Appendix 1

HEDIS 2007
Summary Table of Measures, Product Lines and Changes

APPENDIX 1

SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES

HEDIS 2007 Summary Table of Measures, Product Lines and Changes

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
General Guidelines for Data Collection and Reporting				
	✓	✓	✓	• Modified NCQA HEDIS Compliance Audit section. • Deleted General Guideline: *Point-of-Service Self-Insured Members.* • Added General Guideline: *Accessing Medical Records Prior to Enrollment.* • Clarified Internally Built Administrative Database criteria for database entries. • Added General Guidelines for using Electronic Health Records in HEDIS data collection. • Clarified valid data error criteria. • The final *HEDIS 2007 Volume 2 Technical Update* memo will be issued on October 1, 2006. • Following a Public Comment period from September 1–30, 2006, the final NDC lists for pharmacy-related measures will be posted to the NCQA Web site by November 15, 2006.
General Guidelines for Calculations and Sampling				
	✓	✓	✓	• No changes for 2007.
Effectiveness of Care				
Specific Guidelines for Effectiveness of Care Measures	✓	✓	✓	• No changes for 2007.
Childhood Immunization Status	✓	✓		• Deleted DTP, as the use of this vaccine was discontinued prior to the look-back period for the measure. • Clarified that a history of disease and a seropositive test result cannot be used toward the pneumococcal conjugate vaccine rate. • Deleted CPT codes 90701, 90720 from Table CIS-A. • Added HCPCS codes to Table CIS-A. • Added ICD-9-CM Diagnosis code 138 to Table CIS-A.
Adolescent Immunization Status	✓	✓		• Added HCPCS codes to Table AIS-A.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to: Commercial	Medicaid	Medicare	Changes to HEDIS 2007
Effectiveness of Care				
Appropriate Treatment for Children With Upper Respiratory Infection	✓	✓		• Added CPT codes 99401–99404, 99411, 99412, 99420, 99429, 99499 to Table URI-B. • Deleted CPT codes 99271–99275 from Table URI-B. • Added UB-92 Revenue code 077x to Table URI-B. • Moved UB-92 Revenue code 0456 from Table URI-B to Table URI-C. • Deleted UB-92 Type of Bill code 43x from Table URI-C. • Added Cefazolin, Cephradine, Lomefloxacin to Table URI-D. • Deleted Dirithromycin, Flomefloxacin from Table URI-D.
Appropriate Testing for Children With Pharyngitis	✓	✓		• Added CPT codes 99401-99404, 99411, 99412, 99420, 99429, 99499 to Table CWP-B. • Deleted CPT codes 99271-99275, 99381, 99391 from Table CWP-B. • Added UB-92 Revenue code 077x to Table CWP-B. • Moved UB-92 Revenue code 0456 from Table CWP-B to Table CWP-C. • Deleted UB-92 Type of Bill code 43x from Table CWP-C. • Added Cefazolin, Cephradine, Lomefloxacin to Table CWP-D. • Deleted Dirithromycin, Flomefloxacin from Table CWP-D.
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis	✓	✓		• Added CPT codes 99386, 99396, 99401–99404, 99411, 99412, 99420, 99429, 99499 to Table AAB-B. • Deleted CPT codes 99271–99275, 99381–99384, 99391–99394 from Table AAB-B. • Added UB-92 Revenue code 077x to Table AAB-B. • Moved UB-92 Revenue code 0456 from Table AAB-B to Table AAB-C. • Deleted UB-92 Type of Bill code 43x from Table AAB-C. • Added Aztreonam, Cefixime, Cephradine, Piperacillin-Tazobactam, Ticarcillin-Clavulanate to Table AAB-F. • Deleted Cloxacillin, Dirithromycin, Enoxacin, Flomefloxacin, Fusidic Acid, Methicillin, Mezlocillin, Netilmicin, Pefloxacin, Sulfamethizole, Teicoplanin from Table AAB-F.
Colorectal Cancer Screening	✓		✓	• Added HCPCS codes to Tables COL-A and COL-B. • Moved ICD-9-CM Diagnosis code V76.51 from colonoscopy description to FOBT description in Table COL-A. • Deleted optional data elements from Table COL-2/3.
Breast Cancer Screening	✓	✓	✓	• Decreased the lower age limit to women 40 years of age.

				• Added HCPCS codes to Table BCS-A. • Deleted UB-92 Revenue code 0401 from Table BCS-A.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Effectiveness of Care				
Cervical Cancer Screening	✓	✓		• Raised the lower age limit to 21 years. • Added HCPCS codes to Table CCS-A.
Chlamydia Screening in Women	✓	✓		• Added CPT code 84163 to Table CHL-A. • Deleted CPT codes 88144, 88145 from Table CHL-A. • Added HCPCS codes to Table CHL-A. • Added ICD-9-CM Diagnosis codes V61.6, V61.7 to Table CHL-A. • Replaced ICD-9-CM Diagnosis code 131.00 with 131 (to include any valid fourth or fifth digit) in Table CHL-A. • Added ICD-9-CM Procedure codes 72-75 to Table CHL-A. • Added UB-92 Revenue Codes 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729 to Table CHL-A. • Added LOINC codes 42316-0, 42481-2, 42931-6 to Table CHL-A. • Added LOINC code 42931-6 to Table CHL-B. • Deleted LOINC codes 561-1, 6343-8, 6345-3, 6346-1, 6347-9, 16593-6, 31765-1, 32001-0, 32003-6, 32004-4, 32671-0, 32774-2, 34708-8, 35713-7, 35714-5, 35715-2, 35716-0, 35717-8, 35722-8, 35726-9, 35727-7, 35728-5, 35729-3, 35730-1 from Tables CHL-A and CHL-B.
Osteoporosis Management in Women Who Had a Fracture			✓	• Added CPT codes 22520, 22521, 22523, 22524 to Table OMW-A. • Added HCPCS codes to Table OMW-A. • Added ICD-9-CM Procedure codes 81.65, 81.66 to Table OMW-A. • Added HCPCS code to Table OMW-B. • Deleted fluoride, vitamin D, calcium products from Table OMW-C.
Controlling High Blood Pressure	✓	✓	✓	• Decreased the lower age limit to 18 years of age. • Changed adequately controlled blood pressure from ≤140/90 to <140/90. • Changed methodology for determining representative BP. The lowest BP is used as the representative BP regardless of posture. • Clarified that the lowest systolic and lowest diastolic values can be utilized to fulfill the numerator criteria for the representative BP. • Added Table CBP-A: Codes to Identify Hypertension. • Added CPT codes 99384–99387, 99394–99397 to Table CBP-B. • Added HCPCS codes to Table CBP-C. • Added ICD-9-CM Diagnosis code 585.6 to Table CBP-C.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Effectiveness of Care				
Controlling High Blood Pressure	✓	✓	✓	• Expanded ESRD optional exclusion to include evidence of dialysis and renal transplant; added appropriate codes to Table CBP-C. • Added pregnancy to the optional exclusions; added appropriate codes to Table CBP-C. • Added data element to capture false positive diagnoses.
Beta-Blocker Treatment After a Heart Attack	✓	✓	✓	• No changes to this measure.
Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	✓	• No changes to this measure.
Cholesterol Management for Patients With Cardiovascular Conditions	✓	✓	✓	• Retired LDL-C control <130 mg/dL. • Changed the timing requirement for reporting LDL-C control <100 mg/dL. The value must come from the most recent LDL-screening in the measurement year. • Added HCPCS to table CMC-A. • Added ICD-9-CM Procedure codes 00.66, 36.06, 36.07 to Table CMC-A. • Added ICD-9-CM Diagnosis codes 414.8, 414.9 to Table CMC-B. • Deleted ICD-9-CM Diagnosis codes 437.0, 437.1, 438, 441, 443.9 from Table CMC-B. • Added CPT codes 99304-99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99455, 99456 to Table CMC-C. • Deleted CPT codes 92002–92014, 99271–99275, 99292, 99351–99357 from Table CMC-C. • Deleted UB-92 Revenue codes 0115, 0125, 0135, 0145, 0155, 049x, 050x, 053x, 056x, 065x, 076x, 080x, 082x–085x, 088x, 092x, 094x, 096x, 0972–0979, 0984–0986, 0988, 0989 from Table CMC-C. • Moved UB-92 Revenue code 0456 from outpatient/nonacute inpatient description to acute inpatient/ emergency department description in Table CMC-C. • Added CPT codes 83700, 83701, 83704 to Table CMC-D. • Added LOINC code 39469-2 to Table CMC-D.
Comprehensive Diabetes Care	✓	✓	✓	• Added HbA1c good control (<7.0%) as a first-year indicator. • Restricted LDL-C screening and control criteria to require testing during the measurement year. • Retired LDL-C control <130 mg/dL. • Clarified requirements for the medical attention for nephropathy indicator.

				• Added use of ACE inhibitors/ARBs as numerator compliant for medical attention for nephropathy.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to: Commercial	Medicaid	Medicare	Changes to HEDIS 2007
Effectiveness of Care				
Comprehensive Diabetes Care	✓	✓	✓	• Added blood pressure control <130/80 mm Hg and <140/90 mm Hg as first-year indicators. • Changed 70/30 to Mix 70/30 in Table CDC-A. • Added ActosPlus Met, Apidra, Avandamet, Avandaryl, Byetta, Exubera, Lantus, Levemir, Metaglip, Mix 50/50, Mix 75/25 to Table CDC-A. • Separated diagnosis and visit type codes into two tables (CDC-B, CDC-C). • Added CPT codes 99304-99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99455, 99456 to Table CDC-C. • Deleted CPT codes 99271-99275, 99292, 99351-99357 from Table CDC-C. • Deleted UB-92 Revenue codes 0115, 0125, 0135, 0145, 0155, 049x, 050x, 053x, 056x, 065x, 076x, 092x, 094x, 096x, 0972–0979, 0984–0986, 0988, 0989 from Table CDC-C. • Moved UB-92 Revenue code 0456 from outpatient/nonacute inpatient description to emergency department description in Table CDC-C. • Added CPT code 83037 to Table CDC-D. • Added CPT Category II codes to Tables CDC-D, CDC-F, CDC-G, CDC-I, CDC-J. • Deleted LOINC code 17855-8 from Table CDC-D. • Added Table CDC-E: Codes to Identify HbA1c Levels. • Added CPT codes 67028, 67038-67040 to Table CDC-F. • Deleted CPT code 92287 from Table CDC-F. • Added HCPCS codes to Tables CDC-F, CDC-J. • Deleted ICD-9-CM Diagnosis code V72.0 from Table CDC-F. • Added CPT codes 83700, 83701, 83704 to Table CDC-G. • Added LOINC code 39469-2 to Table CDC-G. • Added Table CDC-H: Codes to identify LDL-C levels. • Deleted CPT codes 83518, 84160, 84165, 84166, 81050 from Table CDC-I. • Added CPT codes 36145, 36831–36833, 90939, 90940 codes to Table CDC-J. • Added ICD-9-CM Diagnosis code 791.0 to Table CDC-J. • Added ICD-9-CM Procedure code 38.95 to Table CDC-J. • Added UB-92 Revenue code 0367 to Table CDC-J. • Added exclusion criteria for members with gestational diabetes and steroid-

				induced diabetes.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Effectiveness of Care				
Use of Appropriate Medications for People With Asthma	✓	✓		• Added Table ASM-A: Codes to Identify Asthma. • Added CPT codes 99341–99345, 99347–99350, 99382–99386, 99392–99396, 99401–99404, 99411, 99412, 99420, 99429, 99499 to Table ASM-B. • Deleted CPT codes 99271–99275, 99292, 99356, 99537 from Table ASM-B. • Moved UB-92 Revenue code 0456 from outpatient description to emergency department description in Table ASM-B. • Added UB-92 Revenue codes 0511–0514, 0522, 0529, 057x–059x, 0771 to Table ASM-B. • Deleted UB-92 Revenue codes 0115, 0125, 0135, 0145, 0155, 076x, 0988 from Table ASM-B.
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	✓	✓	✓	• Clarified the Index Episode Start Date, the Negative Diagnosis History and the allowable gap criteria.
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓	• Added HCPCS codes to Table FUH-B. • Added CPT code 99510 to FUH-B.
Antidepressant Medication Management	✓	✓	✓	• Added HCPCS codes to Table AMM-B.
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓		• Clarified the age criteria. • Added CPT codes 96101, 96116, 96118 to Table ADD-B. • Added HCPCS codes to Table ADD-B. • Revised Continuation and Maintenance (C&M) Phase eligible population criteria.
Glaucoma Screening in Older Adults			✓	• Added HCPCS codes to Table GSO-A. • Changed exclusion criteria to include evidence of glaucoma at any point in member's history. • Removed optional data element "Total exclusions" from Table GSO-3.
Use of Imaging Studies for Low Back Pain	✓	✓		• Clarified the age criteria. • Separated Diagnosis and Visit Type codes into two tables (LBP-A, LBP-B). • Added ICD-9-CM Diagnosis code 722.32 to Table LBP-A.

				• Deleted ICD-9-CM Diagnosis codes 721.90, 722.6 from Table LBP-A. • Added CPT codes 99217–99220, 99411, 99412, 99420, 99429 to Table LBP-B. • Deleted CPT codes 99354–99357, 99387, 99397 from Table LBP-B.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Effectiveness of Care				
Use of Imaging Studies for Low Back Pain	✓	✓		• Added UB-92 Revenue codes 057x-059x, 077x to Table LBP-B. • Deleted UB-92 Revenue codes 050x, 053x from Table LBP-B. • Removed optional data element total exclusions from LBP-1/2.
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓	✓	✓	• Separated Diagnosis and Visit Type codes into two tables (ART-A, ART-B). • Added CPT codes 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99455, 99456 to Table ART-B. • Deleted CPT codes 99351-99355 from Table ART-B. • Added UB-92 Revenue codes 0118, 0128, 0138, 0148, 0158, 019x, 066x to Table ART-B. • Deleted UB-92 Revenue codes 0456, 049x, 050x, 053x, 056x, 076x, 092x, 094x, 096x, 0972–0979, 0984–0986, 0988, 0989 from Table ART-B. • Added Abatacept and Rituximab to Table ART-C. • Added J codes to Table ART-C. • Deleted Occurrence code 10 from Table ART-D.
Annual Monitoring for Patients on Persistent Medications	✓	✓	✓	• Added Amlodipine-benazepril, Candesartan+HCTZ, Enalapril-felodipine, Enalapril-diltiazem, Eprosartan+HCTZ, Irbesartan+HCTZ, Olmesartan+HCTZ, Quinapril+HCTZ, Telmisartan+HCTZ, Valsartan+HCTZ to Table MPM-A. • Deleted LOINC codes 5919-6, 13451-0, 15051-6 from Table MPM-B (serum creatinine). • Added HCTZ/Captopril, HCTZ/Fosinopril, HCTZ/Hydralizaine, HCTZ/Quinapril, HCTZ/ Telmisartan, HCTZ/Triamterene to Table MPM-D. • Deleted Benzthiazide, Hydroflumethazide, Quinethazone, HCTZ/Guanethidine from Table MPM-D. • Added Carbatrol, Di-Phen, Epitol, Equetro, Tegretol, Tegretol XR to Table MPM-E • Deleted Diphenylan, Depacaine, Myoproic Acid from Table MPM-E • Condensed Table MPM-Ea–Table MPM-Ed to Table MPM-E. • Condensed Table MPM-Fa–Table MPM-Fd to Table MPM-F. • Added CPT Code 80050 to Table MPM-H.

				• Deleted Tables MPM-I and MPM-J.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Effectiveness of Care				
Drugs to Be Avoided in the Elderly			✓	• Added Butalbital, Chlordiazepoxide-Methscopolamine, Estinyl, Estrace, Estratab, Estropriate, Gynodiol, Nandrolone, Oxandrolone, Stanozolol, Testosterone to Table DAE-A. • Deleted Mesoridazine, Pemoline, Cyclandelate from Table DAE-A.
Potentially Harmful Drug-Disease Interactions in the Elderly			✓	• First-year measure.
Medical Assistance With Smoking Cessation	✓	✓	✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
Flu Shots for Adults Ages 50–64	✓			• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
Flu Shots for Older Adults			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
Pneumonia Vaccination Status for Older Adults			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
The Medicare Health Outcomes Survey			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 6: Specifications for the Medicare Health Outcomes Survey*.
Management of Urinary Incontinence in Older Adults			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 6: Specifications for the Medicare Health Outcomes Survey.*
Physical Activity in Older Adults			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 6: Specifications for the Medicare Health Outcomes Survey.*
Fall Risk Management			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 6: Specifications for the Medicare Health Outcomes Survey.*
Osteoporosis Testing in Older Women			✓	• This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2007, Volume 6: Specifications for the Medicare Health Outcomes Survey.*

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Access/Availability of Care				
Adults' Access to Preventive/ Ambulatory Health Services	✓	✓	✓	• 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.
Children's and Adolescents' Access to Primary Care Practitioners	✓	✓		• Deleted mental health and chemical dependency services exclusions.
Prenatal and Postpartum Care	✓	✓		• 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.
Annual Dental Visit		✓		• No changes to this measure.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	✓	• 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.
Claims Timeliness	✓	✓	✓	• Retired measure.
Call Answer Timeliness	✓	✓	✓	• No changes to this measure.
Call Abandonment	✓	✓	✓	• No changes to this measure.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to:			Changes to HEDIS 2007
	Commercial	Medicaid	Medicare	
Satisfaction With the Experience of Care				
CAHPS Health Plan Survey 4.0H, Adult Version	✓	✓		• This measure is collected using survey methodology. Detailed specifications are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
CAHPS Health Plan Survey 3.0H, Child Version	✓	✓		• This measure is collected using survey methodology. Detailed specifications are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
Children With Chronic Conditions	✓	✓		• This measure is collected using survey methodology. Detailed specifications are contained in *HEDIS 2007, Volume 3: Specifications for Survey Measures.*
Health Plan Stability				
Practitioner Turnover	✓	✓	✓	• Retired measure.
Years in Business/Total Membership	✓	✓	✓	• No changes to this measure.
Use of Services				
Specific Guidelines for Use of Services Measures	✓	✓	✓	
Frequency of Ongoing Prenatal Care		✓		• No changes to this measure.
Well-Child Visits in the First 15 Months of Life	✓	✓		• No changes to this measure.
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	✓	✓		• No changes to this measure.
Adolescent Well-Care Visits	✓	✓		• No changes to this measure.
Frequency of Selected Procedures	✓	✓	✓	• Added back surgery 65+ years to the commercial product line. • Added back surgery procedure to the Medicare product line. • Added ICD-9-Procedure codes 00.66, 00.70, 00.80, 36.06, 36.07 to Table FSP-A. • Added HCPCS codes to Table FSP-A.
Inpatient Utilization—General Hospital/ Acute Care	✓	✓	✓	• Deleted Occurrence code 10 from Table IPU-B. • Removed "65–74 years" from the Maternity category (commercial, Medicaid, Medicare).
Ambulatory Care	✓	✓	✓	• Moved UB-92 Revenue code 0456 from Table AMB-A to Table AMB-B. • Deleted UB-92 Type of Bill code 43x from Tables AMB-B, AMB-C and Table AMB-D.
Inpatient Utilization—Nonacute Care	✓	✓	✓	• No changes to this measure.

Discharges and Average Length of Stay—Maternity Care	✓	✓		• No changes to this measure.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to: Commercial	Medicaid	Medicare	Changes to HEDIS 2007
Use of Services				
Births and Average Length of Stay, Newborns	✓	✓		• No changes to this measure.
Mental Health Utilization—Inpatient Discharges and Average Length of Stay	✓	✓	✓	• No changes to this measure.
Mental Health Utilization—Percentage of Members Receiving Inpatient and Intermediate Care and Ambulatory Services	✓	✓	✓	• Added HCPCS codes to Table MPT-A.
Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay	✓	✓	✓	• No changes to this measure.
Identification of Alcohol and Other Drug Services	✓	✓	✓	• Added HCPCS codes to Table IAD-B.
Outpatient Drug Utilization	✓	✓	✓	• No changes to this measure.
Antibiotic Utilization	✓	✓	✓	• Added data element "total number of prescriptions by drug class" to Table ABX-B and Table ABX-C. • Clarified the calculation for the average number of antibiotics PMPY, reported by drug class, for selected "antibiotics of concern" and for "all other antibiotics." • Added Aztreonam, Carbenicillin, Cefixime, Cephradine, Piperacillin-Tazobactam and Ticarillin-Clavulanate to Table ABX-A. • Added Aztreonam and Cefixime to Table ABX-B. • Added Cefadroxil Hydrate, Carbenicillin, Cephradine, Piperacillin-Tazobactam and Ticarcillin-Clavulanate to Table ABX-C. • Deleted Cloxacillin, Dirithromycin, Enoxacin, Flomefloxacin, Fusidic Acid, Methicillin, Mezlocillin, Netilmicin, Pefloxacin, Teicoplanin and Sulfamethizole from Tables ABX-A, ABX-B and ABX-C.
Cost of Care				
Specific Guidelines for Cost of Care Measures	✓	✓	✓	• New for HEDIS 2007.
Relative Resource Use for People With	✓	✓	✓	• First-year measure.

Diabetes				
Relative Resource Use for People With Asthma	✓	✓		• First-year measure.

HEDIS 2007 Summary Table of Measures, Product Lines and Changes *(continued)*

HEDIS 2007 Measures	Applicable to: Commercial	Medicaid	Medicare	Changes to HEDIS 2007
Cost of Care				
Relative Resource Use for People With Acute Low Back Pain	✓	✓		• First-year measure.
Relative Resource Use for People With Cardiac Conditions	✓	✓	✓	• This will be a first-year measure in HEDIS 2008. It will not be collected for HEDIS 2007.
Relative Resource Use for People With Uncomplicated Hypertension	✓	✓	✓	• This will be a first-year measure in HEDIS 2008. It will not be collected for HEDIS 2007.
Relative Resource Use for People With COPD	✓	✓	✓	• This will be a first-year measure in HEDIS 2008. It will not be collected for HEDIS 2007.
Informed Health Care Choices				*There are currently no measures in this domain.*
Health Plan Descriptive Information				
Board Certification	✓	✓	✓	• No changes to this measure.
Enrollment by Product Line	✓	✓	✓	• No changes to this measure.
Enrollment by State	✓	✓	✓	• No changes to this measure.
Race/Ethnicity Diversity of Membership		✓	✓	• Clarified race/ethnicity reporting categories using Table RDM-A.
Language Diversity of Membership		✓	✓	• Clarified the responses for “Need/Want Interpreter” data element.
Weeks of Pregnancy at Time of Enrollment in the MCO		✓		• Deleted ICD-9-CM Diagnosis code 644.20 from Table WOP-A.

Appendix 2

Technical Considerations for First-Year Measures

APPENDIX 2

FIRST-YEAR MEASURES

The NCQA Committee on Performance Measurement (CPM) approved four new measures for HEDIS 2007. These measures provide feasible assessment strategies that are meaningful to consumers, purchasers, health plans and clinicians.

As shown below, not all measures are proposed for all three product lines.

New HEDIS 2007 Measure	Product Line			Data Source		
	Commercial	Medicaid	Medicare	Admin	Hybrid	Survey
Effectiveness of Care						
Potentially Harmful Drug-Disease Interactions in the Elderly			✓	✓		
Cost of Care						
Relative Resource Use for People With Diabetes	✓	✓	✓	✓		
Relative Resource Use for People With Asthma	✓	✓		✓		
Relative Resource Use for People With Acute Low Back Pain	✓	✓		✓		

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

Description

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis.

Selected disease/condition and potentially harmful therapeutic agent combinations include:

- *History of falls*
  - Tricyclic antidepressants
  - Antipsychotics
  - Sleep agents
- *Dementia*
  - Tricyclic antidepressants
  - Anticholinergic agents
- *Chronic renal failure*
  - Nonaspirin NSAIDs
  - Cox-2 Selective NSAIDs

Background

Despite publication of several manuscripts that identified drugs considered inappropriate for use in the elderly —particularly in the presence of specific diagnoses—clinical evidence suggests that these agents are being prescribed for persons 65 years of age and older. Their use is identified with adverse drug events that contribute to hospitalization, increased length of hospital stay and duration of illness, nursing home placement and other events, such as falls and fractures, which are associated with physical, functional and social declines in the elderly.

Pharmacotherapy is an essential component of medical treatment for older patients, but medications are also responsible for many adverse events in this group. Almost 90 percent of people 65 years of age or older take at least 1 medication, significantly more than any other age group (AHRQ, 2001). In 1999, Medicare beneficiaries composed only 14 percent of the community population but accounted for more than 41 percent of prescription medication expenses. The average drug expense was about four times higher for Medicare beneficiaries ($990) than for the non-Medicare population ($236) (Stagnitti, 2003). Many older persons take multiple drugs for the treatment of several conditions, which increases the chance of adverse drug reactions (ADR), drug-drug interactions and drug-disease interactions.

Adverse drug reactions occur commonly in older ambulatory adults with a reported prevalence ranging between 5 percent and 35 percent (Hanlon, 2001; Gurwitz, 2003; Hanlon, 1997; Chrischilles, 1992). They are a major threat to the health-related quality of life of community-dwelling older seniors and account for the expenditure of billions of health care dollars each year in the United States (Hanlon, 2001; Kohn, 2000; Ernst, 2001).

Inappropriate medication use and adverse drug-related outcomes in older adults are becoming increasingly serious problems for many managed care organizations (MCO) (Mackinnon, 2003). Zhan and colleagues observed that 21.3 percent of seniors in the ambulatory setting in the United States are prescribed a potentially inappropriate medication (Zhan, 2001).

Health importance

Patient safety is highly important to the health of members, especially patients who are at increased risk of adverse drug events due to coexisting conditions and polypharmacy. Thirty percent of hospital admissions in elderly patients may be linked to drug-related problems or toxic effects (Hanlon, 1997). Adverse drug events (ADE) have been linked to preventable problems in elderly patients, such as depression, constipation, falls, immobility, confusion and hip fractures (Hanlon, 1997; Bootman 1997).

Use of medications that pose high risk to the elderly is likely to increase the cost of care while decreasing its quality. It has been estimated that more than 10 percent of all hospitalizations for the elderly are related to adverse drug expenditures (Williams, 1992; Monane, 1997; Tamblyn, 1996).

Potentially inappropriate prescribing of medications (PIRx) occurs in hospitals, emergency departments (ED) and ambulatory settings. Patients 65 and older are at significant risk of PIRx owing to polypharmacy for multiple conditions, and for resulting adverse drug events that range from minor symptoms to serious adverse effects, including sedation and life-threatening arrhythmia (Lau, 2005).

Financial importance

In 1999, the difference in mean drug expenses between the Medicare and non-Medicare populations came primarily from differences in the quantities of drugs purchased rather than differences in the price paid for drugs. The average number of prescription drug purchases was higher for Medicare beneficiaries than for the non-Medicare population (Stagnitti, 2003).

The cost of medication use by the 24 million Americans (Monane, 1997) over 65 is higher than $25.5 billion per year (Bootman, 1997; Lubitz, 1995). Drug expenses account for 23 percent of the total cost of caring for older persons, largely due to the burden of chronic disease (Beers, 2000).

Recent estimates of the overall human and economic consequences of medication-related problems vastly exceed the findings of the Institute of Medicine on deaths from medical errors, estimated to cost the nation $8 billion annually. It is estimated that medication-related problems cause 106,000 deaths annually, at a cost of $85 billion (Perry, 1999). Others have calculated the cost of medication-related problems to be $76.6 billion to ambulatory care, $20 billion to hospitals, and $4 billion to nursing home facilities (Bootman, 1997; Bates, 1997; Johnson, 1995).

Cost effectiveness

As MCOs consider the best allocation of resources to improve medication use, two major areas of opportunity are medication use in older adults and prevention of drug-related morbidity (DRM). Beers and colleagues recently described the problem of DRM in the elderly in MCOs and concluded that medication misuse in the elderly is a significant problem; yet historically, optimal prescribing for the elderly has been inadequately addressed (Beers, 2000; Beers, 2001). Others have estimated that for every dollar spent on drugs in nursing facilities, $1.33 is spent on health care resources for treatment of drug-related problems (Harrison, 1998). Some DRMs are not preventable; however; estimates from the literature indicate that a minimum of 30 percent—and up to 80 percent—of DRMs are preventable (MacKinnon, 2002).

Reducing high-risk drug prescriptions in the elderly represents an opportunity to reduce the cost associated with harm from medication (e.g., hospitalization caused by drug toxicity), as well as reduce the cost of the medications by encouraging clinicians to consider safer alternatives. Patients receiving a potentially inappropriate medication have significantly higher provider and facility costs and a higher mean number of inpatient, outpatient and ED visits than comparisons after controlling for sex, the Charlson Comorbity Index and the total number of prescriptions (Fick, Walter, et al.).

Potential for improvement

As noted above, different indicator and aggregate measure rates vary by condition and by plan to a different extent. Field test results indicate the potential for improvement appears to be small across the aggregate measure and indicators; however, considering that drug-disease interactions in the elderly are a safety concern, there is room for improvement in the falls, dementia and renal failure.

Scientific Soundness

Clinical importance and evidence

Moderate to high. There is clinical consensus that certain drugs increase the risk of harm in the elderly (Fick, 2003; Beers, 1997; Zahn, 2001) and should generally be avoided. Appropriate use of prescription drugs in the elderly, including proper drug selection, has been identified as an important quality of care issue (Knight, 2001; Classen, 2003), and explicit criteria defining inappropriate drug use is an important tool when evaluating prescribing to populations (Fick, 2003; Beers, 1997; Zahn 2001; Anderson, 1997). A recently published study of inappropriate medication use with the Beers criteria in a Medicare-managed care population found a potentially inappropriate medication (PIM) prevalence of 23 percent (541/2,336) (Fick, Waller).

Drug-disease interactions identified for reporting in this measure are based on the literature and on the key clinical expert consensus process by Beers (2003) that identified potentially inappropriate medication use in older adults with specific diagnoses or conditions. NCQA's medication management expert panel provided advice on the conditions and drugs to be included in this measure, based on the updated Beers list and a Canadian panel (McLeod, 1997) and significance of harm and impact on the older adult population.

The following table illustrates the disease/condition, drug, concern and severity rating as reported in the literature.

Disease/ Condition	Drug	Concern	Severity Rating
History of falls*	• Tricyclic antidepressants • Antipsychotics	• May produce ataxia, impaired psychomotor function, syncope, and additional falls	• High
Dementia*†	• Anticholinergic agents • Tricyclic antidepressants	• Concerns due to central nervous system altering effects • May worsen cognitive and behavioral function	• High • 3.41 mean clinical significance rating (out of 4)
Chronic renal failure†	• Nonaspirin NSAIDs	• May worsen renal failure; may cause salt and water retention	• 3.56 mean clinical significance rating (out of 4)

*2002 Beers Criteria for Potentially Inappropriate Medication Use in Older Adults: Considering Diagnosis or Conditions (Fick, 2003)
†1997 Canadian Criteria Defining Inappropriate Practices in Prescribing for Elderly People (McLeod, 1997)

Validity

High to moderate. This measure identifies the potential for inappropriate prescribing in the elderly population with specific conditions. It provides valid and reliable data on members' experiences with drugs prescribed throughout the year. Field test medical record validation of the denominators ranged from 85 to 96 percent across conditions; in addition, the concordance between administrative and medical record data for the numerators ranged from 86.6 to 98 percent.

Feasibility

Logistically feasible	*High.* This measure has sufficient denominator size for reporting and plans have the necessary data to identify the measure denominator and numerator events.
Auditable	*High to moderate.* While this measure has not yet been implemented, its auditability was reviewed by NCQA's internal HEDIS Audit and Software Certification staff and is constructed in a manner similar to measures known to be auditable.

References

Anderson, G.M., M.H. Beers, K. Kerluke. Auditing prescription practice using explicit criteria and computerized drug benefit claims data. *J Eval Clin Prac.* 1997; 3 (4): 283-294.

Bates, D.W., N. Spell, D.J. Cullen, et al. The Adverse Drug Events Prevention Study Group. The costs of adverse drug events in hospitalized patients. *JAMA*. 1997;277:307-311.

Beers M.H., R.W. Baran, K. Frenia. Drugs and the elderly, Part I: The problems facing managed care. *Am J Managed Care.* 2000;6:1313-20.

Idem. Drugs and the elderly, Part 2: Strategies for improving prescribing in a managed care environment. *Am J Managed Care.* 2001;7:69-72.

Bootman, J.L., D.L. Harrison, E. Cox. The health care cost of drug-related morbidity and mortality in nursing facilities. *Arch Intern Med.* 1997;157:2089-96.

Chrischilles, E.A., E.T. Segar, R.B. Wallace. Self-reported adverse drug reactions and related resource use. A study of community-dwelling person 65 years of age and older. *Ann Intern Med.* 1992;117:634-640.

Classen, D. Editorial: Medication safety. Moving from illusion to reality. *JAMA. 2003;* 289(9): 1154-1156.

Ernst, F.R., and A.J. Grizzle. Drug-related morbidity and mortality: Updating the cost-of-illness model. *J Am Pharm Assoc* (Wash). 2001;41:192-199.

Fick, D.M., J.W. Cooper, W.E. Wade, J.L. Waller, J.R. Maclean, M.H. Beers. Updating the Beers criteria for potentially inappropriate medication use in older adults. *Arch Intern Med.* 2003; 163: 2716-2724.

Grossberg, G.T., and J.A. Grossberg. Epidemiology of psychotherapeutic drug use in older adults. *Clin Geriatr Med.* 1998;14:1-5.

Gurwitz, J.H., T.S. Field, L.R. Harrold, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *JAMA*. 2003;289:1107-1116.

Hanlon, J.T., S.L. Gray, K.E. Schmader. Adverse drug reactions. In: Delafuente, J.C., R.B. Stewart, eds. *Therapeutics in the Elderly.* 3rd ed. Cincinnati, Ohio: Harvey Whitney Books; 2001: 289-314.

Hanlon, J.T., K.E. Schmader, M.J. Koronkowski, et al. Adverse drug events in high risk older outpatients. *J Am Geriatr Soc.* 1997;45:945-948.

Harrison, D.L., J.L. Bootman, E.R. Cox. Cost-effectiveness of consultant pharmacists in managing drug-related morbidity and mortality in nursing facilities. *Am J Health-Syst Pharm*. 1998;55(15):1588-94.

Highlights #9: Health Care Use in America, 1996. April 2001. Agency for Healthcare Research and Quality, Rockville, MD. http:www.meps.ahrq.gov/papers/hl9_99-0029/hl9.htm

Institute of Medicine, (US) Committee on Quality Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century,* Washington D.C., National Academy Press, 2001

Johnson, J.A., and J.L. Bootman. Drug-related morbidity and mortality: a cost-of-illness model. *Arch Intern Med.* 1995;155:1949-1956.

Knight, E.L., and J. Avorn. Quality indicators for appropriate medication use in vulnerable elders. *Anns Int Med 2001;* 135 (8: Part 2): 703-710.

Kohn, L.T., J.M. Corrigan, M.S. Donaldson, eds. for the Committee on Quality of Health Care in America, Institute of Medicine. In: *To Err is Human, Building a Safer Health System.* Washington, DC: National Academy Press; 2000.

Lau, D.T., J.D. Kasper, E.B. Potter, et al. Hospitalization and death associated with potentially inappropriate medication prescriptions among elderly nursing home residents. *Arch Intern Med*. 2005;165:68-74.

Lubitz, J., J. Beebe and C. Baker. Longevity of Medicare expenditures. *N Engl J Med*. 1995;332:999-1003.

MacKinnon, N.J., and C.D. Hepler. Preventable Drug-related Morbidity in Older Adults Part 1: Indicator Development. *J Mg Care Pharm.* 2002; 8 (5): 365-371.

Mackinnon, N.J., C.D. Hepler. Indicators of Preventable Drug-related Morbidity in Older Adults: Use Within a Managed Care Organization. *J Managed Care Pharm.* 2003; 9:134-41.

McLeod, P.J., A.R. Huang, et al. Defining inappropriate practices in prescribing for elderly people: a national consensus panel. *Can Med Assoc J.* 1997;156(3):385-391.

Monane, M., S. Monane, T. Semla. Optimal medication use in elders. Key to successful aging. *West J Med*. 1997;167(4):233-237.

Okano, G.J., D.C. Malone, S.J. Billups, et al. Reduced quality of life in veterans at risk for drug-related problems. *Pharmacotherapy.* 2001;21:1123-29.
Perry, D.P. When medicine hurts instead of helps. *Consultant Pharmacist.* 1999;14:1326-1330.
Ray, W.A., M.R. Griffin, W. Schaffner, et al. Psychotropic drug use and the risk of hip fracture. *N Engl J Med.* 1987;316:363-369.
Shorr, R.I., S.F. Bauwens, C.S. Landefeld. Failure to limit quantities of benzodiazepine hypnotic drugs for outpatients: Placing the elderly at risk. *Am J Med.* 1990;89:725-732.
Stagnitti, M.N., G.E. Miller, J.F. Moeller. Outpatient prescription drug expenses, 1999. Rockville (MD): Agency for Healthcare Research and Quality; 2003. MEPS Chartbook No. 12. AHRQ Pub. No. 04-0001.
Tamblyn, R. Medication use in seniors: Challenges and solutions. *Therapie.* 1996;51:269-282.
Tinetti, M.E., M. Speechley, S.F. Ginter. Risk factors for falls among elderly persons living in the community. *N Engl J Med.* 1988;319:1701-1707.
Tune, L.E. Anticholinergic effects of medication in elderly patients. *J Clin Psychiatry.* 2001;62(Suppl 21):11-14.
Williams, L., and D.T. Lowenthal. Drug therapy in the elderly. *South Med J*. 1992;85(2):127-131.
Zhan, C., J. Sangl, A.S. Bierman, et al. Potentially in appropriate medication use in the community-dwelling elderly. *JAMA*. 2001;286:2823-29.

Relative Resource Use (RRU)

Description

These measures provide a standardized approach to the measurement of resource use. When coupled with the current quality of care HEDIS measures, they provide more information about the *efficiency* or *value* of services rendered by a health plan.

The following measures will be reported and collected as first-year measures for HEDIS 2007.

- Relative Resource Use for People With Diabetes
- Relative Resource Use for People With Asthma
- Relative Resource Use for People With Acute Low Back Pain

The following measures are included in Volume 2 but will be collected as first-year measures beginning in HEDIS 2008.

- Relative Resource Use for People With Cardiac Conditions
- Relative Resource Use for People With Chronic Obstructive Pulmonary Disease (COPD)
- Relative Resource Use for People With Uncomplicated Hypertension

Relevance

Meaningfulness

…to consumers *Moderate.* NCQA is interested in providing these measures in a way that is meaningful and useful to consumers when making cost and quality decisions.

…to purchasers *High.* Purchasers on NCQA's Purchaser Advisory Council indicate that measures of relative resource use for highly prevalent and costly conditions should provide needed additional information. Because these measures hold prices constant, they allow purchasers to better understand the underlying productivity of the health plan. In addition, because the RRU measure eligible populations represent eligible populations in current HEDIS quality measures, purchasers can link the data from the two types of measures (quality and resource) for a better idea of the value of the health plan.

…to plans/ providers *High.* Health plans and providers are likely to find the measure outcomes useful for evaluating their costs for managing chronic illnesses and improving the health status of their membership.

Financial importance

High. Health care costs have continued to escalate at rates that outpace inflation; in 2003, health care expenditures in the United States were nearly $1.7 trillion, representing 15.3 percent of the Gross Domestic Product (GDP) (Henry J. Kaiser Foundation). In 2004, health care premiums experienced their fourth consecutive year of double-digit growth (11 percent), and they continue to increase much faster than overall inflation (2.3 percent) and wage gains (2.2 percent). Since 2000, health care premiums for family coverage have increased by 59 percent, compared with inflation growth of 9.7 percent and wage growth of 12.3 percent (Henry J. Kaiser Foundation).

Containing health care costs is one of the most challenging policy issues facing the United States. Health plans and purchasers are interested in standard

measures of relative resource utilization because of their potential as tools to reduce costs. Health system efficiencies are often defined as attainment compared to the maximum that could be achieved for the observed level of resource use (Tandon, et. Al.). Research by Wennberg, Fisher, Thorpe and others shows that the problem of variation in intensity of treatment for chronic illness is primarily a problem of overuse and waste, not underuse and health care rationing (i.e., poor quality).

NCQA has developed measures of relative resource use for health plans. By holding price constant and linking these measures to quality outcomes measures purchasers, consumers and health plans will be able to better compare their utilization and quality outcomes of their networks with other plan or types of networks.

Strategic importance

High. Because of a purchaser's goal to manage health care dollars and health plan's goals to strategic priorities, development of these metrics is essential to better relate input costs to output for health care services.

Controllability

Health plans can influence resources and types of resources their networks use, while maintaining quality. Examples of influencing resources used include disease management, utilization review, benefit designs, tiered networks and education programs or health promotions.

Scientific Soundness

Reliability

Data has demonstrated that these measures produce results similar to a proprietary, well-respected method at the health plan level. The clinical logic to identify the relevant population is similar to current HEDIS measures. NCQA will supply tables or codes for health plans to use, when applicable. Health plans will submit resource use data to NCQA stratified by age and gender and for particular categories of utilization (e.g., inpatient facility), which NCQA will use to calculate the relative resource use index.

Ability to detect differences among plans

Data shows relative resource consumption varies appreciably between health plans. Specific findings related to these measures provide insights related to the services, conditions and methods used for study.

- *Services.* For a given health plan and clinical category, measures of relative resource utilization were generally similar across different types of service, with only some modest variations. The consistency was greatest for those services comprising a larger portion of overall costs measured (e.g., inpatient and pharmacy).
- *Study conditions.* For a given health plan, measures of relative resource utilization were generally similar across the various conditions (i.e., similar findings were observed for cardiovascular disease, diabetes, depression, asthma/COPD, arthritis and LBP).

Risk adjustment

These measures are risk adjusted, using a nonproprietary age-sex and morbidity approach.

Feasibility

Precisely specified	These measures have detailed and precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting.
Logistically feasible	With precise specifications, these measures will be feasible to implement, though they may require additional time and monetary commitments from health plans in their initial implementation.
Auditable	These measures are considered to be auditable and have been reviewed by NCQA's Audit Methodology Panel.

References

Centers for Medicare & Medicaid Services. *An Overview of the U.S. Healthcare System: Two Decades of Change, 1980-2000*. Office of the Actuary. March 12 2002.

E.S. Fisher, et al., Associations among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors. *Health Services Research*, 34 no. 6 (2000): 1351-1362.

Henry J. Kaiser Foundation and Health Research and Educational Trust. Trends and Indicators in the Changing Health Care Marketplace. http://www.kff.org/insurance/7031/ti2004-1-1.cfm (accessed April 2005).

Henry J. Kaiser Foundation and Health Research and Educational Trust. Summary of Findings, Employer Health Benefits 2004 Annual Survey. http://www.kff.org/insurance/7148/summary/index.cfm (accessed May 2005).

Tandon, A., J.A. Lauer, D.B. Evans, C.J.L. Murray. Health System Efficiency: Concepts. Health System Performance Assessment, chapter 50. http://whqlibdoc.who.int/publications/2003/9241562455_(part4)_ (chp50-60).pdf

Thorpe et. al., *Health Affairs*. August 25, 2004.

Wennberg, J.E., E.S. Fisher, J.S. Skinner. Geography and The Debate Over Medicare Reform. *Health Affairs* Web Exclusive, February 2002.

Appendix 3

Practitioner Types

APPENDIX 3

PRACTITIONER TYPES

Primary care practitioner	Includes physicians and nonphysicians whom members can select as primary care practitioners and who are defined by the MCO as primary care practitioners.
Primary care physician	Includes general or family practice physicians, geriatricians, general internal medicine physicians, general pediatricians and obstetricians/gynecologists (OB/GYN).
Nonphysician primary care practitioner	Includes physician assistants and nurse practitioners.
Prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
OB/GYN and other prenatal care practitioners	Includes both of the following. • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology • Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Chemical dependency practitioner	Includes the following. • Psychologists • Physicians certified in addiction medicine or addiction psychiatry • State-certified or licensed counselors in alcohol, drug abuse, addictions, substance abuse and chemical dependency • National certified addiction counselors (NCAC) • Internationally certified alcohol and drug counselors (ICADC) • Practitioners who hold the national board for certified counselors (NBCC) specialty certification in addiction counseling
Mental health practitioner	Practitioners whom members are able to see for mental health services and who meet any of the following criteria. • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice

- An individual who is licensed as a psychologist in his/her state of practice
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)

Dentist

Practitioners who hold a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and are licensed to practice dentistry by a state board of dental examiners.

Appendix 4

Data Element Definitions

Data Element Definitions

	Admin	Hybrid	Research	Meaning
Measurement year	✓	✓		Data year (i.e., year prior to reporting year). For HEDIS 2007, the measurement year is 2006.
Data collection methodology (administrative or hybrid)	✓	✓		Method used to collect HEDIS data. Administrative method is from transactional data for the eligible population and hybrid method is from medical record or electronic medical record and transactional data for the sample.
Eligible population	✓	✓		• Members who meet all criteria for the population. This is the universe of members for each measure. • For hybrid measures, the eligible population of members is prior to evaluating members for exclusion criteria. • For administrative measures, the eligible population is after evaluation for exclusion criteria.
Eligible population by non-ER/urgent care visits*	✓		✓	• This element is in the Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis. It is optional for plans to report this element. • Members who meet all criteria for the population. This is the universe of members for each measure. • For administrative measures, the eligible population is after evaluation for exclusion criteria. • This measure is for NCQA research and will not be used in the calculation of the measure.
Eligible population by ER/urgent care visits*	✓		✓	• This element is in the Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis measure. It is optional for plans to report this element. • Members who meet all criteria for the population. This is the universe of members for each measure. • For administrative measures, the eligible population is after evaluation for exclusion criteria. • This measure is for NCQA research and will not be used in the calculation of the measure.
Number of numerator events by administrative data in eligible population (before exclusions)		✓		The number of members in the eligible population who met the numerator criteria.
Current year's administrative rate (before exclusions)		✓		Numerator events by administrative data in eligible population ÷ eligible population.
Minimum required sample size (MRSS) or other sample size		✓		When selecting the sample, this is the required number of members in the sample. Plans can reduce their samples using Tables 2 and 3 in the sampling guidelines.
Oversampling rate		✓		The percentage of additional records needed to replace exclusions and valid data errors in the denominator. The oversample is in 5% increments. Plans that need more than a 20% oversample must contact NCQA.
Final sample size (FSS)		✓		Minimum required sample size + oversample.
Number of numerator events by administrative data in FSS		✓		Number of members in the final sample size who meet numerator criteria through system/ transactional data.

Data Element Definitions (continued)

	Admin	Hybrid	Research	Meaning
Administrative rate on FSS		✓		Numerator events by administrative data in the FSS ÷ FSS.
Number of original sample records excluded because of valid data errors		✓		If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error.
Number of administrative data records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using system or transactional data.
Number of medical record data records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using medical record data.
Number of employee/dependent medical records excluded		✓		Number of records in the sample excluded because the member was an MCO employee or a dependent of an MCO employee.
Total exclusions	✓		✓	The number of records/members excluded due to the optional exclusion criteria. NCQA will use this element for research and analysis. The element will not be used in the calculation of the measure.
Exclusions for comorbid conditions*	✓		✓	This is an optional data element in the Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis measure. NCQA will analyze the exclusion criteria. Plans may choose to report their exclusions using this element; however, this element will only be used for analysis and not for calculating the measure.
Exclusions for competing diagnosis*	✓		✓	This is an optional data element in the Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis measure. NCQA will analyze the exclusion criteria. Plans may choose to report their exclusions using this element; however, this element will only be used for analysis and not for calculating the measure.
Exclusions for medication history*	✓		✓	This is an optional data element in the Inappropriate Antibiotic Treatment for AdultsWith Acute Bronchitis measure. NCQA will analyze the exclusion criteria. Plans may choose to report their exclusions using this element; however, this element will only be used for analysis and not for calculating the measure.
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error.
Denominator		✓		MRSS – exclusions + members added from the auxiliary list. This population is the denominator used to report the measure.
Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using system or transactional data.
Numerator events by medical records		✓		The number of members in the denominator who met numerator criteria using medical record data.

*These data elements are optional.

Data Element Definitions (continued)

	Admin	Hybrid	Research	Meaning
Numerator events by non-ER/urgent care visits*	✓		✓	This is an optional data element for the Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis measure. NCQA will analyze the numerator specification. Plans may choose to report their numerator events using the numerator criteria in the measure; however, this element will only be used for analysis and will not be used in calculating the measure.
Numerator events by ER/urgent care visits*	✓		✓	This is an optional data element for the Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis measure. NCQA will analyze the numerator specification. Plans may choose to report their numerator events using the numerator criteria in the measure; however, this element will only be used for analysis and will not be used in calculating the measure.
Numerator events by therapeutic class*	✓		✓	This is an optional data element for the Drugs to Avoid in the Elderly measure. NCQA will analyze the various therapeutic classifications. Plans may choose to report their numerator events using the classifications in the measure; however, this element will only be used for analysis and will not be used in calculating the measure.
Reported rate	✓	✓		Numerator events by administrative data + numerator events by medical records/denominator.
Lower 95% confidence interval	✓	✓		The MCO is 95% sure that the reported rate falls between this lower rate and the upper confidence interval. This is a calculated field in the DST.
Upper 95% confidence interval	✓	✓		The MCO is 95% sure that the reported rate falls between this higher rate and the lower confidence interval. This is a calculated field in the DST.

*****These data elements are optional.

Standard Administrative Data Element Table

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

*****These data elements are only included in first and second year administrative measures. The total exclusions will be included in analysis of the measure.

Standard Hybrid Data Element Table

	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 or electronic medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Appendix 5

Measure Abbreviations

APPENDIX 5

MEASURE ABBREVIATIONS

Domain	Measure Abbreviation	Measure Name
EOC	CIS	Childhood Immunization Status
EOC	AIS	Adolescent Immunization Status
EOC	URI	Appropriate Treatment for Children With Upper Respiratory Infection
EOC	CWP	Appropriate Testing for Children With Pharyngitis
EOC	AAB	Inappropriate Antibiotic Prescriptions for Adults with Acute Bronchitis
EOC	COL	Colorectal Cancer Screening
EOC	BCS	Breast Cancer Screening
EOC	CCS	Cervical Cancer Screening
EOC	CHL	Chlamydia Screening in Women
EOC	OMW	Osteoporosis Management in Women Who Had a Fracture
EOC	CBP	Controlling High Blood Pressure
EOC	BBH	Beta-Blocker Treatment After a Heart Attack
EOC	PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
EOC	CMC	Cholesterol Management for Patients With Cardiovascular Conditions
EOC	CDC	Comprehensive Diabetes Care
EOC	ASM	Use of Appropriate Medications for People With Asthma
EOC	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
EOC	FUH	Follow-Up After Hospitalization for Mental Illness
EOC	AMM	Antidepressant Medication Management
EOC	ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD)
EOC	GSO	Glaucoma Screening in Older Adults
EOC	LBP	Use of Imaging for Low Back Pain
EOC	ART	Disease Modifying Anti-Rheumatic Drug Therapy (DMARD) in Rheumatoid Arthritis
EOC	MPM	Annual Monitoring for Patients on Persistent Medications
EOC	DAE	Drugs to Be Avoided in the Elderly
EOC	DDE	Potentially Harmful Drug-Disease Interactions in the Elderly
EOC	MSC	Medical Assistance With Smoking Cessation
EOC	FSA	Flu Shots for Adults Ages 50-64
EOC	FSO	Flu Shots for Older Adults
EOC	PNU	Pneumonia Vaccination Status for Older Adults
EOC	HOS	The Medicare Health Outcomes Survey
EOC	MUI	Management of Urinary Incontinence in Older Adults
EOC	PAO	Physical Activity in Older Adults
EOC	FRM	Fall Risk Management
EOC	OTO	Osteoporosis Testing in Older Women

Domain	Measure Abbreviation	Measure Name
AAC	AAP	Adults' Access to Preventive/Ambulatory Health Services
AAC	CAP	Children and Adolescents' Access to Primary Care Practitioners
AAC	PPC	Prenatal and Postpartum Care
AAC	ADV	Annual Dental Visit
AAC	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
AAC	CAT	Call Answer Timeliness
AAC	CAB	Call Abandonment
SEC	CPA	CAHPS Health Plan Survey 4.0H, Adult Version
SEC	CPC	CAHPS Health Plan Survey 3.0H, Child Version
SEC	CCC	Children With Chronic Conditions
HPS	YIB	Years in Business/Total Membership
COS	RDI	Relative Resource Use for People With Diabetes
COS	RAS	Relative Resource Use for People With Asthma
COS	RLB	Relative Resource Use for People With Acute Low Back Pain
UOS	FPC	Frequency of Ongoing Prenatal Care
UOS	W15	Well-Child Visits in the First 15 Months of Life
UOS	W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
UOS	AWC	Adolescent Well-Care Visits
UOS	FSP	Frequency of Selected Procedures
UOS	IPU	Inpatient Utilization—General Hospital/Acute Care
UOS	AMB	Ambulatory Care
UOS	NON	Inpatient Utilization—Nonacute Care
UOS	MAT	Discharges and Average Length of Stay—Maternity Care
UOS	NEW	Births and Average Length of Stay—Newborns
UOS	MIP	Mental Health Utilization—Inpatient Discharges and Average Length of Stay
UOS	MPT	Mental Health—Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
UOS	CIP	Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay
UOS	IAD	Identification of Alcohol and Other Drug Services
UOS	ORX	Outpatient Drug Utilization
UOS	ABX	Antibiotic Utilization
HPD	BCR	Board Certification
HPD	ENP	Enrollment by Product Line
HPD	EBS	Enrollment by State
HPD	RDM	Race/Ethnicity Diversity of Membership
HPD	LDM	Language Diversity of Membership
HPD	WOP	Weeks of Pregnancy at Time of Enrollment in the MCO

Appendix 6

HEDIS Compliance Audit Guidelines for Advertising and Marketing

APPENDIX 6

GUIDELINES FOR NCQA HEDIS COMPLIANCE AUDIT ADVERTISING AND MARKETING

The NCQA HEDIS Compliance Audit program assures both purchasers and consumers of fair and accurate comparisons of MCO performance. NCQA encourages health plans to make their HEDIS Audit status a visible part of their advertising and marketing materials.

References to the terms "advertising," "advertising material" or "advertising and marketing materials" in the following guidelines include all external communications, including:

- *Broadcast:* Radio, television
- *Print:* Newspapers, magazines, newsletters, directories
- *Durables:* Mugs, t-shirts
- Electronic and Web-based materials.

Review and Approval Process

Health plans should thoroughly read these guidelines before producing any advertising and marketing material referencing NCQA or the HEDIS Audit.

An MCO that refers to the HEDIS Audit or any HEDIS data audited by a Certified HEDIS Compliance Auditor must adhere to the following guidelines. Health care organizations *are not* required to submit advertising materials to NCQA for review and approval; however, these organizations will be held accountable for any violations of this policy.

Contact the NCQA Marketing Department at (202) 955-3509 for additional information or clarification about the guidelines. An organization that encounters advertising or marketing material from its competitors or others that appears inconsistent with these guidelines should notify the NCQA Marketing Department by fax at (202) 955-6428 or e-mail it to marketing@ncqa.org.

How to Advertise an NCQA HEDIS Compliance Audit

An MCO that has undergone an audit may state so, display the audit seal and list all measures audited and reported with an approved rate. The MCO may not advertise or market any measure that is *Not Reportable*.

Recommended Language

The MCO must use the following statements, alone or in combination, to identify or describe NCQA, the audit process or HEDIS. The organization may also consult the NCQA Web site at www.ncqa.org for additional descriptive information.

The National Committee for Quality Assurance (NCQA), or NCQA…

- Is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.
- Is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care organizations, managed behavioral healthcare organizations, physician organizations and credentials verification organizations.

- Is committed to providing information on the quality of MCOs. Consumers can easily access MCO NCQA Accreditation statuses and other information on health care quality on the NCQA Web site at www.ncqa.org, or by calling the NCQA Customer Support Center at 888-275-7585.
- Is governed by a Board of Directors that includes employers, consumer and labor representatives, MCOs, quality experts, regulators and representatives from organized medicine.
- The NCQA mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make better-informed decisions.

The NCQA HEDIS Compliance Audit

- The NCQA HEDIS Compliance Audit is a precise, standardized methodology that enables purchasers and consumers to make direct comparisons of MCO performance.
- The NCQA audit methodology was developed to assess the standardization of quality performance reporting throughout the health care industry.
- The NCQA HEDIS Compliance Audit is a two-part process consisting of an information systems capabilities assessment, which is followed by an evaluation of the MCO's ability to comply with HEDIS specifications.

HEDIS (Health Plan Employer Data and Information Set)

- Since its introduction in 1993, the Health Plan Employer Data and Information Set (HEDIS) evolved to become the gold standard in managed care performance measurement.
- Conceived as a way to streamline measurement efforts and promote accountability in managed care, HEDIS measures are now used by approximately 90 percent of all MCOs to evaluate performance in areas ranging from preventive care and consumer experience to heart disease and cancer.
- HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations.

Guidelines for Reporting Audit Results

The audit seal

An MCO that undergoes an audit receives a seal that may be placed on advertising and marketing material. The seal signifies that the MCO's HEDIS data were audited according to the HEDIS Audit specifications. The seal clearly indicates the year in which the data were audited. NCQA provides logo slicks of the seal to these MCOs for the appropriate entities that have undergone an audit.

The seal can be placed on advertising or marketing materials that contain some language or information about the HEDIS Audit, which is in accordance with these guidelines. The seal *may not* be used on durable goods.

The seal must not be manipulated in any way and the overall depiction should be consistent with NCQA's graphical image.

Required language

The MCO must use the language below to indicate that its performance measures were audited according to the HEDIS Audit standards. This language should appear in the main text at the beginning of the document and may not be placed in a footnote.

"The NCQA HEDIS Compliance Audit includes the following domains: Effectiveness of Care; Access/Availability of Care; Satisfaction With the Experience of Care; Health Plan Stability; Use of Services; Cost of Care; and Health Plan Descriptive Information. [Health care organization A] has undergone an audit. The following [NCQA performance measures/ HEDIS measures] were deemed reportable according to the NCQA HEDIS Compliance Audit standards."

Optional language

"The audit was conducted by NCQA-Certified Auditors from (name of Licensed Organization), an NCQA-Licensed Organization."

NCQA Trademarks

HEDIS®

The Health Plan Employer Data and Information Set (HEDIS) is a registered trademark of NCQA. The registered trademark symbol should be applied directly after the word "HEDIS." The organization need only apply the trademark to the *first reference* of the term "HEDIS" within the written material. At the bottom of the page on which the registered trademark first appears should be a footnote that states:

"HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

Quality Compass®

Quality Compass is a registered trademark of NCQA. The registered trademark symbol should be applied directly after the word "Compass." The organization need only apply the trademark to the *first reference* of the term "Quality Compass" within the written material. At the bottom of the page on which the registered trademark first appears should be a footnote that states:

"Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

NCQA HEDIS Compliance Audit™

NCQA HEDIS Compliance Audit is a trademark of NCQA. The trademark symbol should be applied directly after the word "Audit." The organization need only apply the trademark to the *first reference* of the term "NCQA HEDIS Compliance Audit" within the written material. At the bottom of the page on which the registered trademark first appears should be a footnote that states:

"NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA)."

HEDIS Software Certification℠

NCQA HEDIS Software Certification℠ is a service mark of NCQA. The service mark symbol should be applied directly after the word "Certification." The organization need only apply the service mark to the *first reference* of the term "HEDIS Software Certification" within the written material. At the bottom of the page on which the service mark first appears should be a footnote that states:

"HEDIS Software Certification℠ is a service mark of the National Committee for Quality Assurance (NCQA)."

Certified HEDIS Software℠

The NCQA-Certified HEDIS Software℠ seal is a service mark of NCQA. Only vendors whose software achieves certification status as evidenced by NCQA's Certification Report receive and may use the seal for marketing and advertising purposes. The organization need only apply the service mark to the *first reference* of the term "Certified HEDIS Software" within the written material. At the bottom of the page on which the seal first appears should be a footnote that states:

> *"Certified HEDIS Software℠ is a service mark of the National Committee for Quality Assurance (NCQA)."*

Noncompliance Policies

Any advertising material or other promotional effort that refers to the HEDIS Audit and violates the *Guidelines for Advertising*, or which is in any way false or misleading as determined by NCQA, may be grounds for revocation of the organization's HEDIS Audit status.

NCQA reserves the right to require an organization to withdraw advertising material from distribution immediately or to publish, at the organization's cost, a retraction or clarification in connection with any false or misleading statements or any violation of these *Guidelines for Advertising*. Each organization agrees in advance to remedy such violation with the action deemed appropriate by NCQA. In addition, NCQA reserves the right to audit an organization's NCQA-related advertising and marketing materials at any time.

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