancy (90 days or fewer prior to delivery)
- Unknown

Administrative The MCO uses enrollment data and delivery data to determine the number of weeks prior to delivery for each woman enrolled in the MCO. Refer to the *Administrative Specification* above to identify the correct reporting category for each woman.

Medical record Estimate the weeks of pregnancy at time of enrollment. This can sometimes be estimated through the use of the delivery date. In other cases, either the last EDD noted in the patient's prenatal care record or the gestational age of the fetus obtained from the patient's delivery records must be used in following these steps:

- *If EDD data are used.* Count the number of weeks elapsed between the enrollment date and EDD and subtract this number from 40 (weeks). The result gives an estimate of the weeks of pregnancy at time of enrollment in the MCO.

If gestational age is used. Count the number of weeks elapsed between enrollment in the MCO and delivery date. Subtract this number from the gestational age of the fetus (in weeks) at the time of delivery. The result is the number of weeks of pregnancy at time of enrollment in the MCO. This will be a negative number if a woman enrolls prior to pregnancy.

Note

- *To be consistent with the* Prenatal and Postpartum Care *measure in the Access/Availability of Care domain, this measure examines only enrollment of women who have live births.*
- *Stage of pregnancy at enrollment refers to the estimated weeks of pregnancy on the first date for which capitation payment provides coverage (for the most recent enrollment period).*

Table WOP-1: Weeks of Pregnancy at Time of Enrollment

Weeks of Pregnancy	Number	Percentage
Measurement Year		
≤0 weeks (280 days or more prior to delivery)	_____	_____
1-12 weeks (279-196 days prior to delivery)	_____	_____
13-27 weeks (195-91 days prior to delivery)	_____	_____
28 or more weeks (≤90 days prior to delivery)	_____	_____
Unknown	_____	_____
Total all pregnancies:	_____	_____