HEDIS®  
2013 Volume 3

### Specifications for Survey Measures

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Acknowledgments

NCQA is proud to release *HEDIS 2013 Volume 3: Specifications for Survey Measures*. NCQA’s Committee on Performance Measurement (CPM) has long felt that consumer experience with health care is a critical component of quality of care, that experience affects care outcome—and that experience is itself a measure of outcome. Survey results give health plans the opportunity for continuous improvement in member care.

The HEDIS survey measurement set would not exist without the contributions of many stakeholders, external and internal to NCQA. The Agency for Healthcare Research and Quality (AHRQ) oversees the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[[1]](#footnote-1) program. Its objective is to improve state-of-the-art methods for assessing members’ experiences with care. The CPM contributes its time, energy and expertise to develop and refine the HEDIS measurement set.

Sincerely,



Margaret E. O’Kane  
President

Committee on Performance Measurement

|  |  |
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Overview

HEDIS 2013

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used set of health care performance measures in the United States. The term “HEDIS” originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990’s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations.HEDIS 2013 is published across a number of volumes and includes 80 measures across 5 domains of care:

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| * Effectiveness of Care. * Access/Availability of Care. * Experience of Care. | | * Utilization and Relative Resource Use. * Health Plan Descriptive Information. |
| *Volume 1:* Narrative | A general overview of the HEDIS measurement set and how the data are used. | |
| *Volume 2:* Technical  Specifications | The technical specifications for the HEDIS nonsurvey measures for organizations and how to collect data for each measure, as well as general guidelines for calculations and sampling. | |
| Technical Specifications for Physician Measurement | The technical specifications for the HEDIS quality and cost of care measures for physician-level measurement. | |
| *Volume 3:* Specifications for Survey Measures | The technical specifications for HEDIS survey measures and standardized surveys from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program. | |
| Specifications for the CAHPS PCMH Survey | The technical specifications and standardized questionnaires for the CAHPS survey for the Patient-Centered Medical Home (PCMH). | |
| *Volume 4:* A Road Map for Information Systems | An overview of the information systems necessary to support HEDIS. The most recent version of this archived volume was published in 1998. | |
| *Volume 5:* HEDIS Compliance Audit™: Standards, Policies and Procedures | The accepted method for auditing the HEDIS production process, including an information systems capabilities assessment and an evaluation of compliance with HEDIS specifications. Standards that Certified HEDIS Compliance Auditors must use when conducting a HEDIS audit. | |
| *Volume 6:* Specifications for the Medicare Health Outcomes Survey | The technical specifications for the Health Outcomes Survey (HOS). | |

How HEDIS Is Developed

NCQA’s Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, health care providers and policy makers, oversees the evolution of the measurement set. Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Advisory Group (TAG) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

What’s New in Volume 3?

For HEDIS 2013, NCQA updated the CAHPS survey questionnaire from version 4.0H to version 5.0H*.* Revisions include changes to the number, order and wording of survey questions for consistency across CAHPS survey products. Refer to each measure’s *Summary of Changes* section for additional information on changes*.*

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| Technical update | If necessary, NCQA will post a HEDIS 2013, Volume 3 *Technical Update* to the NCQA Web site at www.ncqa.org on November 15, 2012, to communicate essential clarifications or updates to the specifications in this volume. Health plans and survey vendors are responsible for incorporating all changes listed in the update. |

How This Volume Is Organized

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| Introduction | Acquaints the reader with HEDIS surveys and NCQA’s Survey Vendor Certification Program. |
| General Guidelines | Instructions and definitions to help health plans and survey vendors successfully collect and report HEDIS survey measures. |
| Effectiveness of Care | Specifications for *Aspirin Use and Discussion, Medical Assistance With Smoking and Tobacco Use Cessation, Flu Shots for Adults Ages 50–64, Flu Shots for Older Adults* and *Pneumococcal Vaccination Status for Older Adults.* |
| Experience of Care | Information on the HEDIS/CAHPS adult and child surveys, including measure descriptions, HEDIS protocols and guidelines for calculating results and specifications for the *Children With Chronic Conditions* measure. |
| Appendices | The HEDIS/CAHPS questionnaires, mailing materials, general recommendations for oversampling and Internet data collection methodology (optional). |

If You Have Questions About the Specifications

Policy Clarification Support

NCQA provides different types of policy support to customers, including a function that allows customers to submit specific policy interpretation questions to NCQA staff: the Policy Clarification Support (PCS) system. The PCS can be accessed on the NCQA Web site ([www.ncqa.org/pcs](http://www.ncqa.org/pcs)).

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS uses and specifications and are posted to the NCQA Web site on the 15th of each month.

Additional Resources

In addition to the specification volumes, NCQA provides a variety of resources to help organizations understand measure specifications, collect HEDIS data and report results:

* Each organization implementing HEDIS is strongly encouraged to join NCQA’s HEDIS Users Group (HUG) for technical assistance and guidance on interpreting the specifications. Membership benefits include NCQA HEDIS and accreditation publications, newsletters, Internet seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information.
* All HEDIS publications are available as easy-to-use electronic publications (“e-pubs”), which contain the complete text of NCQA printed publications and are sold by user license. E-pubs are protected Microsoft Word and Excel files sent to the purchaser via e-mail. E-pubs are simple to download onto a PC, network or intranet.
* Save programming hours, eliminate the manual search for codes and reduce keying errors with the HEDIS Electronic Coding Table (ECT). The ECT is an easy way to incorporate CPT2, HCPCS, ICD-9-CM, UB-revenue and type of bill, DRG and LOINC®3 into an organization’s data collection program. The ECT is available in XML and has a release schedule of early September with a final release in December.
* NCQA produces many publications that are relevant to organizations and physicians interested in improving the quality of health care. To obtain a list or to order publications, go to the NCQA Publications Center at [www.ncqa.org/publications](http://www.ncqa.org/publications) or call Customer Support at 888-275-7585.
* NCQA educational seminars provide valuable information on NCQA standards and the survey process. Several course offerings range from a basic introduction to HEDIS and NCQA standards to advanced techniques for quality improvement. For information about NCQA conferences, go to <http://www.ncqa.org/education/> or call NCQA Customer Support at 888-275-7585.

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Introduction

Introduction

HEDIS Survey Measures

HEDIS 2013, Volume 3 contains technical specifications for eight survey measures that span two domains of care and are collected through three surveys.

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| Measure | Survey4 |
| **Effectiveness of Care** | |
| Aspirin Use and Discussion | CAHPS Health Plan Survey 5.0H, Adult Version |
| Medical Assistance With Smoking and Tobacco Use Cessation | CAHPS Health Plan Survey 5.0H, Adult Version; Medicare CAHPS4 |
| Flu Shots for Adults Ages 50–64 | CAHPS Health Plan Survey 5.0H, Adult Version |
| Flu Shots for Older Adults | Medicare CAHPS |
| Pneumococcal Vaccination Status for Older Adults | Medicare CAHPS |
| **Experience of Care** | |
| CAHPS Health Plan Survey 5.0H, Adult Version | CAHPS Health Plan Survey 5.0H, Adult Version |
| CAHPS Health Plan Survey 5.0H, Child Version | CAHPS Health Plan Survey 5.0H, Child Version |
| Children With Chronic Conditions (CCC) | CAHPS Health Plan Survey 5.0H, Child Version |

CAHPS Program

The Consumer Assessment of Healthcare Providers and Systems Program (CAHPS) program is overseen by the United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer and patient perspectives on health care quality. NCQA uses the adult and child versions of the CAHPS Health Plan Surveys for HEDIS and refers to them as *CAHPS Health Plan Survey 5.0H, Adult Version* and *CAHPS Health Plan Survey 5.0H, Child Version.*

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4 The Medicare CAHPS survey collects results for only one *Medical Assistance With Smoking and Tobacco Use Cessation* rate: *Advising Smokers and Tobacco Users to Quit*.

HEDIS Survey Vendor Certification

NCQA developed its Survey Vendor Certification Program to ensure standardization of data collected by multiple survey vendors and, thereby, the comparability of results across health plans. To become an NCQA Certified HEDIS Survey Vendor, an organization must demonstrate that it has the capabilities, experience and expert personnel to accurately collect and report survey results. Each year, NCQA trains, certifies and publishes a list of certified survey vendors.

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| Vendor criteria: | NCQA issues a solicitation each year for organizations interested in becoming certified survey vendors and evaluates all submitted proposals against the following criteria. |
| Relevant survey experience | Technical competence in running large-scale survey research operations, experience working with health plans and with consumer satisfaction surveys. Experience with large-scale mail and computer-assisted telephone interviewing (CATI) data collection efforts. |
| Organizational/ survey capacity | Access to requisite resources (computer and technical equipment) and personnel. Capacity to handle a large volume of mail questionnaires and to conduct highly standardized CATI interviews in a short time frame. |
| Personnel | Relevant background and experience of key staff. Role, qualifications and name of any subcontractors. |
| Quality control/ management plan | The nature of personnel training and quality control mechanisms employed to ensure high response rates and valid, reliable survey data. Ability to implement an intensive work plan for five months of data collection. |
| Past performance | Letters of reference from two recent clients. Review of past performance conducting large-scale health surveys.  Survey vendor requirements are designed to ensure the standardized collection of valid and reliable survey results, essential for comparing results across health plans and over time. |
| Annual training and certification | NCQA requires all survey vendors to participate in its annual HEDIS survey vendor training. Survey vendors are trained specifically on HEDIS sampling and data collection protocols, the NCQA Quality Assurance Plan (QAP) and submission of survey data to NCQA for calculation of HEDIS survey results. Upon successful completion of HEDIS survey vendor training, vendors are certified to collect and report HEDIS survey measures for one year. NCQA posts the list of certified survey vendors on its Web site (www.ncqa.org), and health plans and other survey sponsors can contract with survey vendors on this list to administer HEDIS surveys.  NCQA certifies survey vendors for a specified maximum number of survey samples based on assessment of their capacity, their ability to conduct the required volume of surveys and other concurrent commitments. Recertification is contingent on acceptable performance in survey administration and annual participation in HEDIS survey vendor training. |

General Guidelines for  
Data Collection and Reporting

General Guidelines for   
Data Collection and Reporting

## Summary of Changes to HEDIS 2013

* NCQA no longer generates and provides summary-level data .txt files. All results are included in the HEDIS Survey Results Reports, which are PDF documents.

Specific Tasks

1. NCQA Must…

* Train and certify survey vendors to administer HEDIS surveys.
* Provide quality oversight to NCQA Certified HEDIS Survey Vendors during survey administration to ensure standardization and protocol adherence.
* Provide the health plan and survey vendor with organization identification numbers and HEDIS submission identification numbers.
* Process member-level data files submitted by NCQA Certified HEDIS Survey Vendors.
* Generate HEDIS survey results reports, validated member-level data files and summary-level data files containing HEDIS survey results.
* Provide the health plan and survey vendor with HEDIS survey results reports, validated member-level data files and summary-level data files via a secure NCQA Internet site, the Interactive Data Submission System (IDSS).
* For health plans that elect to publicly report, include its HEDIS survey results in *Quality Compass* and other NCQA information products.

2. Health Plans Must…

* Contract with an NCQA Certified HEDIS Survey Vendor to administer HEDIS surveys.
* Contract with an NCQA licensed organization to conduct a HEDIS Compliance Audit.
* Ascertain from the survey vendor the date when the validated sample frame is due. Survey vendors set these dates independently of NCQA. Dates are based on many factors, including the length of the survey protocol, the due date for member-level data file submission and the time needed to draw the random sample and generate the final member-level data file.

Health plans must deliver the validated sample frame by the specified date so that the survey vendor can administer the survey and submit member-level data files to NCQA by May 31, 2013. If a health plan cannot provide the validated sample frame on time, the survey implementation timeline will be delayed and the survey vendor may not be able to submit the member-level data files to NCQA by the required date.

Health plans face the following consequences if member-level data files are submitted after May 31, 2013:

* Final survey results reports will not be available on June 3, 2013, and the health plan will have less than two weeks to review survey results before submitting the signed attestation to NCQA by June 17, 2013. If the health plan does not submit a signed attestation by June 17, 2013, NCQA cannot guarantee that survey results will be included in published benchmarks and thresholds or in *Quality Compass.*
* A health plan seeking accreditation must pay an additional late fee for submission after June 17.
* Generate a complete, unbiased sample frame that represents the HEDIS reporting entity for each survey sample. A health plan that outsources sample frame generation to a survey vendor must provide the vendor with a membership file containing its entire population and, when necessary, claims and encounters data, from which the vendor generates the sample frame prior to sampling. Refer to the *General Guidelines* for instructions on defining the HEDIS reporting entity.
* Arrange to have HEDIS survey sample frames validated by an NCQA Certified HEDIS Compliance Auditor before the survey vendor draws the sample and administers the survey. This will allow enough time to correct errors, minimizing the possibility that the survey is administered to a biased sample and an audit result of *Not Reportable (NR)* for the measure. Survey vendors set the date when the validated sample frame must be received, and arrange for validation to be completed by that date. A health plan that outsources sample frame generation to a survey vendor must arrange for an NCQA Certified HEDIS Compliance Auditor to work directly with the survey vendor to validate the integrity of the sample frame.
* Submit a completed Healthcare Organization Questionnaire (HOQ) to NCQA. This allows NCQA to generate organization and submission ID numbers for the health plan. The HOQ covers both survey and nonsurvey HEDIS data for all product lines and products. Every year, NCQA makes the HOQ available to every health plan in its database (including plans that previously reported HEDIS results and plans in the accreditation process) via a secure site on the NCQA Web site.

A health plan that has never reported HEDIS results or sought accreditation must request a Program Login ID in order to access the HOQ. E-mail requests to [hoq@ncqa.org](mailto:hoq@ncqa.org).

* Through the certified survey vendor, submit member-level data files to NCQA by May 31, 2013, for calculation of HEDIS survey results.
* Log on to IDSS to obtain HEDIS survey results, validated member-level data files and summary-level data files.
* Submit a signed Attestation of Accuracy, Public Reporting Authorization and Data Use Agreement to NCQA by June 17, 2013.

3. NCQA Certified HEDIS Survey Vendors Must…

* Follow the sampling protocols contained in this volume. Prior to sampling, obtain confirmation from the health plan that a certified auditor has validated the sample frame.
* Administer HEDIS surveys according to the data collection protocols contained in this volume.
* Adhere to the guidelines in the NCQA QAP, including those for ensuring member confidentiality and requirements for protocol adherence. Submit required project reports as detailed in the QAP including interim reports and test data file submissions.
* Verify that each client has access to the HOQ (NCQA will notify certified survey vendors when the HOQs are available on the NCQA secure site). Clients that do not have access to the HOQ must e-mail NCQA at [hoq@ncqa.org](mailto:hoq@ncqa.org) to obtain a Secure Site Login ID.
* Submit clean member-level data files to NCQA for calculation of HEDIS survey results by May 31, 2013, in accordance with the HEDIS survey file layouts.
* Store data in secure and confidential storage, as described in the NCQA QAP.

4. NCQA Certified HEDIS Compliance Auditors Must…

* Ascertain from the health plan the date for delivery of the validated sample frame to the survey vendor and arrange for the validation to be completed by that date.
* Verify that the health plan can produce an unbiased sample frame that includes all required data elements.
* Provide the health plan with written documentation of the sample frame validation.

HEDIS Reporting

5. Defining the HEDIS Reporting Entity

To determine how many HEDIS surveys to administer, the health plan must define itself using criteria specified by NCQA. The HEDIS reporting entity must be consistent for the health plan’s surveys and other HEDIS results. HEDIS survey sample frames must reflect the exact product line/product combination defined by the HEDIS reporting entity.

If the health plan is seeking accreditation, HEDIS results must correspond with the product line/product combination for which it seeks accreditation. NCQA defines the health plan for accreditation and HEDIS reporting as part of the accreditation application process. Refer to *General Guideline 13: How NCQA Defines a Health Plan for Accreditation*.

If the health plan is not seeking accreditation, it must define itself using the criteria in *General Guideline 13* and should request assistance from the NCQA Policy Department via the PCS system at [www.ncqa.org/pcs](http://www.ncqa.org/pcs) if it cannot determine the HEDIS reporting entity.

6. Product-Line Reporting

HEDIS survey results must be collected and reported separately for populations covered by commercial insurance, Medicare and Medicaid.

7. Product-Specific Reporting

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| *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. An HMO is accountable for assessing access and ensuring quality and appropriate care. |
| *POS* | Point of service. An HMO with an opt-out option. In this type of health plan, members may choose to receive services either within the organization’s health care system (e.g., an in-network practitioner) or outside the organization’s health care delivery system (e.g., an out-of-network practitioner).  The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of “POS” include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an “HMO swing-out plan,” an “out-of-plan benefits rider to an HMO” or an “open-ended HMO.” |
| *PPO* | Preferred provider organization. PPOs 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 and is usually required to be licensed as defined by law. Practitioners affiliated with the health care system render health care services. In an HMO, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement. |

At the discretion of individual health plans, HEDIS survey results may be reported separately by product (HMO, POS, PPO) or combined (HMO/POS), consistent with how a health plan reports other HEDIS measures. A health plan that wants to report a PPO product combined with the HMO/POS products (HMO/POS/PPO) must submit a written request to PCS at [www.ncqa.org/pcs](http://www.ncqa.org/pcs) for approval. The request must specifically address all the elements contained in *General Guideline 13* and *General Guideline 14: HEDIS Reporting for Accreditation*.

The health plan must submit data for an entire product; this includes consumer-directed or high-deductible health plan (e.g., CDHP, HDHP) products that may be offered under an HMO or a PPO license. The health plan must include all members—including administrative services only (ASO) members—except when a purchaser contract prohibits it from contacting members under any circumstances (a “no-touch” contractual agreement). The health plan may exclude no-touch members from HEDIS reports. Refer to *General Guideline 28: Self-Insured Members* for more information.

8. Mixed-Model Health Plans

**Mixed-model** health plans (e.g., a health plan with an IPA and a group model) should report survey data for all model types combined. **Model type** is the type of structure the health plan uses to provide members with care (e.g., Staff, Group, IPA, Direct Contract, Network, Mixed).

9. Reporting HEDIS Survey Results for Medicaid

Separate Medicaid HEDIS survey results should be collected and reported for each state with which the health plan has a Medicaid contract. A health plan that contracts with a local entity (e.g., a county) rather than a state should discuss with the state the possibility of providing one comprehensive Medicaid HEDIS survey that encompasses all geographic areas in the state served by the health plan.

10. Reporting HEDIS Survey Results for Medicare

Beginning in 2011, CMS will require all Medicare Advantage and Prescription Drug Plan contracts with at least 600 enrollees to contract with CMS-approved survey vendors to collect and report CAHPS survey data following a specific timeline and protocols established by CMS. To learn more about the MA and PDP CAHPS surveys, including background information, policy updates, survey administration protocols and procedures, training opportunities and participating in the survey, visit the MA and PDP CAHPS Web site at [www.MA-PDPCAHPS.org](http://www.MA-PDPCAHPS.org). For Medicare product lines, administration of the 2012 Medicare CAHPS survey satisfies the HEDIS 2012 reporting requirements for *Experience of Care, Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit* rate only)*, Flu Shots for Older Adults* and *Pneumococcal Vaccination Status for Older Adults.*

11. Reporting HEDIS for CHIP

States may contract with a health plan to provide care to Children’s Health Insurance Program (CHIP) enrollees as part of the health plan’s Medicaid product line, the commercial product line, or separate from both the Medicaid and commercial product lines. A state that contracts with a health plan to care for CHIP enrollees should enable the contracting health plan to identify CHIP enrollees, when possible.

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| Reporting guidelines | Reporting performance measures for CHIP enrollees should be consistent with the health plan’s Medicaid contracting status and the direction of the state.  *If the state has identified CHIP enrollees to a contracting health plan and the contracting health plan also collects and reports Medicaid HEDIS results,* the health plan should perform one of the following, as directed by the state.   * Report required HEDIS measures separately for CHIP enrollees, ***or*** * Include CHIP enrollees in its Medicaid product line reports.   The health plan must exclude CHIP enrollees from its commercial product line reports because including CHIP enrollees in HEDIS reports for commercially enrolled populations may affect plan-to-plan comparison.  A health plan with a small number of eligible CHIP enrollees (i.e., the health plan cannot achieve the minimum denominator of 100 required for *Reportable [R]* results) should consult with its respective states to determine specific CHIP HEDIS reporting requirements.  NCQA will continue to work with CMS, AHRQ, states and health plans to gain additional experience with issues and opportunities for future reporting of children covered by CHIP. |
| Specification requirements | Specifications for the Medicaid product line should be used for all CHIP surveys (i.e., the CAHPS Health Plan Survey 5.0H, Child Version). This includes using Medicaid continuous enrollment requirements and sample sizes, as well as use of the Medicaid version of the questionnaire. |

Using HEDIS Survey Results in Accreditation

12. HEDIS Submissions for Health Plans Seeking Accreditation

HEDIS survey results must correspond with the product line/product combination for which a health plan seeks accreditation. NCQA defines the health plan for accreditation and HEDIS reporting as part of the accreditation application process.

13. How NCQA Defines a Health Plan for Accreditation

NCQA’s definition of the accreditable health plan (also called the “accreditable entity”) is based on the legal entity and management structure and delivery system that support the product lines/products NCQA accredits. NCQA’s goal is to arrive at accreditation decisions that reflect the health plan that is legally accountable for services provided to its members and represents an organizational and delivery structure that is meaningful to members.

1. Legal entity. The first factor that NCQA considers when defining a health plan is its legal structure. The goal is to identify the legal entity that issues a contract for insurance for a defined population or contracts with an employer to provide managed care services to a self-insured population.

If the health plan consists of multiple legal entities within a state, but otherwise operates as a single, statewide health plan (i.e., same management structure; a single practitioner/provider network for the entire state; centralized key functions, including quality improvement, credentialing and utilization management), NCQA awards accreditation decisions for each legal entity, but the health plan may submit one statewide HEDIS submission that is applied to each legal entity.

2. Practitioner and provider network. The health plan must have a single practitioner or provider network. If there are separate and distinct practitioner or provider networks, NCQA may consider each network, along with the accompanying management structure, to be a separate health plan.

NCQA recognizes that health plans sometimes market individual products with practitioner or provider networks that are subsets of a larger network. In this case, NCQA may define the health plan at the level of the broader network.

If the health plan wants to report a PPO product combined with the HMO/POS product, it must have HMO/POS and PPO practitioner and provider networks that are at least 80 percent the same. If more than 20 percent of practitioners and providers do not participate in networks for both the HMO/POS and PPO products, NCQA requires separate HEDIS reporting.

3. Centralization. NCQA considers the degree of centralization of key functions assessed by the accreditation standards. The health plan should have a single QI program and a single set of policies and procedures for the functions evaluated by the standards, including disease management; complex case management; utilization management; credentialing; managing member complaints and appeals; and developing member materials. If key functions are decentralized, with distinct policies and procedures, NCQA may determine that there is more than one accreditable entity.

4. Licensure. NCQA considers licensure when defining a health plan. The health plan may have multiple licenses, especially if its service area crosses state lines.

5. HEDIS/CAHPS reporting unit. NCQA considers the health plan’s HEDIS/CAHPS reporting unit in its definition. Because evaluation of HEDIS/CAHPS results is a component of the accreditation score and NCQA issues a unique status for each HEDIS/CAHPS reporting unit, the accreditable entity is the same as the HEDIS/CAHPS reporting unit. Refer to *HEDIS Reporting for Accreditation*, below, for the definition of a reporting unit.

6. Product/product line. HEDIS results must reflect the exact product/product line combination for which the organization seeks accreditation and must include all members covered by the product/product line (e.g., insured and self-insured), unless noted otherwise in the HEDIS specifications.

NCQA combines accreditation standard score with specified HEDIS and CAHPS score for each product/product line, and issues accreditation decisions by product/product line (e.g., commercial HMO, commercial PPO, Medicare HMO).

7. Geographic unit. HEDIS performance varies geographically throughout the United States. To be meaningful to consumers and purchasers, results must reflect geographic variation. For HMO and POS plans—which are generally incorporated locally and regulated individually by states—the size of the geographic unit is limited by the legal entity. Plans must report HEDIS/CAHPS for HMO and POS products at a reporting unit no larger than each legal entity*.*

For PPO products, which may have a service area that is larger than a single state, health plans are required to report HEDIS/CAHPS results for geographic regions no larger than a state, except as noted below under *Minimum enrollment thresholds.*

Current NCQA policies that allow HEDIS/CAHPS reporting across state lines in large metropolitan areas, or when a health plan has a small population out of state, remain unchanged.

14. HEDIS Reporting for Accreditation

NCQA combines Accreditation Survey results with specified HEDIS results for the product lines/products defined below, and issues accreditation decisions by product line/product.

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| HEDIS/CAHPS  reporting unit | NCQA evaluates a health plan’s HEDIS/CAHPS results at the time of its Accreditation Survey and annually, between surveys, based on its performance on the measures. NCQA uses the following criteria to define a HEDIS/CAHPS reporting unit:   * Product line and product (refer to General Guidelines 6 and 7). * Geographic unit. |
| Minimum enrollment thresholds | NCQA’s goal is to maximize a health plan’s ability to produce HEDIS/CAHPS results. A HEDIS/CAHPS reporting unit (accreditable entity) must have a sufficient number of members in order to calculate rates. NCQA recognizes that producing HEDIS/CAHPS results can be resource intensive, and has established a minimum membership threshold for requiring HEDIS reporting. A geographic unit with 15,000 or more members in a product/product line must submit audited HEDIS/CAHPS results to NCQA to be scored as part of accreditation.  If the reporting unit has fewer than 15,000 members, NCQA has established alternative accreditation policies for combining HEDIS/CAHPS reporting units, or accrediting a health plan on standards or standards and CAHPS only. |
| Combining reporting units with <15,000 members | Entities may be combined when, based solely on geographic reporting policy, a single legal entity is considered to have multiple HEDIS/CAHPS reporting units, and therefore has multiple accreditable entities, one or more of which does not meet the minimum membership threshold. Refer to *Combining accreditable entities and HEDIS/CAHPS reporting units,* below.  A reporting unit with fewer than 15,000 members that cannot meet the criteria for combining results must follow the alternative policies described below. |
| Reporting units with <15,000 members | A HEDIS/CAHPS reporting unit (accreditable entity) with fewer than 15,000 members may choose one of the following options for reporting.   * Submit a unique set of audited HEDIS/CAHPS results to NCQA to be scored as part of accreditation. If the results submitted have too many *Small Denominator (NA) or No Benefit (NB) rates*, the reporting unit may be scored on accreditation standards and CAHPS only or on standards only. * Combine its membership with another reporting unit in accordance with the policies described below, if applicable, in order to submit audited HEDIS/ CAHPS results. * Submit CAHPS results only. * Submit neither HEDIS nor CAHPS and be scored on standards only.   **Note:** Before the survey begins, the health plan specifies the option on which it will be scored.  NCQA awards a status no higher than *Commendable* when accrediting a health plan on standards and CAHPS only or standards only. |

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| Combining accreditable entities and HEDIS/CAHPS reporting units | Health plans may combine two or more HEDIS/CAHPS reporting units (accreditable entities) into a single unit in order to achieve the minimum reporting threshold if they meet the following criteria:   * Reporting units are part of a single legal entity. * When combined, reporting units meet all other NCQA criteria for being defined as a single accreditable entity (e.g., licensure, centralization, provider network). * Reporting units share contiguous geographic borders (e.g., side-by-side or corner-to-corner states) and are within the same CMS region.   The health plan may not combine reporting for product lines (commercial, Medicare, Medicaid), and must combine the fewest number of reporting units necessary to meet the threshold, allowing all reporting units to be able to report HEDIS/CAHPS for accreditation. Health plans must submit HEDIS/CAHPS results for all reporting units within a CMS region when combining results. |
| Combining across CMS regions in limited situations | Reporting units may combine membership for bordering states that cross CMS regions if all other conditions for combining are met, and the health plan is not “licensed” or “selling” in the adjacent state but has members residing across the border. |
| Approval process for all HEDIS state combining requests | Health plans that want to combine states for HEDIS reporting must submit a request to NCQA for review and approval before each accreditation cycle. Requests must be submitted through the NCQA PCS system; must include membership by state as of July 1 of the HEDIS measurement year and by applicable product or product line; and must document how the policies for combining are met. NCQA will respond to the request within 20 business days. Requests must be submitted annually by December 31 of the year prior to reporting.  The flow chart on the next page illustrates the combining policy. |



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| *Example 1* | Under NCQA’s definition of accreditable entity, Plan A and Plan B are each a distinct accreditable entity and a HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders; each has a membership of 8,000. They meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders. Plan A and Plan B may combine into a single accreditable entity and HEDIS/CAHPS reporting unit. |
| *Example 2* | Under NCQA’s definition of accreditable entity, Plan A, Plan B and Plan C are each a distinct accreditable entity and a HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders; each has a membership of 8,000. All health plans meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders.  If Plan A and Plan B combine, the resulting accreditable entity/reporting unit meets the threshold and leaves Plan C unable to report HEDIS/CAHPS for accreditation. Therefore, all three plans may combine into a single accreditable entity and HEDIS/CAHPS reporting unit. |
| *Example 3* | Under NCQA’s definition of accreditable entity, Plan A, Plan B, Plan C and Plan D are each a distinct accreditable entity and a HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders. Plans A and B have 7,000 members each. Plans C and D have 8,000 members each. All plans meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders.  Under the policy, Plans A and B could combine, and because they will be short of the minimum threshold requirement of 15,000 members, they may add Plan C. This would leave Plan D unable to report and require all four plans to combine. But the intent of the policy is for the *fewest entities* to combine to meet the minimum, and therefore, Plan A should combine with Plan C, and Plan B should combine with Plan D, creating two reporting units (Plan A and Plan B) with 15,000 members each. |

15. Health Plans Seeking Accreditation for Commercial or Medicaid Product Lines

Commercial health plans seeking accreditation between July 1, 2013, and June 30, 2014, must collect and report audited CAHPS Health Plan Survey 5.0H, Adult Version, *Medical Assistance With Smoking and Tobacco Use Cessation* (*Advising Smokers and Tobacco Users to Quit* rate) and *Flu Shots for Adults Ages 50–64* results for the relevant product lines. Each product line must be collected and reported separately in 2013 and for the subsequent two years.

Organizations seeking accreditation for a Medicaid product line must collect and submit CAHPS Health Plan Survey 5.0H, Adult Version or CAHPS Health Plan Survey 5.0H, Child Version (with or without CCC) survey results to NCQA. If the organization elects to use the CAHPS Health Plan Survey 5.0H, Child Version (with CCC), CAHPS 5.0H results from the General Population are used for accreditation scoring.

*Note*

* *Additional accreditation information and HEDIS reporting requirements are provided in the Standards and Guidelines for the Accreditation of Health Plans.*

16. Survey Reporting Dates for Health Plans Seeking Accreditation for Commercial or Medicaid Product Lines

Health plans submit member-level data files to NCQA through the certified survey vendor for calculation of HEDIS survey results by May 31, 2013, and return a signed Attestation of Accuracy, Public Reporting Authorization and Data Use Agreement to NCQA by June 17, 2013. NCQA sends an invoice to health plans upon receipt of the data and Attestation.

*Note*

* *Member-level data files may be submitted after May 31, 2013, but submission must be at least eight weeks before the accreditation survey date, and there is an additional fee.*
* *The Attestation may be submitted after June 17, 2013, but submission must be at least six weeks before the accreditation survey date, and there is an additional fee.*

17. Health Plans Seeking Accreditation for a Medicare Product Line

For health plans seeking accreditation for a Medicare product line, NCQA uses CAHPS Health Plan Survey, *Medical Assistance With Smoking and Tobacco Use Cessation* (Advising Smokers and Tobacco Users to Quit rate only), *Flu Shots for Older Adults* and *Pneumococcal Vaccination Status for Older Adults* results from the 2013 Medicare CAHPS survey.

18. Health Plans Seeking Separate Accreditation for Products

Health plans seeking separate accreditation for products (HMO, POS, PPO) must collect and report HEDIS/ CAHPS survey results separately for each product, for the entire three-year accreditation cycle.

19. Health Plans Seeking Accreditation for a Combined Product

A health plan that seeks accreditation for a combined product must do so for the entire three-year accreditation cycle. The health plan must choose one of two options:

1. Collect and report HEDIS/CAHPS survey results using one sample frame that includes members from all product populations.
2. Collect and report HEDIS/CAHPS results separately for each product. NCQA gives survey vendors instructions for submitting member-level data files for health plans adopting this approach.

Audit Requirements for HEDIS Survey Measures

20. Audit Requirements for Data Submission

Only HEDIS survey measures that have been validated through a HEDIS Compliance Audit™ are eligible for use in accreditation scoring or for inclusion in NCQA information products *(Quality Compass).*

21. Audit Validation of Survey Sample Frames

The HEDIS Compliance Auditor verifies that the health plan’s method for generating the sample frame produces an unbiased sample frame that includes all required data elements. For each sample frame the auditor assigns a result, as shown below.

* *Supports Reporting.* The survey sample frame was reviewed and approved.
* *Not Reportable.* Indicates the survey sample frame was incomplete or materially biased.

The health plan’s process for managing membership is formally reviewed during the phase of the audit that occurs after HEDIS surveys are administered. If findings from the onsite review indicate problems with the membership systems, the auditor may change a *Supports Reporting* resultto *NR*.

**Note:** Refer to HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures for additional information about the compliance audit.

22. Arranging Audit Validation of the Sample Frame

The health plan arranges for validation to be completed by the date set by the survey vendor. If the health plan outsources sample frame generation to a survey vendor, it arranges for an NCQA Certified HEDIS Compliance Auditor to work directly with the vendor to validate the sample frame’s integrity *before* the vendor draws the sample and administers the survey. This allows enough time for the health plan to correct errors, minimizing the possibility that the survey is administered to a biased sample and of the health plan receiving an *NR* audit result for the measure.

23. Material Bias

For survey measures, **material bias** is caused by a (+/-)10 percent difference between the eligible population and the survey sample frame. For example, if an error in the generation of the sample frame results in the exclusion of more than 10 percent of eligible members, the sample frame is considered materially biased, and the health plan receives an audit result of *NR* for the survey and any measure collected through that survey.

The Final Audit Reports submitted by the auditor include a final measure result for each survey measure, as described below.

* *Reportable.* The sample frame was validated by a HEDIS Compliance Auditor and data were collected by an NCQA Certified HEDIS Survey Vendor, in accordance with all HEDIS protocols.
* *Not Reportable.*
* The survey sample frame was incomplete or materially biased.
* The organization chose not to report the measure.
* The organization was not required to report the measure.
* *Unaudited*. The sample frame was not validated by a HEDIS Compliance Auditor.

NCQA calculates a rate or result for *Reportable* and *Unaudited* survey submissions. *Not Reportable* measures receive a result of *NR.*

Which Members Should Be Included in HEDIS Surveys?

24. Eligible Population

The **eligible population** includes all members who meet the specified criteria, including any age and enrollment criteria. Refer to the measure specifications for the eligible population criteria for a specific measure.

There are no exclusions for HEDIS survey measures. A health plan that excludes members from the sample frame must clearly document the exclusions and provide them to the auditor during the validation of the sample frame. The auditor evaluates the exclusions for material bias.

25. Commercial Members

Include members enrolled through an employer group policy or through an individual or family policy in the sample frame for the commercial product line.

26. The “Working Aged” and Retirees

Include employees 65 years of age and older and retirees only in the product line that provides their primary coverage (Medicare or commercial).

27. Medicaid/Medicare Eligible Members

Include members enrolled in a Medicare Advantage contract (or Section 1876 Cost contract) and in a Medicaid managed care contract in the sample frame for the Medicaid product line. Members who have Medicare Fee for Service (FFS) or unknown Medicare coverage as their primary insurer may be excluded from the Medicaid survey.

28. Self-Insured Members

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| Administrative services only | Include self-insured ASO members in the health plan’s HEDIS reports. Self-insured members may be excluded from the HEDIS reports in either one of the following circumstances.   * There are “no-touch” contractual agreements with identified purchasers. A no-touch contractual agreement is a contract or other written agreement between the organization (i.e., HMO or PPO) and the ASO purchaser specifically stating that the organization cannot contact these members under any circumstances. |

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|  | * The health plan is not responsible for administering both in-network and out-of-network claims for members (i.e., employer carve-out). If claims are administered through a third party on behalf of the health plan (i.e., health plan carve-out), the third party is responsible for administering the claims. |

29. Members With Dual Coverage in Different Health Plans

Health plans should not try to account for coordination of benefits with other insurance carriers. NCQA recommends that, for members with coverage in different health plans, both include the members in their HEDIS reports, regardless of which insurer is primary. For example, include dependent children who are enrolled in one health plan’s commercial product line under the mother’s insurance and are enrolled in another health plan’s commercial product line under the father’s insurance.

30. Members With Dual Coverage in the Same Health Plan

Health plans that have members with dual coverage (e.g., children enrolled under each parent) must adhere to the following:

* Include members who are enrolled twice in an HMO product only once in the HMO report.
* Include members with dual coverage in the HMO and POS products in both HEDIS reports, if HMO and POS products are reported separately.
* Include members who are enrolled in each product only once in the HMO/POS or HMO/POS/PPO combined report, if HMO and POS products are reported combined or HMO/POS/PPO products are reported combined.

Enrollment

31. Continuous Enrollment

**Continuous enrollment** is one of several criteria used to identify the eligible population. It specifies the minimum amount of time a member must be enrolled in a health plan before becoming eligible for the measure. The intent of continuous enrollment is to ensure that the member has had the opportunity to experience a variety of interactions with the health plan. The continuous enrollment period is specified in each measure, along with any allowable gap for the continuous enrollment period. An allowable gap can occur any time during the continuous enrollment period.

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| Examples | 1. If a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member is covered by the organization on both June 30 and July 1. However,  if the member disenrolls on June 30 and re-enrolls on July 2, leaving the member without coverage on July 1, there is a one-day gap.  2. The commercial HEDIS/CAHPS survey requires continuous enrollment throughout the measurement year and allows one gap in enrollment of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year. |
| Measurement year | The calendar year (January 1–December 31) is the standard measurement year for HEDIS data. |

32. Current Enrollment

Health plans and vendors make the effort to ensure that members included in the survey are enrolled in the health plan when the survey is completed. The intent of current enrollment is to ensure robust response rates and that members answer survey questions based on their recent experience with the health plan.

Members generally complete HEDIS surveys 1–4 months after the end of the measurement year. Survey questions ask about members’ experience “in the last 12 months” (commercial) or “in the last 6 months” (Medicaid, Medicare); therefore, responses from a member who is not enrolled in a health plan when the survey is completed will not accurately reflect the member’s experience with that health plan.

Health plans and survey vendors take the following actions to ensure that members are enrolled in the health plan when the survey is conducted.

* Health plans exclude members from the sample frame who are not enrolled when the sample frame is generated.
* Health plans oversample if not all disenrolled members can be excluded from membership files by the date when the sample frame is generated. The survey vendor can exclude disenrolled members at a later date, using a disenrollment file provided by the plan. The vendor assigns an “Ineligible” code to members whose disenrollment date is on or before the date of the first questionnaire mailing.

Some members may be enrolled when the sample frame is generated or on the date of the first questionnaire mailing, but not when they complete the survey. Exclusion of these members from survey results is based on their responses to Q1 and Q2 (survey vendors assign an “Ineligible” code).

33. Medicaid Continuous Enrollment

A member who was enrolled in the health plan the last six months of the measurement year and had no more than one gap in enrollment at any time from July 1–December 31 is considered continuously enrolled.

For a health plan that applies a full-month eligibility criterion to Medicaid enrollees and verifies enrollment prospectively in monthly intervals (in increments of one month) on its information systems, the gap in enrollment may not exceed 45 days (a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

If the health plan is notified prospectively of enrollment, use the actual date of enrollment to calculate continuous enrollment, not the notification date.

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| *Retroactive eligibility* | The elapsed time between the actual date when the health plan became financially responsible for the Medicaid member and the date when it received notification of the new member. For measures with a continuous enrollment requirement, the health plan has the option to exclude a member if the retroactive eligibility period exceeds the allowable gap requirement. If the health plan excludes Medicaid members with retroactive eligibility gaps, it must do so consistently across all HEDIS measures*.* |

Membership Changes

34. Members Who Switch Health Plans

Members who switch health plans may be counted as continuously enrolled if they joined a health plan that assumes ownership of, or responsibility for, membership records for the entire period of continuous enrollment specified in the measure. If the health plan reports these members as continuously enrolled, it must follow the same definition of continuous enrollment described above and all other guidelines affecting continuous enrollment (allowed switching between product lines [commercial, Medicaid, Medicare] or product types [HMO and POS]).

35. Members Who Switch Health Plans Because of a Merger or Acquisition

Health plans may count as continuously enrolled a member who switches health plans because of a merger that occurred during the measurement year. This guideline must be adopted consistently across all survey and nonsurvey measures.

36. Members Who Switch Product Lines

Members enrolled in different product lines at different times during the measurement year should be reported in the product line to which they belonged at the end of the continuous enrollment period. For example, a member enrolled in Medicaid who switches to the commercial product line during the continuous enrollment period is reported in commercial HEDIS.

37. Members Who Switch Products

* *If the health plan reports separately by product:* Members who switch from the commercial HMO product to the commercial POS product (or vice versa) in the time specified for continuous enrollment should be considered continuously enrolled and should be included in the product-specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period.
* *For HMO or POS HEDIS reporting:* Count PPO enrollment in the same manner as a gap in continuous enrollment.
* *For PPO HEDIS reporting:* Count enrollment in an HMO or POS product as a gap in continuous enrollment.
* *For combined reporting (HMO/POS or NCQA approved combined HMO/POS/PPO reporting):* Members who switch between products included in the HEDIS reporting entity are considered continuously enrolled and should be included in the combined HEDIS report.

38. Members Who Switch Product Lines/Products After the End of the Measurement Year

Survey measures have two enrollment criteria: continuous enrollment and current enrollment. If a health plan reports separately by product, members must be enrolled in the same product and product line at the following times, in order to be included in the eligible population:

* At the end of the continuous enrollment period, ***and***
* On the date when the health plan generates the sample frame.

For example, if the health plan conducts separate surveys for its HMO and POS products, members who were enrolled in the HMO product at the end of the continuous enrollment period and enrolled in the POS product when the sample frame is generated are excluded from the sample frame for both products.

For combined reporting (e.g., HMO/POS reporting or NCQA approved combined HMO/POS/PPO reporting), members need not be enrolled in the same product and product line on the two dates, provided they are enrolled in *any* of the products included in the HEDIS reporting entity on both dates. For example, if the health plan reports HMO/POS combined, a member who was enrolled in the HMO product at the end of the continuous enrollment period and enrolled in the POS product at the time the sample frame is generated is included in the sample frame for the HMO/POS reporting entity.

HEDIS Coding Conventions

39. Administrative Database

A health plan that collects *Children With Chronic Conditions (CCC)* results must use claims data to assign a prescreen status code for each child member in the CAHPS 5.0H Child Survey sample frame. Refer to the CCC measure specifications for instructions on assigning the prescreen status code.

40. Coding Systems Included in Volume 3

This volume includes codes from the following coding systems:

* Current Procedural Terminology (CPT).
* International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
* Uniform Bill (UB) Revenue.

41. Presentation of Codes

Unless otherwise noted, codes are stated to the minimum specificity required. If a code is presented to the third digit, any valid fourth or fifth digits may be used for HEDIS reporting. For example, when a table lists ICD-9-CM Diagnosis code 240, the codes 240.0 and 240.9 are used for HEDIS reporting.

When reading HEDIS coding tables, assume there is an “or” in between each column; each code set is not dependent on another code set.

42. Principal Diagnosis and Secondary Diagnosis

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| *Principal diagnosis* | The diagnosis given at discharge and the diagnosis listed in the first position on a claim form. |
| *Secondary diagnosis* | A diagnosis that is not classified as the principal diagnosis when listed on a claim form.  A claim form may contain several secondary diagnoses. |

The CCC measure allows the use of either a principal or a secondary diagnosis to identify members for the supplemental sample. For example*,* a diagnosis of cystic fibrosis makes a child eligible for the CCC supplemental sample; thus, if a member’s claim form lists the principal diagnosis as “otitis media,” but cystic fibrosis is listed as a second, third, fourth or fifth diagnosis on the same claim form, the member is considered eligible for CCC sampling.

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

43. Mapping Proprietary Codes or Other Codes

A health plan that does not use the coding systems specified for the CCC measure must “map” or translate its codes to the codes specified for the measure. It is important that mapped codes match the clinical specificity required for HEDIS. For audit purposes, the health plan should document the methodology it used to map codes. At a minimum, documentation should include a crosswalk containing the relevant codes, descriptions and clinical information. The health plan must document the policies and procedures used to implement codes. Auditors may request additional information.

NCQA encourages health plans to update their information systems as necessary and to ensure that complete, accurate and consistent coding is used for all encounters and claims so health plans can follow the HEDIS specifications. This will help the industry move toward a uniform system of performance measurement.

44. Retiring Obsolete Codes

NCQA annually tracks billing, diagnostic and procedure codes designated obsolete. NCQA does not remove codes in the year in which they receive the designation because of the look-back period in many HEDIS measures. Codes designated obsolete are not deleted from the specifications until the look-back period for applicable measures is exhausted, plus one additional year. For example, since the CCC measure uses claims from the measurement year or the year prior to the measurement year, it has a two-year look-back period. A code that is designated obsolete effective January 1, 2010, is deleted from the specifications in HEDIS 2013 after the two-year look-back period (2011, 2012), plus one additional year (2010), is exhausted.

HEDIS Survey Data Submission and Reporting

45. Member-Level Data File Submission Date

Survey vendors submit health plans’ member-level data files to NCQA by **May 31, 2013,** for calculation of HEDIS survey results.

46. Calculation of HEDIS Survey Results

NCQA calculates HEDIS survey results using member-level data files submitted by certified survey vendors. To be considered HEDIS, survey results must be calculated by NCQA, which ensures consistency and comparability of HEDIS survey results and reduces costs and burden associated with collecting and reporting the measures.

NCQA uses the IDSS to provide health plans and certified survey vendors with HEDIS survey results reports. Reports are PDF documents that contain NCQA calculated survey results for the submission.

47. Attestation of Accuracy, Public Reporting Authorization and Data Use Agreement Date

After reviewing final results calculated by NCQA, health plans must submit a signed Attestation of Accuracy, Public Reporting Authorization and Data Use Agreement to NCQA by June 17, 2013.

48. Small Numbers

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| Small denominator threshold | Health plans must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator for a particular survey result calculation is less than 100, NCQA assigns a measure result of *NA*.   * The denominator for a rating equals the total number of responses to that question. * The denominator for a composite is the average number of responses across all questions in the composite. * The denominator for a question summary rate is identified in *Calculation of HEDIS/CAHPS Survey Results* and *Calculation of Children With Chronic Conditions Results.*   Medicare results for *Medical Assistance With Smoking and Tobacco Use Cessation* (Advising Smokers and Tobacco Users to Quit rate only) requires a minimum denominator of at least 30 responses. |
| Appendix 7 | Health plans are strongly encouraged to use the information in Appendix 7 to decide whether it is in their best interest to use the required sample size or to oversample. |
| Implications | *NA* results are not used to calculate national, regional, state or metro-area averages or accreditation thresholds, and are not eligible for use in accreditation scoring. In *Quality Compass*, results are reported as *NA* and the number of responses is reported in the *Detailed* section.  NCQA determines a maximum number of allowable *NA* results; a health plan that exceeds the maximum number is eligible for Commendable accreditation status, but not for Excellent status.  **Note:** Refer to the Standards and Guidelines for the Accreditation of Health Plans for more information about accreditation. |
| Small health plans | A health plan with a small number of eligible members (so that it anticipates achieving a denominator of less than 100 for most HEDIS survey calculations) should contact NCQA to determine its specific HEDIS survey reporting requirements. The health plan must submit its concerns, along with supporting documentation, through the NCQA PCS system at [www.ncqa.org/pcs](http://www.ncqa.org/pcs), or by fax to the attention of HEDIS Policy at 202-955-3599. |

49. Employer-Specific HEDIS Reports

NCQA does not recommend assigning employer-specific identifiers to members of a survey sample in order to calculate employer-specific results because of confidentiality and statistical concerns arising from small numbers.

50. Rolling Average

The rolling average method is used for several survey measures, and affects how results are collected and calculated.

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| Data collection | The **rolling average method** allows a health plan to have up to two consecutive years of data collection to obtain a denominator sufficient to calculate results for a measure. Smaller sample sizes are required, thereby reducing the health plan’s survey burden. |
| Results calculation | Rolling average results are calculated using data reported for the current year and, when available, data reported for the prior year. Result calculation and assignment are contingent on denominator size, as follows.   * *A health plan with two consecutive years of reported data.* * If the rolling average denominator is less than 100, NCQA assigns a measure result of *NA.* * If the rolling average denominator is 100 or more, NCQA calculates a rate. * *A health plan that did not report results in the prior year but reports results for the current year.* * If the denominator is less than 100, NCQA assigns a measure result of *NA.* * If the denominator is 100 or more, NCQA calculates a rate; therefore, a health plan that did not report results the prior year can elect to oversample during the current year in order to obtain a reportable rate for a rolling average measure. * *A health plan that does not report results for the current year.* * NCQA assigns a result of *NR.*   Measure-specific instructions for calculating the rolling average and rolling average denominator are included in the results calculation section of the measure specification. |
| Changes in submission entity | Calculating a rolling average requires significant programming complexity. Under rare circumstances, it is impractical to calculate results for a rolling average composite or question summary rates. If a health plan changes how it reports HEDIS/CAHPS results from one year to the next, the change may affect its ability to report rolling average composite results, though results for noncomposite rates *(Aspirin Use and Discussion, Medical Assistance With Smoking and Tobacco Use Cessation, Flu Shots for Adults Ages 50–64)* may still be calculated. For example, if a plan reports HMO and POS products separately in the prior year and reports HMO/POS combined in the current year, NCQA performs the following.   * For *Aspirin Use and Discussion, Medical Assistance With Smoking and Tobacco Use Cessation* and *Flu Shots for Adults Ages 50–64,* Year 1 numerators and denominators are created by combining data from the separate HMO and POS results. The combined Year 1 numerators and denominators are used for the rolling average calculations. * For the *Plan Information on Costs* composite and question summary rates for questions in that composite, the prior year data are not used in the rolling average calculations. Because of the complexity associated with combining Year 1 member-level data and infrequency in which this situation occurs, it is not practical to set up HEDIS/CAHPS programs to calculate results under these conditions.   Alternatively, if the plan reports HMO/POS combined in the prior year and reports HMO and POS separately in the current year, the reporting entity is considered changed and the prior year’s data are not used to calculate any rolling averages. |

51. Member-Level Data

NCQA generates a validated member-level data file containing HEDIS survey results and provides it to the health plan and survey vendor through the IDSS. The validated data file is an ASCII fixed-width text file that contains information about the health plan, the survey submission, the blinded sample and the response data for each sampled member. The file layout identifies the data elements and their positions and is posted on the NCQA Web site. The survey vendor may provide the health plan with additional member-level data elements when it can demonstrate that member confidentiality is not compromised, but *may never* submit member-identified data to the health plan.

52. Public Reporting

Health plans should include the results of HEDIS surveys in public releases of HEDIS information. Survey data are important indicators of health plan performance and are of interest to purchasers and consumers.   
A health plan may represent that it has HEDIS survey results only when it contracts with an NCQA Certified HEDIS Survey Vendor to administer the entire survey without amendment and comply with the sampling and data collection protocols contained in this volume, including submitting member-level data files to NCQA for calculation of HEDIS results.

1. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). [↑](#footnote-ref-1)