Appendix 6

IS Standards Compliance Tool

APPENDIX 6

IS STANDARDS COMPLIANCE TOOL

IS Standards Compliance Tool Instructions

This tool is used to record details about the organization’s compliance with the IS standards and the impact on measure reporting. A thoroughly completed, organization-specific copy of this tool must appear in the auditor’s work papers.

**KEY: S = Significant impact on reporting M = Minimal impact on reporting N = No impact on reporting**

**Note:** If the Reporting Impact is S or M, record the recommended corrective actions.

### IS Standards’ Audit Team Participants

| Standard | Audit Activities | | | HEDIS Impact |
| --- | --- | --- | --- | --- |
| Pre-Onsite Review and Results | Onsite Review  and Results | Post-Onsite Review  and Results | S, M, N Comments |
| **IS 1.0 MEDICAL SERVICES DATA—SOUND CODING METHODS and DATA CAPTURE, TRANSFER AND ENTRY** | | | | |
| ***IS 1.1*** Industry standard codes (e.g., ICD-9, CPT, DRG, HCPCS) are used and all characters are captured. |  |  |  |  |
| ***IS 1.2*** Principal codes are identified and secondary codes are captured. |  |  |  |  |
| ***IS 1.3*** Nonstandard coding schemes are fully documented and mapped back to industry standard codes. |  |  |  |  |
| ***IS 1.4*** Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards. |  |  |  |  |
| ***IS 1.5***Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for measure reporting. |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Procedural Terminology © 2012 American Medical Association. All rights reserved.

| Standard | Audit Activities | | | HEDIS Impact |
| --- | --- | --- | --- | --- |
| Pre-Onsite Review and Results | Onsite Review  and Results | Post-Onsite Review and Results | S, M, N Comments |
| **IS 1.0 MEDICAL SERVICES DATA—SOUND CODING METHODS, DATA CAPTURE, TRANSFER AND ENTRY** | | | | |
| ***IS 1.6*** The organization continually assesses data completeness and takes steps to improve performance. |  |  |  |  |
| ***IS 1.7*** The organization regularly monitors vendor performance against expected performance standards. |  |  |  |  |
| **IS 2.0 ENROLLMENT DATA—DATA CAPTURE, TRANSFER AND ENTRY** | | | | |
| ***IS 2.1***The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy. |  |  |  |  |
| ***IS 2.2*** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files. |  |  |  |  |
| ***IS 2.3*** The organization continually assesses data completeness and takes steps to improve performance. |  |  |  |  |
| ***IS 2.4*** The organization regularly monitors vendor performance against expected performance standards. |  |  |  |  |
| **IS 3.0 PRACTITIONER DATA—DATA CAPTURE, TRANSFER AND ENTRY** | | | | |
| ***IS 3.1*** Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting. |  |  |  |  |
| ***IS 3.2*** The organization has effective procedures for submitting HEDIS-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy. |  |  |  |  |
| ***IS 3.3*** Data entry processes are timely and include edit checks to ensure accurate entry of submitted data in transaction files. |  |  |  |  |
| ***IS 3.4***The organization continually assesses data completeness and takes steps to improve performance. |  |  |  |  |

| Standard | Audit Activities | | | | | HEDIS Impact |
| --- | --- | --- | --- | --- | --- | --- |
| Pre-Onsite Review  and Results | | Onsite Review  and Results | | Post-Onsite Review  and Results | S, M, N Comments |
| **IS 3.0 PRACTITIONER DATA—DATA CAPTURE, TRANSFER AND ENTRY** | | | | | | |
| ***IS 3.5*** The organization regularly monitors vendor performance against expected performance standards. |  |  | |  | |  |
| **IS 4.0 MEDICAL RECORD REVIEW PROCESSES—TRAINING, SAMPLING, ABSTRACTION AND OVERSIGHT** | | | | | | |
| ***IS 4.1*** Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off). |  |  | |  | |  |
| ***IS 4.2*** Retrieval and abstraction of data from medical records is reliably and accurately performed. |  |  | |  | |  |
| ***IS 4.3*** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. |  |  | |  | |  |
| ***IS 4.4*** The organization continually assesses data completeness and takes steps to improve performance. |  |  | |  | |  |
| ***IS 4.5*** The organization regularly monitors vendor performance against expected performance standards. |  |  | |  | |  |
| **IS 5.0 SUPPLEMENTAL DATA—CAPTURE, TRANSFER AND ENTRY** | | | | | | |
| ***IS 5.1*** Nonstandard coding schemes are fully documented and mapped to industry standard codes. |  |  | |  | |  |
| ***IS 5.2*** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy. |  |  | |  | |  |
| ***IS 5.3*** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. |  |  | |  | |  |
| ***IS 5.4*** The organization continually assesses data completeness and takes steps to improve performance. |  |  | |  | |  |

| Standard | Audit Activities | | | | | HEDIS Impact |
| --- | --- | --- | --- | --- | --- | --- |
| Pre-Onsite Review  and Results | | Onsite Review  and Results | | Post-Onsite Review  and Results | S, M, N Comments |
| **IS 5.0 SUPPLEMENTAL DATA—CAPTURE, TRANSFER AND ENTRY** | | | | | | |
| ***IS 5.5*** The organization regularly monitors vendor performance against expected performance standards. |  |  | |  | |  |
| **IS 6.0 MEMBER CALL CENTER DATA—CAPTURE, TRANSFER AND ENTRY** | | | | | | |
| ***IS 6.1*** Member call center data are reliably and accurately captured. |  |  | |  | |  |
| **IS 7.0 DATA INTEGRATION—ACCURATE HEDIS REPORTING, CONTROL PROCEDURES THAT SUPPORT HEDIS REPORTING INTEGRITY** | | | | | | |
| ***IS 7.1*** Nonstandard coding schemes are fully documented and mapped to industry standard codes. |  |  | |  | |  |
| ***IS 7.2*** Data transfers to HEDIS repository from transaction files are accurate. |  |  | |  | |  |
| ***IS 7.3*** File consolidations, extracts and derivations are accurate. |  |  | |  | |  |
| ***IS 7.4*** Repository structure and formatting are suitable for measures and enable required programming efforts. |  |  | |  | |  |
| ***IS 7.5*** File consolidations, extracts and derivations are accurate. |  |  | |  | |  |
| ***IS 7.6*** Report production is managed effectively and operators perform appropriately. |  |  | |  | |  |
| ***IS 7.7*** Measure reporting software is managed properly with regard to development, methodology, documentation, revision control and testing. |  |  | |  | |  |
| ***IS 7.8*** Physical control procedures ensure data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection. |  |  | |  | |  |

| Standard | Audit Activities | | | | | HEDIS Impact |
| --- | --- | --- | --- | --- | --- | --- |
| Pre-Onsite Review  and Results | | Onsite Review  and Results | | Post-Onsite Review  and Results | S, M, N Comments |
| **IS 8.0 WELLNESS AND HEALTH PROMOTION DATA—WHP AUDITS** | | | | | | |
| ***IS 8.1*** Participant eligibility data have necessary procedures to ensure accuracy. |  |  | |  | |  |
| ***IS 8.2*** Health appraisal submission forms capture all fields relevant to WHP reporting. |  |  | |  | |  |
| ***IS 8.3*** Wellness and health promotion intervention tools capture all data relevant to WHP reporting. |  |  | |  | |  |
| ***IS 8.4*** Data transfers to WHP repository are accurate and repository structure and formatting are suitable for WHP measure production. |  |  | |  | |  |
| ***IS 8.5*** Physical control procedures, such as physical security, data access authorization, disaster recovery facilities and fire protection, ensure WHP data integrity. |  |  | |  | |  |
| **IS 9.0 DISEASE MANAGEMENT DATA—DM AUDITS** | | | | | | |
| ***IS 9.1*** Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry. |  |  | |  | |  |
| ***IS 9.2*** DM eligibility data have necessary procedures to ensure accuracy. |  |  | |  | |  |
| ***IS 9.3*** DM registry tools and systems capture all data relevant to reporting. |  |  | |  | |  |
| ***IS 9.4*** Supplemental data—Capture, Transfer and Entry. |  |  | |  | |  |
| ***IS 9.5*** Data transfers to DM repository are accurate and repository structure and formatting are suitable for DM measure production. |  |  | |  | |  |
| ***IS 9.6*** Physical control procedures ensure DM data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection. |  |  | |  | |  |

Appendix 7

Glossary

APPENDIX 7

GLOSSARY

|  |  |
| --- | --- |
| accuracy | The extent to which recorded data (on medical records, forms and computer databases) are error-free and reflect the defining events. Error sources are miscoding, misrepresenting facts, maintaining out-of-date findings, recording data  for the wrong person, data entry and computer programming errors. |
| administrative method | Requires the organization to identify the denominator and numerator using transaction data or other administrative databases. The denominator comprises all eligible members (see **eligible population**). The organization reports a rate based on all members who meet the denominator criteria and who are found through administrative data to have received a particular service. |
| algorithm | A method used to create a calculated result. For example, algorithms are used to combine medical record results with administrative results to produce a measure’s rate. |
| anchor date | The date when the member must be enrolled with the organization. No gaps in enrollment may include this date. |
| attestation | A statement ensuring the validity of a report or document (e.g., practitioner attestation, submission tool attestation, Roadmap attestation). |
| audit result | Defines the suitability of measures for reporting. The result can be an approved rate of calculation or indication the measure is *Not Reportable (NR)*. |
| bias (degree  of bias) | Degree of error. HEDIS rate measures are reported using a 95 percent confidence interval. For certain measures, a >5 percentage point error in the reported rate makes the measure materially biased and *NR*; for others, an error causing a  >10 percent change in the rate makes the measure materially biased and *NR*. |
| bundling | An organization accepts a single code as representative of several services or encounters. For example, prenatal care visits are bundled with delivery, or all hospital services may be under the revenue code for room and board. |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems. A set of standardized surveys that measure patient satisfaction with the experience of care. |
| carve out | A plan sponsor (e.g., employer or purchaser) contracts for a service or function (e.g., mental health or laboratory) to be performed by an entity other than the organization. |
| claims audit or error rate | A rate that indicates the reliability of a claims processing system. Most organizations review a sample of claims after they are processed to compute an error rate, usually expressed as financial and nonfinancial. |
| claims dependent denominator | To determine the eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing of insulin). |

|  |  |
| --- | --- |
| comprehensive data | Complete records of patient care. Information about a member’s every encounter with the health care system. |
| concurrent audit | Evaluation of methods and data during the data collection period. HEDIS Compliance Audits take place during data collection, allowing plans to correct errors before data are reported. |
| continuous enrollment | The minimum amount of time, including allowed gaps, that a member must be enrolled in the organization to be eligible for the measure. |
| corrective action | An activity the plan completes before data submission to correct problems that may result in a measure being *NR*. |
| CPM | Committee on Performance Measurement. The committee that decides which measures will be included in HEDIS and content changes that will be made to the measures. |
| database | Data collected and organized in a computer file for ease of expansion, updating and retrieval. |
| data completeness | The state of data available to meet all the requirements of the HEDIS technical specifications. |
| data completeness assessment | Determination or evaluation of missing data. Data completeness issues must be quantified and an assessment that a measure is *NR* must be supported by determination of material bias for the reporting method used. |
| data consolidation | A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources. |
| data extraction | Collecting data from medical records or from electronic and automated systems. |
| data integration | Combining data from multiple sources, with additional steps that ensure that duplicate data are removed and remaining data are refined. |
| data integrity | Unimpaired data (not altered or destroyed). |
| data reliability | A measure of data consistency based on reproducibility and an estimation of measurement error. |
| delegate | A formal process by which the organization gives another entity the authority to perform certain functions on its behalf, such as provision of mental health care, laboratory services and vision services.  Delegation can also include service functions, such as claims processing and call center functions. Delegates used in NCQA Accreditation may also perform credentialing (CR), utilization management (UM) and quality improvement (QI). |
| deviation | Any process that does not strictly comply with HEDIS standards as published by NCQA. |
| EDI | Electronic data interface. Standard electronic formats used for collecting data that are imported into or exported from various systems. |

|  |  |
| --- | --- |
| external administrative database | Automated data supplied by contracted practitioners, vendors or public agencies (e.g., immunization registries, schools, state public health agencies). The organization must use these data as administrative data, not medical record data. |
| FAQ | Frequently asked question. FAQs are posted to the NCQA Web site on the 15th of each month. |
| HEDIS repository | A database or file system that stores all the HEDIS information, including practitioners, claims and membership, and which may be updated during the data collection period. |
| HMO | Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. |
| homegrown code | A diagnosis or procedure code not recognized nationally but used by the organization. Commonly found in mental health and preventive care. |
| hybrid measure | A measure that requires the organization to identify the numerator using both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure’s eligible population. |
| inclusiveness | The extent to which an entire population or defined group is intentionally included in a database. |
| industry standard code | A code used by the majority of health care facilities and providers. HEDIS uses these codes in the specifications (CPT, ICD-9-CM, MS-DRG, HCPCS, place of service, UB Type of Bill, revenue). |
| interrater reliability | A methodology for quality control and evaluation of the medical record review process. Plans use this method to compare a record reviewer’s results to those of another reviewer. Plans must strive for consistency among reviewers. |
| internally built database | An organization-created database containing claims or medical record information. These databases are often designed for other purposes and, if used for HEDIS, are subject to audit. Examples include case management databases, utilization management databases or databases populated with medical record information. |
| logical group | A category that contains measures with similar characteristics, such as dependence on carve-out benefits, practitioner specialty, contraindications and diagnosis code specificity. Logical groups can be used for measure selection (core set, convenience sample, medical record review validation) and expansion. |
| map | A document showing how the organization cross-references homegrown codes to codes specified by HEDIS. The map must be complete and accurate. |
| measurement year | The year that the health plan is evaluating HEDIS measures, often referred to as the data year. The measurement year is also the year prior to the HEDIS reporting year; for example, HEDIS reporting year 2012 is based on measurement year 2011. |

\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Procedural Terminology © 2012 American Medical Association. All rights reserved.

|  |  |
| --- | --- |
| member | A person who pays premiums to an organization and who, in addition to eligible dependents, is part of the organization’s enrollment population. Members usually receive specified health care services from a defined network for a specified period. |
| nonstandard  code | A code not used or recognized by the majority of practitioners and facilities (see **industry standard code** and **homegrown code**). These plan-specific codes must be mapped to industry codes for inclusion in HEDIS. |
| PHI | Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information. |
| POS | Point of service. An HMO with an opt-out option that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population. |
| positive numerator event | Evidence of one measure-required service, event or diagnosis in either the administrative data or the medical record. |
| positive numerator hit | A member who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the *Childhood Immunization Status* measure, the DTP/DTaP numerator requires four separate immunizations for a member to be a positive numerator hit. |
| PPO | Preferred provider organization. An accreditable entity whose performance NCQA assesses using the NCQA PPO Plan Accreditation standards. PPO plans take responsibility for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers, either by assuming insurance risk or by providing only administrative services. |
| practitioner | A professional who provides health care services. Practitioners are usually required to be licensed as defined by law. |
| product | An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, PPO). |
| product line | The programs offered to distinct populations brought forward by an organization for evaluation. Organization product lines are commercial, Medicare and Medicaid. Disease management (DM) product lines are programs directed toward populations with specific diseases (e.g., asthma, diabetes). |
| provider | An institution or organization that provides services for the organization’s members. Examples of providers include hospitals and home health agencies.  NCQA uses the term “practitioner” to refer to professionals who provide health care services, recognizing that a “provider directory” generally includes both providers and practitioners and that the inclusive definition is the more common use of the word. |
| rater-to-standard | A methodology for evaluating the medical record review process. Plans using this method compare their medical record reviewers’ results to a supervisor or lead reviewer’s results, and strive for consistency of reviewer results. |

|  |  |
| --- | --- |
| retrospective audit | Evaluation of methods and data after the data collection period has ended. With this type of audit, plans are not given a chance to correct errors before data are reported. HEDIS Compliance Audits are conducted using a concurrent audit. |
| reporting year | The year in which HEDIS is reported and for which the volume is named; the year immediately following the measurement year. |
| required benefit | HEDIS measures evaluate performance and hold plans accountable for services provided in their members’ benefits package. Measure specifications include benefits or coverage categories (e.g., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. |
| sample frame | The eligible population for survey measures. The sample frame must be approved by the auditor before it is sent to or administered by the Certified Survey Vendor. |
| service event | A claim or call into a call center. |
| service measure | One of two Access and Availability measures: *Call Answer Timeliness* and *Call Abandonment.* |
| SNP | Special Needs Plan. Created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. |
| supplemental database | Data other than claims and encounters used by the organization to collect information about the delivery of health services to members. |
| systematic sample | The methodology that NCQA requires the organization to use to create a subset of members from the eligible population. This subset or sample is used for reporting hybrid measures. |
| validity | How well data correspond to an actual event or documentation that supports a measure. |
| WHP program | Wellness and health promotion program. A comprehensive plan that helps eligible individuals change their lifestyle and move toward a state of optimal health. It is specific to each employer and plan sponsor and includes health appraisals, interventions and activities. |

Appendix 8

Survey Sample Frame Validation

APPENDIX 8

SURVEY SAMPLE FRAME VALIDATION

## Criteria to Assign Survey Sample Frame Results

*Appendix 8 is excerpted verbatim from HEDIS 2013 Volume 3: Specifications for Survey Measures. Volume 3 uses the term “health plan” rather than “organization.*

Description

A Certified Auditor must validate the survey frame before the Certified Survey Vendor draws the final sample and administers the survey. This validation allows the health plan to correct errors and minimizes the possibility that the survey is administered to a biased sample, which would result in the measures and their components being assigned *Not Reportable (NR).*

Included in the table below are specific criteria for assigning validations results for each survey measure.

**Note:** In the table below, “assigned correctly” means the value in the sample frame data file matches the value in the health plan’s enrollment system. If the value is missing from the system and the sample frame indicates the data are missing, the value was assigned correctly.

Missing data that exceed the material bias threshold do not necessarily result in an *NR* validation result, but the auditor should notify the health plan when missing data results in a threat to survey administration (e.g., if a significant portion of member zip codes are missing, the auditor should notify the health plan but may assign a validation result of *Supports Reporting*). The NCQA Certified HEDIS Survey Vendor will attempt to update the zip code during address validation prior to survey administration.

| **Sample Frame** | **Required Criteria to Assign a *Supports Reporting* Sample Frame  Data File Validation Result** |
| --- | --- |
| CAHPS Adult Sample Frame | * The health plan indicated it is collecting CAHPS Health Plan Survey 5.0H, Adult Version. * The sample frame contains the entire eligible population or a correctly **reduced sample frame** that includes 30,000 members randomly selected from the entire Eligible Population (missing members do not result in material bias). * Data elements in field positions 1–322 are assigned correctly and all required fields contain allowed values. * The data element **Member product line** is assigned correctly and no records have missing data. * The data element **Member product** is assigned correctly and no records have missing data. * The data element **Member first name** is assigned correctly and missing data do not result in material bias. * The data element **Member last name** is assigned correctly and missing data do not result in material bias. * The data element **Member gender** is assigned correctly and missing data (value label = 9) do not result in material bias. * The data element **Member date of birth** is assigned correctly and missing data do not result in material bias. * The data element **Flu Shots for Adults Ages 50-64 Eligibility Flag** is assigned correctly and no records have missing data. * The data element **Member age as of December 31 of the measurement year** is assigned correctly. |

| **Measure Name** | **Required Criteria to Assign a *Supports Reporting* Sample Frame  Data File Validation Result** |
| --- | --- |
| CAHPS Child Sample Frame (Without CCC) | * The health plan indicated it is collecting CAHPS Health Plan Survey 5.0H, Child Version. * The sample frame contains the entire eligible population or a correctly **reduced sample frame** that includes 30,000 members randomly selected from the entire Eligible Population (missing members do not result in material bias). * Data elements in field positions 1–370 are assigned correctly. * The data element **Product line** is assigned correctly and no records have missing data. * The data element **Product** is assigned correctly and no records have missing data. * The data element **Member first name** is assigned correctly and missing data do not result in material bias. * The data element **Member last name** is assigned correctly and missing data do not result in material bias. * The data element **Member gender** is assigned correctly and missing data (value label = 9) do not result in material bias. * The data element **Member date of birth** is assigned correctly and missing data do not result in material bias. |
| CAHPS Child Sample Frame (With CCC) | * The health plan indicated it is collecting CAHPS Health Plan Survey 5.0H, Child Version. * The health plan indicated it is collecting *Children With Chronic Conditions*. * The sample frame contains the entire eligible population or a correctly **reduced sample frame** that includes 30,000 members randomly selected from the entire Eligible Population (missing members do not result in material bias). * Data elements in field positions 1–371 are assigned correctly. * The data element **Product line** is assigned correctly and no records have missing data. * The data element **Product** is assigned correctly and no records have missing data. * The data element **Member first name** is assigned correctly and missing data do not result in material bias. * The data element **Member last name** is assigned correctly and missing data do not result in material bias. * The data element **Member gender** is assigned correctly and missing data (value label = 9) do not result in material bias. * The data element **Member date of birth** is assigned correctly and missing data do not result in material bias. * The data element **Prescreen status code (field position 371)** is assigned correctly and no records have missing data. |

## CAHPS Health Plan Survey, 5.0H Adult Version (CPA)

## Summary of Changes to HEDIS 2013

* Updated the survey questionnaire from version 4.0H to version 5.0H. Revisions include changes to the number, order and wording of survey questions, as well as the following changes to ratings and composites.
* Revised *Rating of Specialist Seen Most Often*; minor wording change is not expected to impact trending.
* Revised *Health Education and Promotion* question wording and response choices; impacts on trending are expected.
* Revised *Getting Needed Care* composite; wording changes not expected to impact trending.
* Revised *Getting Care Quickly* composite; wording changes not expected to impact trending.
* Revised Shared Decision Making composite; added one question and significantly altered the existing questions and response choices. Impacts on trending are expected.
* Added reminder postcards to the data collection protocol.

**Note:** Due to significant specification changes, NCQA will not publicly report results for Health Education and Promotion or Shared Decision Making in HEDIS 2013.

Description

This survey provides information on the experiences of commercial and Medicaid members with the health plan and gives a general indication of how well the health plan meets members’ expectations. Results summarize member experiences through ratings, composites and question summary rates.

Four global rating questions reflect overall satisfaction.

|  |  |
| --- | --- |
| 1. Rating of All Health Care. 2. Rating of Personal Doctor. | 1. Rating of Specialist Seen Most Often. 2. Rating of Health Plan. |

Seven composite scores summarize responses in key areas.

|  |  |
| --- | --- |
| 1. Claims Processing *(commercial only).* 2. Customer Service. 3. Getting Care Quickly. 4. Getting Needed Care. | 1. How Well Doctors Communicate. 2. Shared Decision Making. 3. Plan Information on Costs *(commercial only).* |

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts.

|  |  |
| --- | --- |
| 1. Health Promotion and Education. | 1. Coordination of Care. |

When administered properly in conjunction with the HEDIS protocols for sampling and data collection, the CAHPS Health Plan Survey 5.0H, Adult Version gives a reliable overall assessment of member experience with the health plan. Any alteration to the sampling protocol, the CAHPS 5.0H questionnaire or its administration, other than in conjunction with the HEDIS protocols, may not yield an accurate measurement. Therefore, in order to avoid misleading impressions, **no health plan may represent that it has HEDIS/ CAHPS 5.0H Survey results unless it both administers the entire survey without amendment and complies with the instructions for data collection and reporting contained in *Volume 3: Specifications for Survey Measures*.**

Flu Shots for Adults Ages 50–64 Eligibility Flag

The health plan assigns a *Flu Shots for Adults Ages 50–64* Eligibility Flag for each member in the CAHPS 5.0H adult survey sample frame data file.

|  |
| --- |
| Flu Shots for Adults Ages 50–64 Eligibility Flag |
| **1 = Eligible** (the member was born on or between September 2, 1947, and September 1, 1962) |
| **2 = Ineligible** (the member was born before September 2, 1947, or after September 1, 1962) |

The Flu Shots for Adults Ages 50–64 Eligibility Flag identifies the population eligible for the *Flu Shots for Adults Ages 50–64* measure. NCQA calculates the results using responses from respondents with a flag of   
“1 = Eligible.” The use of an eligibility flag protects member confidentiality (using the date of birth could result in a breach of confidentiality).

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 18 years and older as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year.  *Medicaid:* The last six months of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (the member must be enrolled for 5 of the last 6 months of the measurement year). |
| Current enrollment | Enrolled at the time the survey is completed. |

## CAHPS Health Plan 5.0H, Child Version (CPC)

## Summary of Changes to HEDIS 2013

* Updated the survey questionnaire from version 4.0H to version 5.0H. Revisions include changes to the number, order and wording of survey questions, as well as the following changes to ratings and composites.
* Revised *Rating of Specialist Seen Most Often*; minor wording change is not expected to impact trending.
* Revised *Health Education and Promotion* question wording and response choices; impacts on trending are expected.
* Revised *Getting Needed Care* composite; wording changes not expected to impact trending.
* Revised *Getting Care Quickly* composite; wording changes not expected to impact trending.
* Revised Shared Decision Making composite; added one question and significantly altered the existing questions and response choices. Impacts on trending are expected.
* Added reminder postcards to the data collection protocol.

**Note:** Due to significant specification changes, NCQA will not publicly report results for Health Education and Promotion or Shared Decision Making in HEDIS 2013.

Description

This measure provides information on parents’ experience with their child’s health plan. Results summarize member experiences through ratings, composites and individual question summary rates.

Four global rating questions reflect overall satisfaction.

|  |  |
| --- | --- |
| 1. Rating of All Health Care. 2. Rating of Personal Doctor. | 1. Rating of Specialist Seen Most Often. 2. Rating of Health Plan. |

Five composite scores summarize responses in key areas.

|  |  |
| --- | --- |
| 1. Customer Service. 2. Getting Care Quickly. 3. Getting Needed Care. | 1. How Well Doctors Communicate. 2. Shared Decision Making. |

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts.

|  |  |
| --- | --- |
| 1. Health Promotion and Education (Q8). | 1. Coordination of Care (Q25, without CCC version of questionnaire). |

When administered properly in conjunction with the protocols for sampling and data collection, the CAHPS Health Plan Survey 5.0H, Child Version gives a reliable overall assessment of member experience with the health plan. Any alteration to the sampling protocol, the CAHPS 5.0H questionnaire or its administration, other than in conjunction with the HEDIS protocols, may not yield an accurate measurement. Therefore, in order to avoid misleading impressions, **no health plan may represent that it has HEDIS/CAHPS 5.0H Survey results unless it both administers the entire survey without amendment and complies with the instructions for data collection and reporting contained in *Volume 3: Specifications for Survey Measures*.**

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 17 years and younger as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year.  *Medicaid:* The last six months of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (the member must be enrolled for 5 of the last 6 months of the measurement year). |
| Current enrollment | Enrolled at the time the survey is completed. |

## Protocols for Administering HEDIS/CAHPS 5.0H Surveys

NCQA designed the HEDIS sampling and data collection protocols for the CAHPS surveys to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures outlined below promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data about health plans. **For results to be considered HEDIS/CAHPS survey results, the health plan must follow one of the standard HEDIS/CAHPS survey protocols or an enhanced protocol preapproved by NCQA.** NCQA provides certified survey vendors with further instruction and training in the protocols and a Quality Assurance Plan (QAP) at HEDIS 2013 Survey Vendor Training.

Sample Frame Data File Generation

Health plans are responsible for generating a complete, accurate and valid sample frame data file that is representative of the entire eligible population. Health plans arrange for an NCQA Certified HEDIS Compliance Auditor to verify the integrity of the sample frame before the survey vendor draws the sample and administers the survey.

Health plans have the option of producing a complete sample frame or a reduced sample frame.

* A **complete sample frame** includes the entire Eligible Population.
* A **reduced sample frame** includes 30,000 members randomly selected from the entire eligible population. The HEDIS Compliance Auditor validates the health plan’s method for selecting the random sample.

A sample frame is produced for each HEDIS/CAHPS survey submission. For example, separate sample frames are produced for commercial and Medicaid, and if the health plan reports results separately by product (HMO, POS, PPO), it must produce sample frames separately by product.

Health plans are *strongly encouraged* to generate sample frames no earlier than January 2013, and *not before* eliminating disenrolled and deceased members and updating membership files with address and telephone number corrections. Health plans may generate the sample frame in December of the measurement year, but it must oversample to compensate for members who will disenroll between sample frame generation and administration of the survey. A health plan that generates the sample frame in December of the measurement year must adhere to steps 1–7 of the oversampling process described in the *Sampling Protocol* section in *Volume 3: Specifications for Survey Measures*.

Health plans must generate a sample frame data file for each product line and product, if applicable, to enable the survey vendor to generate the random sample; must use the standardized layout and format provided for the sample frame data file; and must include all data elements (Tables S-1, S-2).

|  |  |
| --- | --- |
| Standardized format | The standardized format for the sample frame is an ASCII fixed-width text file with defined, fixed column positions for each data element. It contains one record or line for each member who meets the eligible population criteria (one record/member per line; one line per record).  Data elements adhere to the value label characteristics described in Tables S-1 and  S-2 and are placed in the designated columns (field positions). No delimiters are used. All data elements are required. For example, a health plan must assign *Member age as of December 31 of the measurement year* in the adult sample frame even if it does not intend to report the *Aspirin Use and Discussion* measure. |

|  |  |
| --- | --- |
|  | Field contents are aligned to the left, and data start in the first position of each field. If data are not available, field positions are left blank.  If applicable, sample frames for different product lines and products may be combined into data one file. Separate layouts are specified for the adult and child surveys; therefore, adult and child data may not be combined into one file.  Additional data elements requested by the survey vendor or provided by the health plan are appended to the end of the data file and are not reviewed during the HEDIS Compliance Audit. |

### Table S-1: Standardized Layout for Sample Frame Data File (Adult Survey)

| Required Data Element | Field Positions | | | Value Labels |
| --- | --- | --- | --- | --- |
| Length | Start | End |
| Health plan name | 60 | 1 | 60 |  |
| Member product line\* | 1 | 61 | 61 | 1 = Commercial 2 = Medicaid |
| Member product\* | 1 | 62 | 62 | 1 = HMO 2 = POS 3 = PPO |
| Subscriber or family ID number | 25 | 63 | 87 |  |
| Member-unique ID | 25 | 88 | 112 | This ID differentiates between individuals when family members share the subscriber ID |
| Member first name | 25 | 113 | 137 |  |
| Member middle initial | 1 | 138 | 138 |  |
| Member last name | 25 | 139 | 163 |  |
| Member gender\* | 1 | 164 | 164 | 1 = Male  2 = Female  9 = Missing/not available |
| Member date of birth | 8 | 165 | 172 | MMDDYYYY |
| Member mailing address 1 | 50 | 173 | 222 | Street address or post office box |
| Member mailing address 2 | 50 | 223 | 272 | Mailing address second line (if needed) |
| Member city | 30 | 273 | 302 |  |
| Member state | 2 | 303 | 304 | 2-character state abbreviation |
| Member zip code | 5 | 305 | 309 | 5-digit number |
| Member telephone number | 10 | 310 | 319 | 3-digit area code plus 7-digit phone number; no separators or delimiters |
| Flu Shots for Adults Ages 50-64  Eligibility Flag\* | 1 | 320 | 320 | 1 = Eligible  2 = Ineligible  0 = Member is in the Medicaid product line for which the measure *is not* reported |
| Member age as of December 31 of the measurement year\* | 2 | 321 | 322 | Numeric, 2-digit variable.  For members age 80 years and older, code as 80. For example, a member who is 89 years of age as of December 31 of the measurement year will be coded 80. |

\*A valid value is required for every member in the record.

### Table S-2: Standardized Layout for Sample Frame Data File (Child Survey without CCC)

| Required Data Element | Field Positions | | | Value Labels |
| --- | --- | --- | --- | --- |
| Length | Start | End |
| Health plan name | 60 | 1 | 60 |  |
| Product line\* | 1 | 61 | 61 | 1 = Commercial 2 = Medicaid |
| Product \* | 1 | 62 | 62 | 1 = HMO 2 = POS 3 = PPO |
| Subscriber or family ID number | 25 | 63 | 87 |  |
| Member-unique ID | 25 | 88 | 112 | This ID differentiates between individuals when family members share the subscriber ID |
| Member first name | 25 | 113 | 137 |  |
| Member middle initial | 1 | 138 | 138 |  |
| Member last name | 25 | 139 | 163 |  |
| Member gender\* | 1 | 164 | 164 | 1 = Male 2 = Female 9 = Missing/not available |
| Member date of birth | 8 | 165 | 172 | MMDDYYYY |
| Member mailing address 1 | 50 | 173 | 222 | Street address or post office box |
| Member mailing address 2 | 50 | 223 | 272 | Mailing address second line (if needed) |
| Member city | 30 | 273 | 302 |  |
| Member state | 2 | 303 | 304 | 2-character state abbreviation |
| Member zip code | 5 | 305 | 309 | 5-digit number |
| Member telephone number | 10 | 310 | 319 | 3-digit area code plus 7-digit phone number; no separators or delimiters |
| Parent/caretaker first name | 25 | 320 | 344 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker middle initial | 1 | 345 | 345 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker last name | 25 | 346 | 370 | Required only if mailing materials are to be addressed to the parent or caretaker |

\*A valid value is required for every member in the record.

*Note*

* *For the CAHPS 5.0H Child Survey, the health plan selects one of the following options for personalizing correspondence and, based on this determination, provides either the parent/caretaker’s mailing address or child member’s mailing address information in field positions 173–309:*
* *Parent/caretaker’s name and child’s name are used in all cover letters, postcards and envelopes. Parent/ caretaker’s address is used for addressing all mailing pieces.*
* *Child surveys are addressed “To the parent/caretaker of [child member’s name].” Child member’s address is used for addressing all mailing pieces.*

## Children With Chronic Conditions (CCC)

## Summary of Changes to HEDIS 2013

* Updated question numbers to be consistent with the 5.0H version of the child CAHPS survey.
* Deleted obsolete CPT codes 90918–90920, 90922–90924, 99293–99296, 99298–99300, 99431–99433, 99435 from Table CCC-3.

Description

This measure provides information on parents’ experience with their child’s health plan for the population of children with chronic conditions.

Results include the same ratings, composites and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Version. In addition, three CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions.

1. Access to Specialized Services.
2. Family Centered Care: Personal Doctor Who Knows Child.
3. Coordination of Care for Children With Chronic Conditions.

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

1. Access to Prescription Medicines.
2. Family Centered Care: Getting Needed Information.

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 17 years and younger as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year.  *Medicaid:* The last six months of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (a member must be enrolled for 5 of the last 6 months of the measurement year). |
| Current enrollment | Enrolled at the time the survey is completed. |

\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Procedural Terminology © 2012 American Medical Association. All rights reserved.

## Protocols for Children With Chronic Conditions

Sample Frame Data File Generation

|  |  |
| --- | --- |
| Prescreen status code | Health plans use transaction data or administrative databases to assign a prescreen status code to each child member in the CAHPS child survey sample frame data file. The prescreen status code identifies a set of children who are more likely to have a chronic condition.  Health plans search claims and encounters for the measurement year and the year prior to the measurement year and assign codes as follows.  **1** = No claims or encounters during the measurement year or the year prior to the measurement year that meet the criteria listed for prescreen status code 2.  **2** = The member has claims or encounters during the measurement year or year prior to the measurement year that meet one or more of the following criteria.   * At least one encounter in an outpatient, nonacute inpatient, acute inpatient or emergency department setting during the measurement year or the year prior to the measurement year with a diagnosis in Table CCC-1. The diagnosis does not have to be the principal diagnosis. Use the codes in Table CCC-3 to identify the visit type. * At least two encounters in an outpatient setting on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis listed in Table CCC-2. Two visits must have the same diagnosis (for example, one visit for asthma and one visit for conduct disorder do not qualify). The diagnosis does not have to be the principal diagnosis. Use the codes in Table CCC-3 to identify visit type. * At least one encounter in an acute inpatient, nonacute inpatient or emergency department setting during the measurement year or the year prior to the measurement year with a diagnosis listed in Table CCC-2. Use the codes in Table CCC-3 to identify visit type. |

### Table CCC-1: Codes to Assign the Prescreen Status Code

|  |  |
| --- | --- |
| Description | ICD-9-CM Diagnosis |
| Infectious disease | 010-018, 030, 040.2, 042, 046, 079.5, 135, 136.3 |
| Malignancies | 140-209, 230-239 |
| Thyroid disorders | 240-246 |
| Diabetes | 250 |
| Other endocrine disorders | 252, 253, 255 |
| Nutritional deficiencies | 260-263, 268.0-268.1 |
| Metabolic disorders | 270-273, 275, 279 |
| Cystic fibrosis | 277 |
| Blood disorders | 281-284, 286, 288 |
| Psychoses | 290-299 |
| Neuroses, alcohol/drugs, depression, eating disorders | 300-311 |
| Developmental delay (speech, reading, coordination) | 315 |
| Mental retardation | 317-319 |
| Central nervous system diseases, hereditary and degenerative | 330, 331.3-331.4, 331.89, 333.5, 333.7, 334-335 |
| Central nervous system diseases, other | 340-341, 344, 352.6, 356 |
| Cerebral palsy | 343 |
| Epilepsy | 345 |
| Muscular dystrophy | 359 |
| Eye disorders | 365.14, 369 |
| Hearing loss | 389 |
| Other circulatory system disorders | 393-398, 424.1, 424.3, 425, 446.0, 446.2-446.4, 446.6-446.7 |
| Other respiratory diseases | 496, 516 |
| Ulcer | 531-534 |
| Noninfectious enteritis and colitis | 555-556 |
| Other digestive diseases | 571.4-571.9, 577.1, 579.0-579.1, 579.8 |
| Nephritis, nephrosis | 581-583, 585-586, 588.0-588.1 |
| Skin diseases | 695.4 |
| Arthropathies | 710, 714 |
| Connective tissue diseases or disorders | 720, 728 |
| Osteopathies | 730.1, 732 |
| Spina bifida | 741 |
| Congenital anomalies (except spina bifida) | 742, 745-749, 750.3, 751.2, 751.61, 751.62, 752.7, 753, 754.3, 755.2-755.3, 755.55, 756, 758, 759.5, 759.7-759.8, 760.71 |
| Prematurity | 765 |
| Perinatal diseases | 770.7, 771.1-771.2 |
| Severe injury | 854, 952.0, 952.1, 994.1 |

**Note:** Include all paid, suspended, pending and denied claims.

### Table CCC-2: Codes to Assign the Prescreen Status Code

|  |  |
| --- | --- |
| Description | ICD-9-CM Diagnosis |
| Conduct disorder | 312 |
| Emotional disturbance | 313 |
| ADHD | 314 |
| Asthma | 493 |
| Failure to thrive | 783.0, 783.21, 783.4 |

**Note:** Include all paid, suspended, pending and denied claims.

### Table CCC-3: Codes to Identify Visit Types

|  |  |  |
| --- | --- | --- |
| Description | CPT | UB Revenue |
| Outpatient | 90801, 90802, 90804-90815, 90951-90959, 90963-90965, 90967-90969, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411, 99412, 99420, 99429 | 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983 |
| Nonacute inpatient | 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 | 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525 |
| Acute inpatient | 90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 99292, 99460-99463, 99468, 99469, 99471, 99472, 99475-99480 | 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 017x, 020x, 021x, 072x, 080x, 0987 |
| Emergency department | 99281-99285 | 045x, 0981 |

**Note:** Include all paid, suspended, pending and denied claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Procedural Terminology © 2012 American Medical Association. All rights reserved.

### Table S-2 (CCC): Standardized Layout for Sample Frame Data File (Child Survey With CCC)

| Required Data Element | Field Positions | | | Value Labels |
| --- | --- | --- | --- | --- |
| Length | Start | End |
| Health plan name | 60 | 1 | 60 |  |
| Product line\* | 1 | 61 | 61 | 1 = Commercial 2 = Medicaid |
| Product\* | 1 | 62 | 62 | 1 = HMO 2 = POS 3 = PPO |
| Subscriber or family ID number | 25 | 63 | 87 |  |
| Member-unique ID | 25 | 88 | 112 | This ID differentiates between individuals when family members share the subscriber ID |
| Member first name | 25 | 113 | 137 |  |
| Member middle initial | 1 | 138 | 138 |  |
| Member last name | 25 | 139 | 163 |  |
| Member gender\* | 1 | 164 | 164 | 1 = Male 2 = Female 9 = Missing/not available |
| Member date of birth | 8 | 165 | 172 | MMDDYYYY |
| Member mailing address 1 | 50 | 173 | 222 | Street address or post office box |
| Member mailing address 2 | 50 | 223 | 272 | Mailing address 2nd line (if needed) |
| Member city | 30 | 273 | 302 |  |
| Member state | 2 | 303 | 304 | 2-character state abbreviation |
| Member zip code | 5 | 305 | 309 | 5-digit number |
| Member telephone number | 10 | 310 | 319 | 3-digit area code plus 7-digit phone number; no separators or delimiters |
| Parent/caretaker first name | 25 | 320 | 344 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker middle initial | 1 | 345 | 345 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker last name | 25 | 346 | 370 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Prescreen status code\* | 1 | 371 | 371 | 1 = No claims or encounters that meet criteria 2 = Claims or encounters that meet criteria |

\*A valid value is required for every member in the record.

*Note*

* *For the CAHPS 5.0H Child Survey, the health plan selects one of the following options for personalizing correspondence and, based on this determination, provides either the parent/caretaker’s mailing address or child member’s mailing address information in field positions 173–309:*
* *Parent/caretaker’s name and child’s name are used in all cover letters, postcards and envelopes. Parent/ caretaker’s address is used for addressing all mailing pieces.*
* *Child surveys are addressed “To the parent/caretaker of [child member’s name].” Child member’s address is used for addressing all mailing pieces.*

Appendix 9

Software Certification Measures

APPENDIX 9

SOFTWARE CERTIFICATION MEASURES

Measures Eligible for Software Certification

|  |  |
| --- | --- |
| Effectiveness of Care | * Adult BMI Assessment (ABA) * Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) * Childhood Immunization Status (CIS) * Immunizations for Adolescents (IMA) * Human Papillomavirus Vaccine for Female Adolescents (HPV) * Lead Screening in Children (LSC) * Breast Cancer Screening (BCS) * Cervical Cancer Screening (CCS) * Colorectal Cancer Screening (COL) * Chlamydia Screening in Women (CHL) * Glaucoma Screening in Older Adults (GSO) * Care for Older Adults (COA) * Appropriate Testing for Children With Pharyngitis (CWP) * Appropriate Treatment for Children With Upper Respiratory Infection (URI) * Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) * Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) * Pharmacotherapy Management of COPD Exacerbation (PCE) * Use of Appropriate Medications for People With Asthma (ASM) * Medication Management for People With Asthma (MMA) * Asthma Medication Ratio (AMR) * Cholesterol Management for Patients With Cardiovascular Conditions (CMC) * Controlling High Blood Pressure (CBP) * Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) * Comprehensive Diabetes Care (CDC) * Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) * Osteoporosis Management in Women Who Had a Fracture (OMW) * Use of Imaging Studies for Low Back Pain (LBP) * Antidepressant Medication Management (AMM) * Follow-Up Care for Children Prescribed ADHD Medication (ADD) * Follow-Up After Hospitalization for Mental Illness (FUH) * Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) * Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) |

|  |  |
| --- | --- |
|  | * Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) * Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) * Annual Monitoring for Patients on Persistent Medications (MPM) * Medication Reconciliation Post-Discharge (MRP) * Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) * Use of High-Risk Medications in the Elderly (DAE) |
| Access/ Availability of Care | * Adults’ Access to Preventive/Ambulatory Health Services (AAP) * Children and Adolescents’ Access to Primary Care Practitioners (CAP) * Annual Dental Visit (ADV) * Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) * Prenatal and Postpartum Care (PPC) |
| Utilization | * Frequency of Ongoing Prenatal Care (FPC) * Well-Child Visits in the First 15 Months of Life (W15) * Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) * Adolescent Well-Care Visits (AWC) * Frequency of Selected Procedures (FSP) * Ambulatory Care (AMB) * Inpatient Utilization—General Hospital/Acute Care (IPU) * Identification of Alcohol and Other Drug Services (IAD) * Mental Health Utilization (MPT) * Antibiotic Utilization (ABX) * Plan All-Cause Readmissions (PCR) |
| Relative Resource Use | * Relative Resource Use for People With Diabetes (RDI) * Relative Resource Use for People With Cardiovascular Conditions (RCA) * Relative Resource Use for People With Hypertension (RHY) * Relative Resource Use for People With COPD (RCO) * Relative Resource Use for People With Asthma (RAS) |
| Health Plan Descriptive Information | * Enrollment by Product Line (ENP) * Enrollment by State (EBS) * Language Diversity of Membership (LDM) * Race/Ethnicity Diversity of Membership (RDM) * Weeks of Pregnancy at Time of Enrollment (WOP) * Total Membership (TLM) |
| Other | * Systematic Sampling Logic * Survey Sample Frame Logic |

Measures Not Eligible for Software Certification

|  |  |
| --- | --- |
| Effectiveness of Care | * The Medicare Health Outcomes Survey (HOS)\* * Fall Risk Management (FRM)\* * Management of Urinary Incontinence in Older Adults (MUI)\* * Osteoporosis Testing in Older Women (OTO)\* * Physical Activity in Older Adults (PAO)\* * Aspirin Use and Discussion (ASP)\* * Flu Shots for Adults Ages 50–64 (FSA)\* * Flu Shots for Older Adults (FSO)\* * Medical Assistance With Smoking Cessation and Tobacco Use Cessation (MSC)\* * Pneumococcal Vaccination Status for Older Adults (PNU)\* |
| Access/Availability of Care | * Call Answer Timeliness (CAT) |
| Descriptive Information | * Board Certification (BCR) |

**\***Survey measure.

Appendix 10

Bias Determination

APPENDIX 10

HEDIS BIAS DETERMINATION

Bias Determination by Measure

|  |  |
| --- | --- |
| Bias Determination, Rule 1  *(+/–)5 percentage point difference in the reported rate* | * Adult BMI Assessment (ABA) * Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) * Childhood Immunization Status (CIS) * Immunizations for Adolescents (IMA) * Human Papillomavirus Vaccine for Female Adolescents (HPV) * Lead Screening in Children (LSC) * Breast Cancer Screening (BCS) * Cervical Cancer Screening (CCS) * Colorectal Cancer Screening (COL) * Chlamydia Screening in Women (CHL) * Glaucoma Screening in Older Adults (GSO) * Care for Older Adults (COA) * Appropriate Testing for Children With Pharyngitis (CWP) * Appropriate Treatment for Children With Upper Respiratory Infection (URI) * Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) * Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) * Pharmacotherapy Management of COPD Exacerbation (PCE) * Use of Appropriate Medications for People With Asthma (ASM) * Medication Management for People With Asthma (MMA) * Asthma Medication Ratio (AMR) * Cholesterol Management for Patients With Cardiovascular Conditions (CMC) * Controlling High Blood Pressure (CBP) * Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) * Comprehensive Diabetes Care (CDC) * Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) * Osteoporosis Management in Women Who Had a Fracture (OMW) * Use of Imaging Studies for Low Back Pain (LBP) * Antidepressant Medication Management (AMM) * Follow-Up Care for Children Prescribed ADHD Medication (ADD) * Follow-Up After Hospitalization for Mental Illness (FUH) * Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) * Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) |

|  |  |
| --- | --- |
|  | * Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) * Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) * Annual Monitoring for Patients on Persistent Medications (MPM) * Medication Reconciliation Post-Discharge (MRP) * Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) * Use of High-Risk Medications in the Elderly (DAE) * Adults’ Access to Preventive/Ambulatory Health Services (AAP) * Children and Adolescents’ Access to Primary Care Practitioners (CAP) * Annual Dental Visit (ADV) * Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) * Prenatal and Postpartum Care (PPC) * Call Answer Timeliness (CAT) * Frequency of Ongoing Prenatal Care (FPC) * Well-Child Visits in the First 15 Months of Life (W15) * Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) * Adolescent Well-Care Visits (AWC) |
| Bias Determination Rule 2 *(+/–)10% change in the reported rate* | * Frequency of Selected Procedures (FSP) * Ambulatory Care (AMB) * Inpatient Utilization—General Hospital/Acute Care (IPU) * Identification of Alcohol and Other Drug Services (IAD) * Mental Health Utilization (MPT) * Antibiotic Utilization (ABX) * Plan All-Cause Readmissions (PCR) * Board Certification (BCR) * Enrollment by Product Line (ENP) * Enrollment by State (EBS) * Language Diversity of Membership (LDM) * Race/Ethnicity Diversity of Membership (RDM) * Weeks of Pregnancy at Time of Enrollment (WOP) * Total Membership (TLM) |

|  |  |
| --- | --- |
| Bias Determination Rule 3 *(+/–)5% change in the reported rate* | * Relative Resource Use for People With Diabetes (RDI) * Relative Resource Use for People With Cardiovascular Conditions (RCA) * Relative Resource Use for People With Uncomplicated Hypertension (RHY) * Relative Resource Use for People With COPD (RCO) * Relative Resource Use for People With Asthma (RAS) |
| Bias Determination Rule 4 *(+/-)10 percent change in the index hospital stays or numerator* | * Plan All-Cause Readmission (PCR) |
| Other:  *Material bias of (+/–)10% difference between the eligible population and  the survey sample frame* | * CAHPS 5.0H Adult Survey Sample Frame Logic (CPA) * CAHPS 5.0H Child Survey (without CCC) Sample Frame Logic (CPC) * Indicators for Children With Chronic Conditions CAHPS 5.0H Child Survey (With CCC) Sample Frame Logic (CCC) |

WHP BIAS DETERMINATION

Bias Determination by Measure

|  |  |
| --- | --- |
| Bias Determination, Rule 1  *(+/–)5 percentage point difference in  the reported rate* | * Health Appraisal Completion (HAC) – Incentive rates * Health Promotion for the Population (HPP) –Interactive contact rate * Staying Healthy (STH) –Zero risk rate * Prevalence of Core Risks Identified on HAs (PRI) – Core risk rates * Number of Core Risks Identified on HAs (NRI) – Core risk rates * Participation (PAR) - Contacts by core risk rates * Risk Reduction-Overall (RRO) – Risk reduction rates * Risk Reduction-BMI Reduction and Maintenance (RRB) * Risk Reduction-Smoking or Tobacco Use Quit Rate (RRS) * Risk Reduction-Physical Activity Level (RRP) |
| Bias Determination Rule 2 *(+/–)10% change in the reported rate* | * Health Promotion for the Population (HPP) –Average number of contacts * Participation (PAR) - Types of communication used by type of core risk * Participation (PAR) - Types of communication used by number of core risks |

DM BIAS DETERMINATION

Bias Determination by Measure

|  |  |
| --- | --- |
| Bias Determination, Rule 1  *(+/–)5 percentage point difference in  the reported rate* | * Management of People With Heart Failure (DHFM) * Management of People With Ischemic Vascular Disease (DIVD) * Management of People With COPD (DCOP) * Management of People With Asthma (DASM) * Management of People With Diabetes (DCDC) |

Appendix 11

Guidelines for Licensed Organization Advertising and Marketing

APPENDIX 11

GUIDELINES FOR LICENSED ORGANIZATION  
ADVERTISING AND MARKETING

NCQA encourages Licensed Organizations to display their NCQA Licensed status in their advertising and marketing materials.

References to the terms “advertising,” “advertising material” and “advertising and marketing materials” in the following guidelines include all external communications, including the following.

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

Review and Approval Process

Licensed Organizations should read these guidelines thoroughly before producing any advertising and marketing material referring to NCQA or the Licensed Organization seal.

Contact the NCQA Audit Department by e-mail for additional information or clarification about these guidelines. A Licensed Organization that encounters advertising or marketing material from its competitors or others that appears inconsistent with these guidelines should notify the NCQA Audit Department by e-mail.

Recommended Language

A Licensed Organization may state that it is licensed by NCQA, that date on which licensure started and display the NCQA Compliance Audit Organization seal. The organization *must* use the following statements, alone or in combination, to identify or describe NCQA, the audit process or HEDIS. The organization may consult the NCQA Web site (www.ncqa.org) for additional descriptive information.

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

* Is a private, non-profit organization dedicated to improving health care quality.
* Is an independent, non-profit organization that accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90 percent of the nation’s health plans.
* Is committed to providing health care quality information through the web and the media in order to help consumers, employers and others make informed health care choices. Consumers can easily access organizations’ NCQA Accreditation, Certification and Recognition statuses and other information on   
  health care quality on NCQA’s Web site at [www.ncqa.org](http://www.ncqa.org), or by calling NCQA Customer Support at   
  888-275-7585.
* Is governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, regulators and representatives from organized medicine.
* NCQA’s mission is to improve the quality of health care delivered.

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 organization 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 an organization’s ability to comply with HEDIS specifications.

HEDIS (Healthcare Effectiveness Data and Information Set)

* Since its introduction in 1993, the Healthcare Effectiveness 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 managed care organizations 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 help purchasers and consumers make reliable comparison of organization performance.

Use of NCQA Logo and Other NCQA Seals

|  |  |
| --- | --- |
| Use of NCQA logo | The use and reproduction of NCQA’s logo is strictly prohibited. Organizations that have received NCQA Accreditation, Certification, Recognition or other distinction are prohibited from using the NCQA logo in any marketing and advertising materials, including e-mails, Web sites and other Web-based applications. If you want to provide a link to NCQA’s Web site, use [www.ncqa.org](http://www.ncqa.org). |
| Link to NCQA Web site | NCQA encourages Licensed Organizations to use the NCQA Web site as a resource. You may provide a link to the NCQA Web site. E-mail marketing@ncqa.org if you have questions. |

NCQA Trademarks

|  |  |
| --- | --- |
| HEDIS® | The Healthcare Effectiveness 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).”* |

|  |  |
| --- | --- |
| HEDIS Compliance Audit™ | The 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 “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:  *“HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).”* |
| HEDIS Software CertificationSM | The HEDIS Software CertificationSM 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****SM*** *is a service mark of the National Committee for Quality Assurance (NCQA).”* |
| Certified HEDIS SoftwareSM | The Certified HEDIS SoftwareSM 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****SM*** *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 *Marketing and Advertising Guidelines*, 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 *Marketing and Advertising Guidelines*. Each Licensed Organization agrees in advance to remedy such violation with the action deemed appropriate by NCQA. In addition, NCQA reserves the right to audit a Licensed Organization’s NCQA related advertising and marketing materials at any time.