**HEDIS®  
2016 Volume 2**

**Technical**

**Specifications for  
Health Plans**

###### NCQA_pmscolor_tag

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

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without the written permission of NCQA.

© 2015 by the National Committee for Quality Assurance  
1100 13th Street, NW, Suite 1000  
Washington, DC 20005

All rights reserved. Printed in the U.S.A.

NCQA Customer Support: 888-275-7585

NCQA Fax: 202-955-3599

NCQA Web Site: www.ncqa.org

NCQA Policy Clarification Support at: http://my.ncqa.org

*Item #10284-100-16*

**Acknowledgments**

NCQA is proud to release HEDIS 2016, the Healthcare Effectiveness Data and Information Set for the   
2015 measurement year. HEDIS 2016 would not have been possible without the contributions of many stakeholders, external and internal to NCQA. In particular, the members of the Committee on Performance Measurement generously donated their time, energy and intellect toward developing the final HEDIS 2016 specifications.

Improvements and enhancements to this volume are the result of a team effort of staff from the NCQA Analysis Department, the Measure Validation Department, the Policy Measures Department, the Information Systems Department and the Performance Measurement Department.

HEDIS is produced with contributions of a wide range of collaborators. The members of NCQA’s Measurement Advisory Panels, Technical Measurement Advisory Panel and HEDIS Expert Panels contributed greatly to the 2016 version of HEDIS.

Sincerely,



Margaret E. O’Kane  
President

Committee on Performance Measurement

|  |  |
| --- | --- |
| **Peter Bach, MD**  Memorial Sloan Kettering Cancer Center  **Bruce Bagley, MD** Independent Consultant  **Andrew Baskin, MD** Aetna  **Patrick Conway, MD, MSC**  Center for Medicare & Medicaid Services  **Jonathan D. Darer, MD**  Geisinger Health System  **Helen Darling** National Business Group on Health  **Rebekah Gee, MD, MPH, FACOG**  LSU School of Medicine and Public Health  **Foster Gesten, MD** Quality and Patient Safety  **Marge Ginsburg, RN, MPH**  Center for Healthcare Decisions  **David Grossman, MD, MPH**  Group Health Physicians  **Christine S. Hunter, MD (Co-Chair)** US Office of Personnel Management  **Jeffrey Kelman, MMSc, MD** Centers for Medicare & Medicaid Services | **Bernadette Loftus, MD**  The Permanente Medical Group  **J. Brent Pawlecki, MD, MMM** The Goodyear Tire & Rubber Company  **Susan Reinhard, RN, PhD** AARP Public Policy Institute  **Eric C. Schneider, MD, MSc, FACP (Co-Chair)** The Commonwealth Fund  **Marcus Thygeson, MD, MPH** Blue Shield of California Liaisons **Mark S. Antman, DDS, MBA** American Medical Association  **Paul Jeffrey Brady, MD, MPH** Agency for Healthcare Research and Quality  **Helen Burstin, MD, MPH** National Quality Forum  **Carole Redding Flamm, MD, MPH** Blue Cross Blue Shield Association  **Gail Janes, PhD, MS** Centers for Disease Control and Prevention  **Kristin Janssen, RN** Veteran’s Health Administration |

**Table of Contents**

**Overview**

HEDIS 2016 1

How HEDIS Is Developed 2

What’s New in Volume 2? 2

If You Have Questions About the Specifications 3

Reporting Hotline for Fraud and Misconduct 4

**General Guidelines for Data Collection and Reporting**

HEDIS Reporting 7

How NCQA Defines an Organization for Accreditation 9

HEDIS Reporting for Accreditation 10

The HEDIS Compliance Audit 15

HEDIS Audit Timeline 16

In Which Reports Do HEDIS Members Remain? 17

Membership Changes 19

Required Enrollment Periods and Benefits 20

HEDIS Data Submission and Reporting 22

Data Collection Methods and Data Sources 23

HEDIS Coding Conventions 32

Measures Reportable With a Partial Year of Data 35

**Guidelines for Calculations and Sampling**

How to Use the Administrative Method 39

Guidelines for the Hybrid Method 39

Drawing the sample prior to the reporting year 39

Membership-dependent denominators 40

Claim-dependent denominators 40

Determining the required sample size 41

Population definition 41

Finite population correction 41

Organization responsibility for chart review 41

Calculating the 95 percent confidence interval 42

Statistical assumptions for sample size 42

Systematic Sampling Methodology 45

Oversample requests to NCQA 46

Oversampling methodology 47

Complex Probability Sampling 48

Organization responsibility 48

Substituting Medical Records 49

Acceptable circumstances for substitution 49

Hybrid Method: Three Approaches 50

References 50

***Note:*** *The three-letter measure identifier is listed in italics in front of the measure name.*

**Effectiveness of Care**

Guidelines for Effectiveness of Care Measures 52

**Prevention and Screening**

*ABA* Adult BMI Assessment 56

*WCC* Weight Assessment and Counseling for Nutrition and Physical Activity for   
Children/Adolescents 59

*CIS* Childhood Immunization Status 64

*IMA* Immunizations for Adolescents 69

*HPV* Human Papillomavirus Vaccine for Female Adolescents 72

*LSC* Lead Screening in Children 75

*BCS* Breast Cancer Screening 77

*CCS* Cervical Cancer Screening 79

*COL* Colorectal Cancer Screening 83

*CHL* Chlamydia Screening in Women 86

*COA* Care for Older Adults 89

**Respiratory Conditions**

*CWP* Appropriate Testing for Children With Pharyngitis 96

*SPR* Use of Spirometry Testing in the Assessment and Diagnosis of COPD 100

*PCE* Pharmacotherapy Management of COPD Exacerbation 103

*MMA* Medication Management for People With Asthma 106

*AMR* Asthma Medication Ratio 111

**Cardiovascular Conditions**

*CBP* Controlling High Blood Pressure 116

*PBH* Persistence of Beta-Blocker Treatment After a Heart Attack 122

*SPC* Statin Therapy for Patients With Cardiovascular Disease 125

**Diabetes**

*CDC* Comprehensive Diabetes Care 132

*SPD* Statin Therapy for Patients With Diabetes 146

**Musculoskeletal Conditions**

*ART* Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis 152

*OMW* Osteoporosis Management in Women Who Had a Fracture 155

**Behavioral Health**

*AMM* Antidepressant Medication Management 160

*ADD* Follow-Up Care for Children Prescribed ADHD Medication 164

*FUH* Follow-Up After Hospitalization for Mental Illness 169

*SSD* Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 172

*SMD* Diabetes Monitoring for People With Diabetes and Schizophrenia 176

*SMC* Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia 179

*SAA* Adherence to Antipsychotic Medications for Individuals With Schizophrenia 182

*APM* Metabolic Monitoring for Children and Adolescents on Antipsychotics 186

**Medication Management**

*MPM* Annual Monitoring for Patients on Persistent Medications 190

*MRP* Medication Reconciliation Post-Discharge 194

**Overuse/Appropriateness**

*NCS* Non-Recommended Cervical Cancer Screening in Adolescent Females 198

*PSA* Non-Recommended PSA-Based Screening in Older Men 200

*URI* Appropriate Treatment for Children With Upper Respiratory Infection 202

*AAB* Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis 205

*LBP* Use of Imaging Studies for Low Back Pain 210

*APC* Use of Multiple Concurrent Antipsychotics in Children and Adolescents 213

*DDE* Potentially Harmful Drug-Disease Interactions in the Elderly 217

*DAE* Use of High-Risk Medications in the Elderly 222

**Measures Collected Through Medicare Health Outcomes Survey**

*HOS* Medicare Health Outcomes Survey 228

*FRM* Fall Risk Management 229

*MUI* Management of Urinary Incontinence in Older Adults 230

*OTO* Osteoporosis Testing in Older Women 231

*PAO* Physical Activity in Older Adults 232

**Measures Collected Through the CAHPS Health Plan Survey**

*ASP* Aspirin Use and Discussion 234

*FVA* Flu Vaccinations for Adults Ages 18–64 235

*FVO* Flu Vaccinations for Adults Ages 65 and Older 236

*MSC* Medical Assistance With Smoking and Tobacco Use Cessation 237

*PNU* Pneumococcal Vaccination Status for Older Adults 238

**Access/Availability of Care**

Guidelines for Access/Availability of Care Measures 240

*AAP* Adults’ Access to Preventive/Ambulatory Health Services 241

*CAP* Children and Adolescents’ Access to Primary Care Practitioners 243

*ADV* Annual Dental Visit 245

*IET* Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 247

*PPC* Prenatal and Postpartum Care 251

*CAT* Call Answer Timeliness 259

*APP* Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 261

**Experience of Care**

*CPA* CAHPS Health Plan Survey 5.0H, Adult Version 266

*CPC* CAHPS Health Plan Survey 5.0H, Child Version 267

*CCC* Children With Chronic Conditions 268

**Utilization and Risk Adjusted Utilization**

**Utilization**

Guidelines for Utilization and Risk Adjusted Utilization Measures 270

*FPC* Frequency of Ongoing Prenatal Care 275

*W15* Well-Child Visits in the First 15 Months of Life 281

*W34* Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 284

*AWC* Adolescent Well-Care Visits 287

*FSP* Frequency of Selected Procedures 290

*AMB* Ambulatory Care 299

*IPU* Inpatient Utilization—General Hospital/Acute Care 302

*IAD* Identification of Alcohol and Other Drug Services 307

*MPT* Mental Health Utilization 311

*ABX* Antibiotic Utilization 314

**Risk Adjusted Utilization**

*PCR* Plan All-Cause Readmissions 326

*IHU* Inpatient Hospital Utilization 337

*EDU* Emergency Department Utilization 347

*HPC* Hospitalization for Potentially Preventable Complications 354

**Relative Resource Use**

Guidelines for Relative Resource Use Measures 366

*RDI* Relative Resource Use for People With Diabetes 388

*RCA* Relative Resource Use for People With Cardiovascular Conditions 394

*RHY* Relative Resource Use for People With Hypertension 400

*RCO* Relative Resource Use for People With COPD 405

*RAS* Relative Resource Use for People With Asthma 410

**Health Plan Descriptive Information**

*BCR* Board Certification 418

*ENP* Enrollment by Product Line 422

*EBS* Enrollment by State 426

*LDM* Language Diversity of Membership 427

*RDM* Race/Ethnicity Diversity of Membership 430

*WOP* Weeks of Pregnancy at Time of Enrollment 435

*TLM* Total Membership 438

**Measures Collected Using Electronic Clinical Data Systems**

Guidelines for Measures Collected Using Electronic Clinical Data Systems 442

*DMS* Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults 445

**Appendices**

Appendix 1—HEDIS 2016 Summary Table of Measures, Product Lines and Changes

Appendix 2—Technical Considerations for New Measures

Appendix 3—Practitioner Types

Appendix 4—Data Element Definitions

Appendix 5—Contributors

Appendix 6—Alphabetized List of HEDIS Measures

Appendix 7—Logical Measure Groups

Overview

HEDIS 2016

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 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations.HEDIS 2016 is published across a number of volumes and includes 88 measures across 7 domains of care:

|  |  |  |
| --- | --- | --- |
| * Effectiveness of Care. * Access/Availability of Care. * Experience of Care. * Utilization and Risk Adjusted Utilization. | | * Relative Resource Use. * Health Plan Descriptive Information. * Measures Collected Using Electronic Clinical Data Systems. |
| Volume 1: *Narrative* | A general overview of the HEDIS measurement set and how the data are used. | |
| Volume 2: *Technical  Specifications for Health Plans* | The technical specifications for the HEDIS nonsurvey measures for organizations; instructions on data collection for each measure; general guidelines for calculations and sampling. | |
| Technical Specifications for Physician Measurement | The technical specifications for the HEDIS quality measures for physician-level measurement. | |
| Technical Specifications for ACO Measurement | The technical specifications for the HEDIS quality measures for Accountable Care Organizations. | |
| 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®1) 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 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). | |

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

1CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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. Multiple Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

What’s New in Volume 2?

|  |  |
| --- | --- |
| New measures | * *Statin Therapy for Patients With Cardiovascular Disease.* * *Statin Therapy for Patients With Diabetes.* * *Inpatient Hospital Utilization.* * *Emergency Department Utilization.* * *Hospitalization for Potentially Preventable Complications.* * *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults.* |
| Retired measures | * *Use of Appropriate Medications for People With Asthma.* |
| Revised measures | For specific revisions, refer to each measure’s *Summary of Changes* or to Appendix 1 for a complete summary. |
| Overall changes | * Added a Reporting Hotline for Fraud and Misconduct in the Overview section. * Added the Exclusive Provider Organization (EPO) as a separate product. * Retired the HEDIS measure rotation policy. * Added a data element to collect numerator events by supplemental data to all Effectiveness of Care (EOC) measures and Utilization measures similar to EOC measures (i.e., *Frequency of Ongoing Prenatal Care*, *Well-Child Visits in the First 15 Months of Life*, *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* and *Adolescent Well-Care Visits*).   ***Note:*** *Although supplemental data may be used for measures other than EOC measures, the IDSS will only collect this data element for EOC and EOC-like measures for HEDIS 2016.*   * Added an Overuse/Appropriateness subdomain and applicable measures to the EOC domain. * Added a Risk Adjusted Utilization subdomain and applicable measures to the Utilization domain. * Added Relative Resource Use as a separate domain (formerly a subdomain in the Utilization domain). * Added Measures Collected Using Electronic Clinical Data Systems domain and added the *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults measure* to the new domain. * Added *Appendix 7: Logical Measure Groups.* |

|  |  |
| --- | --- |
| Technical specification updates | NCQA will freeze the specifications on October 1, 2015, with the HEDIS 2016 Volume 2 *Technical Update*:   * *HEDIS 2016 Volume 2 Technical Update memo,* which will be posted to the NCQA Web site (www.ncqa.org). * *HEDIS 2016 Volume 2 Value Set Directory (10/1/2015 Release)*, which will be posted to the NCQA Download Center (https://downloads.ncqa.org/customer/Login.aspx)*.*   Organizations are accountable for all changes included in the *Technical Update*, but are not required to use information posted after the freeze date, with the exception of NDC codes, Standard Pricing Tables (SPT) and HCC Risk Adjustment tables. |
| NDC codes | The final NDC codes will be posted to the NCQA Web site by November 2, 2015. |
| Relative Resource Use SPTs | The SPTs will be posted to the NCQA Web site by November 2, 2015. |
| HCC Risk Adjustment tables | The HCC Risk Adjustment tables will be posted to the NCQA Web site by November 2, 2015. |
| First-year measure evaluation | At the conclusion of the HEDIS 2015 data collection period, NCQA will evaluate first-year status measures/indicators to determine if they will be publicly reported.   * *Non-Recommended PSA-Based Screening in Older Men.* * *Use of Multiple Concurrent Antipsychotics in Children and Adolescents.* * *Metabolic Monitoring for Children and Adolescents on Antipsychotics.* * *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.*   Any changes to the HEDIS 2015 first-year status measures/indicators are included in the Volume 2 *Technical Update,* released on October 1, 2015. |

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 system can be accessed through the NCQA Web site at <http://my.ncqa.org>.

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS uses and specifications, and are posted to the NCQA Web site (www.ncqa.org) 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, online seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information. For more information, e-mail hug@ncqa.org.
* Organizations that are involved in NCQA Accreditation and Certification activities are encouraged to join the Accreditation and Certification Users Group (ACUG). The ACUG provides a learning and development platform for members to discuss updates applicable to their organization’s procedures. Membership benefits include a monthly newsletter, WebEx discussions, and vouchers for publications, educational conferences and Quality Compass. For more information, e-mail acug@ncqa.org or go to http://www.ncqa.org/Programs/Accreditation/AccreditationUsersGroupAUG.aspx for a full description   
  of the program.
* 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.
* 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 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.

Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

### How to Report

* **Toll-Free Telephone:**
* English-speaking USA and Canada: **855-840-0070** (not available from Mexico).
* Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
* **Web Site:** <https://www.lighthouse-services.com/ncqa>
* **E-Mail:** [reports@lighthouse-services.com](mailto:reports@lighthouse-services.com) (must include NCQA’s name with the report).
* **Fax:** 215-689-3885 (must include NCQA’s name with the report).

General Guidelines for  
Data Collection and Reporting

General Guidelines for   
Data Collection and Reporting

Summary of Changes to HEDIS 2016

* Updated deadlines in *General Guideline 9.*
* Removed the May 1 task “Auditor selects measures for MMRV and informs the plan of the selections”from the Audit Timeline in *General Guideline 9.*
* Revised the audit results in *General Guideline 10.*
* Deleted the Measure Rotation guidelines *(*formerly *General Guidelines 12–16).*
* Revised *General Guideline 23 (*formerly *General Guideline 28).*
* Updated submission dates in *General Guideline 30 (*formerly *General Guideline 35*).
* Added a note to *General Guideline 33* (formerly *General Guideline 38*) to clarify how supplemental data numerator events are counted for EOC and EOC-like measures.
* Revised *General Guideline 34* (formerly *General Guideline 39*) to clarify that supplemental data should be the last data source considered and to remove the requirement that supplemental data may only be used to identify eligible-population required exclusions related to the timing of the denominator event or diagnosis.

HEDIS Reporting

1. Product-Line Reporting

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

***Note:*** *A subset of HEDIS measures are collected and reported for the Marketplace product line. For reporting requirements and measure specifications for Marketplace reporting, refer to the Quality Reporting System (QRS) 2016 Reporting Requirements and Guidance on the CMS Web site. These reporting requirements must be used for QRS reporting; Volume 2 may not be used for QRS specific reporting.*

2. Product-Specific Reporting

HEDIS results may be reported separately by product (i.e., HMO, POS, PPO, EPO) or combined (HMO/POS or PPO/EPO). To report a PPO or EPO product combined with an HMO or POS product, submit a written request for approval to PCS at <http://my.ncqa.org>. The request must address all the elements contained in *General Guideline 3: HEDIS Submission for Organizations Seeking Accreditation*.

The organization must submit data for an entire product, including consumer-directed or high-deductible health plan products (e.g., CDHP, HDHP) that may be offered under an HMO, PPO or a EPO license. The organization must include all members—including administrative services only (ASO) members—except when the contract prohibits the organization from contacting members under any circumstances (a “no-touch” contractual agreement). The organization may exclude no-touch members from HEDIS/CAHPS results and from accreditation. Refer to *General Guideline 19: Self-Insured Members* for more information.

|  |  |
| --- | --- |
| Definitions |  |
| *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. Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.  A **practitioner** is a professional who provides health care services and is usually required to be licensed as defined by law. |
| *POS* | Point of service. An HMO with an opt-out option. In this type of organization, 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 organization,” an “out-of-organization benefits rider to an HMO” or an “open-ended HMO.” |
| *PPO* | Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services. |
| *EPO* | Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations. |

3. HEDIS Submission for Organizations Seeking Accreditation

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

Members residing in a state where an organization is not licensed to operate are included in the organization’s “home” state, where it is licensed to operate and where its main membership resides.

How NCQA Defines an Organization for Accreditation

NCQA’s definition of the accreditable organization (also calledthe “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 organization 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 | NCQA identifies the legal entity that issues a contract for insurance for a defined population or that contracts with an employer to provide managed care services to a self-insured population.  If the organization is composed of multiple legal entities within a state, but otherwise operates as a single, statewide organization (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 organization may submit one statewide HEDIS submission that is applied to each legal entity. |
| 2. Practitioner and provider network | The organization has a single practitioner or provider network. If there are separate and distinct practitioner or provider networks, NCQA may consider each network and management structure to be a separate organization.  If individual products are marketed with practitioner or provider networks that are subsets of a larger network, NCQA may define the organization at the level of the broader network.  Organizations that submit a request to report PPO/EPO/HMO/POS products in combination must have HMO/POS and PPO/EPO 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/EPO products, NCQA requires separate HEDIS reporting for PPO/EPO and HMO/POS. |
| 3. Centralization | NCQA considers the degree of centralization of key functions. The organization has 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. * 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 | The organization might have multiple licenses, especially if its service area crosses state lines. |
| 5. HEDIS/CAHPS reporting unit | 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 line/product combination for which the organization seeks accreditation and must include all members covered by the product line/product (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 line/product, and issues accreditation decisions by product line/product (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 report HEDIS/CAHPS for HMO and POS products at a reporting unit no larger than each legal entity. * *For PPO and EPO products* (which may have a service area larger than a single state), plans 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 the organization has a small population out of state, remain unchanged. |
| ***Limiting states included in NCQA Accreditation*** | NCQA allows organizations that operate in multiple states to accredit states where it has membership. An organization may not represent that an excluded state is covered by the accreditation. For example, most of an organization’s members may reside in New York and the rest in Texas. If the organization is accredited only for New York, it may not assert that it is accredited for Texas. |

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.

|  |  |
| --- | --- |
| HEDIS/CAHPS  reporting unit | NCQA evaluates an organization’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 Guideline 1: Product-Line Reporting* and *General Guideline 2: Product-Specific Reporting*). * Geographic unit.   **Note:** For accreditation purposes, the HEDIS/CAHPS reporting unit is the same as the accreditable entity. |
| Minimum enrollment threshold | NCQA’s goal is to maximize an organization’s ability to produce HEDIS/CAHPS results. A HEDIS/CAHPS reporting unit (accreditable entity) must have enough members to calculate rates. Because producing HEDIS/CAHPS results can be resource intensive, NCQA established a minimum membership threshold for requiring HEDIS reporting: |

|  |  |  |
| --- | --- | --- |
|  | * A geographic unit with 15,000 or more members in a product/product line submits audited HEDIS/CAHPS results to NCQA to be scored as part of accreditation.   **Note:** Refer to alternative policies in the following sections for reporting units with fewer than 15,000 members. | |
| 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*. | |
| 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 audit results of Small Denominator (NA) or No Benefit (NB), the reporting unit may be scored on standards and CAHPS only or on standards only. * Combine its membership with another reporting unit in accordance with the policies described below, if applicable, to submit audited HEDIS/CAHPS results. * Submit CAHPS only. * Submit neither HEDIS nor CAHPS and be scored on standards only.   ***Note:*** *Before the survey begins, the organization specifies the option on which it will be scored.*  NCQA awards a status no higher than *Commendable* when accrediting an organization on standards and CAHPS only or standards only. | |
| Combining accreditable entities and HEDIS/CAHPS reporting units | Organizations 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.   Organizations 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. The organization must submit HEDIS/CAHPS results for all reporting units within a CMS region when combining results. |
| Combining across CMS regions in limited situations | Membership for bordering states that cross CMS regions may be combined if all other conditions for combining are met, and the organization is not “licensed” or “selling” in the adjacent state but has members residing across the border. |

|  |  |
| --- | --- |
| Approval process for HEDIS state combining requests | All organizations that want to combine states for HEDIS reporting must submit a request to NCQA for review and approval before each accreditation cycle. Requests:   * Are submitted through the NCQA PCS system at <http://my.ncqa.org>. * Are submitted annually by December 31 of the year prior to reporting. * Include membership by state as of July 1 of the HEDIS measurement year and by applicable product or product line. * Document how policies for combining are met.   NCQA responds to requests within 20 business days.  The flow chart below illustrates the combining policy. |



|  |  |
| --- | --- |
| *Example 1* | Under NCQA’s definition of “accreditable entity,” Plan A and Plan B are each a distinct accreditable entity and HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders; each has a membership of 8,000. They meet the criteria 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 considered distinct accreditable entities and HEDIS/CAHPS reporting units. Each is a PPO plan  that shares contiguous geographic borders; each has a membership of 8,000. All organizations 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 is each a distinct accreditable entity and 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 would combine with Plan C, and Plan B would combine with Plan D, creating two reporting units with 15,000 members each. |

4. HEDIS Submission for Organizations Not Seeking Accreditation

To determine how many HEDIS reports to produce, an organization defines itself using the criteria described above. If an organization cannot determine the HEDIS reporting entity, it must submit written documentation regarding the criteria described in *General Guideline 3: HEDIS Submission for Organizations Seeking Accreditation,* to the NCQA Policy Department via the PCS system at <http://my.ncqa.org>. NCQA staff review the organization’s structure and make a determination.

5. Model Type and Mixed-Model Type Organizations

**Model type** is the type of structure the organization uses to provide members with care (e.g., Staff, Group, IPA, Direct Contract, Mixed, Network).

**Mixed-model** organizations (e.g., an organization with an IPA and a group model) report data for all model types combined.

6. Reporting HEDIS for Medicaid

Separate Medicaid HEDIS reports must be produced for each state with which an organization has a Medicaid contract.

If an organization contracts with a local entity (i.e., with a county, rather than with a state) and with each locality where it provides service, the state and the organization may consider providing a comprehensive Medicaid HEDIS report that encompasses all geographic areas in the state that are served by the organization.

7. Reporting HEDIS for Medicare

All members covered under the organizations and plan benefit packages listed below are included in Medicare HEDIS reporting. CMS communicates directly with all contracted organizations about HEDIS reporting requirements (e.g., organization/plan type, enrollment criteria). HEDIS reporting is required for:

* Medicare Advantage (MA) organizations.
* Coordinated Care Plan (CCP) (local, regional and employer) organizations.
  + Special Needs Plans (SNP) benefit packages, all SNP types (Dual Eligible, Chronic or Disabling Conditions or Institutional).
* Private Fee-for-Service (PFFS) (local and employer) organizations.
* Medical Savings Account (MSA) contracts.
* Section 1876 cost organizations.
* Demonstration organizations:
* Medicare-Medicaid Plan (MMP) benefit packages.

SNPs and MMP plan benefit packages submit an additional subset of HEDIS measures. For more information on SNP reporting requirements, visit the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)).

***Exclusion:*** For Medicare reporting, exclude members who elect to use the hospice benefit (i.e., begin using hospice services) any time during the measurement year. These members must be removed prior to determining a measure’s eligible population and drawing the sample for hybrid measures.

8. Reporting HEDIS for the Children’s Health Insurance Program

|  |  |
| --- | --- |
| CHIP | A state may contract with an organization to provide care to Children’s Health Insurance Programs (CHIP) members as part of the organization’s Medicaid product line or commercial product line, or separate from both the product lines. The state enables the contracting organization to identify CHIP members, when possible. |
| Reporting guidelines | Reporting performance measures for CHIP members must be consistent with the organization’s Medicaid contracting status and the direction of the state.  If the state has identified CHIP members to a contracting organization and the contracting organization also collects and reports Medicaid HEDIS results, the organization follows the state’s direction and:   * Reports required HEDIS measures separately for CHIP members, ***or*** * Includes CHIP members in its Medicaid product-line reports.   The organization excludes CHIP members from its commercial product-line reports because including CHIP members in HEDIS reports for commercially enrolled populations may affect organization-to-organization comparison.  If the organization has a small number of eligible CHIP members, it must follow *General Guideline 32: Small Numbers* and consult with the state to determine specific CHIP HEDIS reporting requirements.  Most states report some or all of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (many are HEDIS measures) to CMS. The organization may be able to support the state’s reporting efforts by reporting its calculated rates or numerators and denominators for HEDIS measures that are part of the initial core set of these measures, after consulting with the state to determine reporting requirements. |
| Continuous enrollment requirements | Whether the CHIP population is reported separately or included in the Medicaid HEDIS report, the organization must follow the Medicaid product line specifications and continuous enrollment requirements. |

The HEDIS Compliance Audit

The HEDIS Compliance AuditTM runs concurrent with HEDIS Data Collection. The audit allows comparability across organizations and ensures validity and integrity of HEDIS data. It is required for organizations seeking NCQA Accreditation or for reporting in NCQA public reporting products, including Quality Compass®, and by CMS and many states and employer groups.

9. Audit Preparation

|  |  |  |  |
| --- | --- | --- | --- |
| Contract with an audit firm | | The organization requests an application for a HEDIS Audit from an NCQA Licensed Organization (www.ncqa.org/audit.aspx), and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations for bids and selects a firm to conduct the HEDIS audit.  The contracting phase includes assessing measures to report, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline.  All Licensed Organizations employ or contract with Certified HEDIS Compliance Auditors (CHCA) and select an audit team for the organization. | |
| HEDIS Roadmap | | Each organization must complete the HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap contains detailed questions about all audit standards and describes the operational and organizational structure of the organization. Auditors use the HEDIS Roadmap to review information about an organization’s systems for collecting and processing data to produce HEDIS reports and to organize the site visit. | |
| Medical record review validation | | The medical record review validation (MRRV) process uses like-measure groupings for measure validation; includes hybrid measure exclusions; applies a different statistical test to the process; and defines MRR milestones clearly to ensure consistency across organizations. Refer to *HEDIS 2016: Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures,* released in November. | |

|  |  |
| --- | --- |
| HEDIS AUDIT TIMELINE | |
| Task | NCQA Deadline |
| Organization contracts with an NCQA Licensed Organization. | December 1 |
| Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor. | December 1 |
| Organization submits the completed current year’s Roadmap to the auditor.  *\*The auditor must receive the Roadmap by January 30 or at least two weeks before the site visit, whichever is earliest.* | January 15–29\* |
| Auditor completes the survey sample frame validation. | January 29 |
| Auditor selects a core set of noncertified measures for code review. | February 12 |
| Auditor receives software vendor’s final certification report and measure identifiers, or organization submits completed source code for auditor review (for noncertified code). | March 1 |
| Organization completes and stops all nonstandard and member-reported supplemental data collection and entry. | March 1 |
| Auditor finalizes approval of *all* supplemental data. PSV for nonstandard and member-reported supplemental data must not occur prior to March 1 unless the organization finished all supplemental data processes, collection and entry. | March 31 |
| Onsite visits completed. | April 29 |
| Preliminary rate review and feedback completed. | May 2 |
| Organization completes the medical record abstraction process for all measures; sends final numerator-compliant counts for all measures and exclusions for MRRV. | May 16 |
| Auditor picks measures from the measure groups and exclusions, selects 16 records from each for MRRV review, and informs the plan of the selections. | May 20 |
| Organization sends selected records to the auditor for validation. | May 27 |
| Auditor begins communicating MRRV results, including MRRV corrective actions, with the organization. | June 1 |
| Organization completes all corrective actions and follow-up requests and submits the plan-locked commercial, Medicaid and Medicare submissions to auditor. | June 8 |
| Auditor performs final rate review and ensures that the MRR numerator counts entered in the IDSS match the lists submitted on May 16. | June 15 |
| Organization submits the auditor-locked commercial, Medicaid and Medicare IDSS submission, with attestation, to NCQA. | June 15 |
| Organization submits patient-level data for Medicare products only. | June 15 |
| Licensed Organization submits commercial, Medicaid and Medicare Final Audit Reports to NCQA. | July 15 |

10. Reporting

|  |  |
| --- | --- |
| Audit results | HEDIS Compliance Audits result in audited rates or calculations at the measure and indicator level, and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below. |

### For Performance Measures

| Rate/Result | Comment |
| --- | --- |
| *R* | *Reportable.* A reportable rate was submitted for the measure. |
| *NA* | *Small Denominator*. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate. |
| *NB* | *No Benefit*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). |
| *NR* | *Not Reported*. The organization chose not to report the measure. |
| *NQ* | *Not Required.* The organization was not required to report the measure. |
| *BR* | *Biased Rate.* The calculated rate was materially biased. |
| *UN* | *Un-Audited.* The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., Measures Collected Using Electronic Clinical Data Systems). |

### For Survey Measures

| Rate/Result | Comment | | |
| --- | --- | --- | --- |
| *SR* | *Supports Reporting.* The survey sample frame was reviewed and approved. | | |
| *NR* | *Not Reportable.* Indicates the survey sample frame was incomplete or materially biased. | | |
| Material bias | | Bias differs by measure and domain and is determined by the degree of data completeness for the data collection method used. Organizations may not report a rate for a measure that the auditor determines is biased. Auditors use a standardized set of bias assessments found in *Appendix 10: Bias Determination* in *Volume 5:* *HEDIS Compliance Audit™: Standards, Policies and Procedures*. |

11. Marketing

Release of HEDIS Audit results must be in accordance with NCQA’s *Guidelines for Advertising and Marketing,* posted on the NCQA Web site at www.ncqa.org*.* Organizations may release the entire Final Audit Report without prior authorization from NCQA, but must obtain written authorization from NCQA before releasing abridged, summarized or quoted information from the Final Audit Report.

Organizations that refer to the HEDIS Audit or any HEDIS data audited by a Certified HEDIS Compliance Auditor must adhere to the Guidelines.

In Which Reports Do HEDIS Members Remain?

12. Eligible Population

The **eligible population** for any measure is all members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement. Organizations must include all members (regardless of benefit type) in the appropriate HEDIS report, with the exception of self-insured members who meet the criteria in *General Guideline 19*.

* *For the Administrative Method,* calculate the rate using the eligible population after exclusions are removed.
* *For the Hybrid Method,* calculate the rate using the denominator (i.e., the systematic sample drawn from the eligible population) after exclusions are removed.

**Note:** Refer to the measurement specifications for eligible population criteria.

13. Commercial Members

Include members enrolled through an employer group policy or through an individual or family policy in the commercial HEDIS report.

14. Employer-Specific HEDIS Reports

NCQA does not recommend calculating employer-specific HEDIS reports because of confidentiality concerns, statistical concerns arising from small numbers and the medical record review burden for measures collected using the Hybrid Method.

15. 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).

16. Medicaid/Medicare-Eligible Members

Include these members in *both* the Medicaid and Medicare HEDIS reports *only* if they are enrolled in the organization’s Medicare contract required to report HEDIS *and* in the organization’s Medicaid managed-care contract. An organization with a Dual-Eligible SNP benefit package must also include these members in its SNP submission.

Members who have Medicare Private Fee-for-Service (PFFS) through another organization or have unknown Medicare coverage as their primary insurer may be excluded from the Medicaid report prior to determining a measure’s eligible population and drawing the sample for hybrid measures. This decision must be applied consistently across all applicable measures.

17. Members With Dual Commercial Coverage in Different Organizations

Do not account for coordination of benefits with other insurance carriers. If members have commercial coverage in two organizations, both organizations must include the members in their HEDIS reports, regardless of the primary insurer. For example, dependent children who are enrolled in one organization’s commercial product line under the mother’s insurance and in another organization’s commercial product line under the father’s insurance, are included in both HEDIS reports.

18. Members With Dual Commercial Coverage in the Same Organization

Adhere to the following criteria for members with dual coverage (e.g., children enrolled under each parent):

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

19. Self-Insured Members

|  |  |
| --- | --- |
| Administrative services only | Include self-insured ASO members in HEDIS reports. Exclude them from HEDIS reports only in either of the following situations and only with auditor approval.   * The contract prohibits the organization from contacting members for any reason. This **“no-touch” contractual agreement** is a contract or other written agreement between the organization (i.e., HMO or PPO or EPO) and the ASO, stating that the organization may not contact these members under any circumstances. The organization may exclude enrolled members with a no-touch agreement in place from HEDIS/CAHPS results and from accreditation because they are not managed in the same way as other members. ASO members may only be excluded through no-touch contractual agreements with purchasers. * The organization 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 organization, the organization is considered responsible for administering claims. |

Membership Changes

20. Members Who Switch Organizations

Members who switch to different organizations or to a sister organization may be counted as continuously enrolled if they joined an organization that assumes ownership of or responsibility for members’ administrative data and medical records for the entire period of continuous enrollment specified in the measure.

If an organization reports these members as continuously enrolled, it follows the definition of “continuous enrollment” in *General Guideline 24: Continuous Enrollment*, and all other guidelines affecting continuous enrollment (i.e., allow switching between products [HMO, POS, PPO, EPO] or product lines [Medicaid, commercial, Medicare]) consistently, across all measures.

21. Members Who Switch Organizations as a Result of a Merger or Acquisition

|  |  |
| --- | --- |
| Measures with  a continuous enrollment period | Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled. This guideline must be used consistently across all measures. |
| Measures without  a continuous enrollment period | The surviving organization may include members from the nonsurviving entity in the eligible population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the nonsurviving entity from the eligible population for January and February. This guideline must be used consistently across all measures. |

22. Members Who Switch Product Lines

|  |  |
| --- | --- |
| Measures with  a continuous enrollment requirement | Assign members who enrolled in different product lines (commercial, Medicaid, Medicare) at different times during the measurement year to the product line they belonged to at the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report.  Members who “age in” to a Medicare product line that began mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps. |
| Measures without  a continuous enrollment requirement | Assign members to a category based on the product line in which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services). |

23. Members Who Switch Products

|  |  |
| --- | --- |
| Measures with  a continuous enrollment requirement | If the organization reports separately by product, members who switch among HMO, POS, PPO and EPO products, in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product-specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period.  The organization must use claims data from all products, even when there is a gap in enrollment.  Enrollment in a Medicare Private Fee-for-Service (PFFS) plan is considered a gap in HMO/POS and PPO/EPO enrollment. |
| Measures without  a continuous enrollment requirement | If the organization reports commercial HEDIS separately by product (i.e., HMO, POS, PPO, EPO), members who switch between products during the measurement year are reported in the product in which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services). | |

Required Enrollment Periods and Benefits

24. Continuous Enrollment

**Continuous enrollment** specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, 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. If the member disenrolls on June 30 and re-enrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

An **allowable gap** can occur any time during continuous enrollment. For example, the *Comprehensive Diabetes Care* measure requires continuous enrollment throughout the measurement year (i.e., January 1–December 31) 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. The member has one 38-day gap (January 1–February 7).

25. Medicaid Continuous Enrollment

If the organization applies a full-month eligibility criterion to Medicaid beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment during the continuous enrollment period may not exceed 45 days. For example, a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

If the organization is notified of prospective member enrollment, use the actual date of enrollment to calculate continuous enrollment, not the notification date.

|  |  |
| --- | --- |
| Retroactive eligibility | The elapsed time between the actual date when the organization 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, members may be excluded if the retroactive eligibility period exceeds the allowable gap requirement. This guideline must be used consistently across all measures. |

26. Continuous Enrollment Over Multiple Years

Unless otherwise specified, for measures that span more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days. For example, in the *Colorectal Cancer Screening* measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

27. Anchor Dates

If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 30-year-old woman who has only one gap in enrollment from November 30 of the measurement year throughout the remainder of the year is not eligible for the *Cervical Cancer Screening* measure. Although she meets the continuous enrollment criteria, she does not meet the anchor date criteria, which requires her to be enrolled as of December 31 of the measurement year.

28. Required Benefits

HEDIS measures evaluate performance and hold organizations accountable for services provided in their members’ benefits package. Measure specifications include benefits (i.e., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS measures do not define benefits at the service level (e.g., if the organization offers a pharmacy benefit but does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit).

|  |  |
| --- | --- |
| *…at the organization level* | Organizations report HEDIS measures requiring a specific benefit provided to members directly or through a contractor.  Organizations are not required to report HEDIS measures specifying a benefit that it does not offer.  Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit. |
| *…at the member level* | Members who do not have a specified benefit are not counted in the measure. For example*,* exclude members without a pharmacy benefit from the *Antibiotic Utilization* measure. |
| Exhausted benefits *(optional)* | *For measures without a continuous enrollment criterion,* include only services or procedures that occurred while the member had a benefit. For a member whose benefit is lost or exhausted during the time specified in the measure, include services or procedures that occurred while the member had the benefit. For example, in the *Antibiotic Utilization* measure, for a member whose pharmacy benefit is exhausted on November 1 of the measurement year, report only the outpatient antibiotic prescriptions that occurred from January 1–October 31.  *For measures with a continuous enrollment criterion*, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap or anchor date. For example, the *Medication Management for People With Asthma* measure requires a pharmacy benefit during the measurement year. Exclude a member whose pharmacy benefit is exhausted in September of the measurement year, because this exceeds the 45-day allowable gap period. |
| Carved-out benefits *(optional)* | Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The employer’s members may be included in the measure. |

This guideline must be used consistently across all measures.

29. Accessing Medical Records Prior to Enrollment

Data that can be accessed from a medical record are used to calculate a measure. If data from a medical record cannot be accessed because data were updated before the member was enrolled, the organization calculates the measure with the data that are available.

HEDIS Data Submission and Reporting

30. HEDIS Reporting Date

The previous calendar year is the standard measurement year for HEDIS data. For HEDIS 2016, commercial organizations that want to report publicly must submit data to NCQA on or before **June 15, 2016**.

State Medicaid agencies will notify a Medicaid-contracting organization of the submission date for Medicaid HEDIS 2016 data, but an organization with a Medicaid product in the accreditation process or that wants to be reported publicly must meet the June 15 submission deadline*.*

CMS requires a Medicare-contracting organization to submit data for Medicare HEDIS 2016. All Medicare-contracting organizations and organizations with a Medicare product in the accreditation process must meet the June 15 submission deadline*.*

**Note:** Organizations must submit and “plan-lock” HEDIS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For HEDIS 2016 reporting, organizations are required to “plan-lock” HEDIS data no later than June 8, 2016.

31. Required Data Elements

Organizations that submit HEDIS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid measures and administrative measures. Refer to *Appendix 4: Data Element Definitions.*

32. Small Numbers

|  |  |  |
| --- | --- | --- |
| Effectiveness of Care and Access/ Availability of Care domains | If fewer than 100 members are in the eligible population for a reported measure during the entire measurement year, include in the denominator all members  who meet the criteria and report a 95 percent confidence interval. If the denominator used to calculate a measure is smaller than 30 using either the Administrative or Hybrid Method, the organization is not required to report the rate but must provide all other information, including:   * A count of all members eligible for the measure, as defined by the measure specification (the **eligible population/denominator**). * A count of all members who received the treatment or service as indicated (the **numerator**).   Separate reporting of numerator and eligible population/denominator information allows CMS and states to aggregate the data with those of other organizations to produce national or statewide data or to calculate a rate. It also serves as a reminder of the threat of small numbers to the credibility of performance measures. Refer to the *Guidelines for Calculations and Sampling* for information on sample size and selection and confidence interval calculation. | |
| Tabular Utilization measures | Organizations may not suppress reporting for any cell in the table (Discharges; Discharges/1,000 Member Months; Procedures; Days/1,000 Member Months), regardless of the total member months or member years for the particular age or gender cohort or the number of measured events (visits, days, discharges, stays, procedures). |
| Utilization measures that request a percentage | For Utilization measures that request a percentage *(Frequency of Ongoing Prenatal Care*, *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life;* and *Adolescent Well-Care Visits)* follow the instructions for Effectiveness of Care measures described above. |

Data Collection Methods and Data Sources

33. Data Collection Methods

HEDIS measures are specified for one or more of three data collection methods:

* Administrative Method.
* Hybrid Method.
* Survey Method.

Each measure specifies the data collection method(s) that must be used. If a measure includes both the Administrative and Hybrid Methods, either method may be used.

|  |  |  |
| --- | --- | --- |
| Administrative Method | | Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator. |
| Hybrid Method | | Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure’s eligible population. Organizations review administrative data to determine if members in the systematic sample received the service, and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator. |
| Survey Method | Requires organizations to collect data through a survey. Specifications for survey measures are included in *HEDIS Volume 3: Specifications for Survey Measures* and *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey.* | |

***Note:*** *Supplemental data are considered an administrative data source. However, for the EOC measures and Utilization measures similar to EOC (i.e., FPC, W15, W34, AWC), numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/ encounter) and medical record data, as indicated in the applicable* Data Elements for Reporting *tables. If supplemental data are not used, report zero in the “Numerator events by supplemental data” element. For all other measures, numerator events identified using supplemental data are reported in the “Numerator events by administrative data” element. Refer to General Guideline 34 for supplemental data requirements.*

34. Supplemental Data

|  |  |
| --- | --- |
| Supplemental data uses | When administrative or medical record data are not available, organizations may use other sources to collect data about their members and about delivery of health services to their members. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the HbA1c control indicators in the *Comprehensive Diabetes Care* measure, the most recent test must be used regardless of data source).  For administrative-only measures, medical record data are considered supplemental data. |
| *Supplemental data may help determine:* | * The numerator. * Optional exclusions. * Eligible-population required exclusions (that are labeled as *required exclusions* in the specification). For example: * *Medication Management for People With Asthma* and *Asthma Medication Ratio.* Organizations may use supplemental data for members who have any condition in step 3, *Required Exclusions* for the event/diagnosis. |
| *Supplemental data may not be used for:* | * Denominator events. Organizations *may not* create and use records to identify denominator events, other than for optional and required exclusions. For example: * *Appropriate Testing for Children With Pharyngitis.* Organizations may not use supplemental data to find additional diagnoses for any claim that qualifies for the eligible population. Exclude “claims” with multiple diagnoses only. |

|  |  |
| --- | --- |
|  | * Organizations *may not* create and use records, on an ongoing basis, for exclusions for clinical conditions that change. * Correcting bills or identifying valid data errors. Organizations *may not* use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed. For example: * Organizations may not exclude a member from the *Osteoporosis Management in Women Who Had a Fracture* measure if the medical record shows that a fracture did not occur in the time frame required by the measure but was billed by a provider for ongoing therapy.   **Note:** Refer to Substituting Medical Records in the Guidelines for Calculations and Sampling for additional information and examples of valid data errors. |

### *Supplemental Data Definitions*

|  |  |
| --- | --- |
| *Standard supplemental data* | Electronic files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.  Electronic files that may be used as standard supplemental data:   * Laboratory result files. * Current or historic state transactional files in a standard electronic format. * Immunization data in state or county registries (might vary from state to state, but are consistent for all records in each state’s registry). * Transactional data from behavioral healthcare vendors. * Electronic health record (EHR) vendor systems. * Prior year’s validated historic hybrid medical record results.   **Audit requirements.** Standard supplemental files are not required to be accompanied by proof-of-service documents and the audit does not require primary source verification, unless requested by the auditor. |
| *Nonstandard supplemental data* | Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard files described above, whether collected by an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.  Organizations must have clear policies and procedures that describe how the data are collected, validated and used for HEDIS reporting.  Organizations *may not* conduct phone calls to members or providers to collect information about services rendered.  Examples of nonstandard supplemental data:   * EHR modules (e.g., eMeasure modules). * Provider portals (i.e., electronic systems providers use to enter information about services rendered). * Health information registries. * Provider abstraction forms. |

|  |  |
| --- | --- |
|  | **Audit requirements.** All nonstandard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit’s annual primary source verification.  Proof-of-service documentation that *is* *allowed* for primary source verification:   * A copy of the information from the member’s chart from the service provider or the PCP. * A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred). * A screen shot of: * Online EHR records. * State- or county-sponsored immunization registry records.   Proof-of-service documentation that is *not allowed:*   * Member surveys. Organizations and providers may not use information obtained from surveys or other documents completed by the member, except for data collected for *Language Diversity of Membership* and *Race/Ethnicity Diversity of Membership*. * Phone calls. Recorded phone calls to collect information about services rendered are not proof of service. |
| *Member-reported services* | Acceptable *only* if accompanied by proof-of-service documents from the legal health record, whether reported to a disease- or case-management clinician, collected during targeted quality improvement programs or reported during any other data collection process.  Proof-of-service documents must be mailed, faxed or otherwise delivered by the member to the entity contacting the member for the information. Permitted proof-of-service documents include:   * Lab or radiology reports. * Sections of the member’s legal health record showing the service or assessment. * Documentation from the legal health record must be recorded, signed and dated by the rendering provider.   When original proof-of-service documents are not available, member-reported information is acceptable only if:   * The information is collected by the end of the measurement year, by a primary care practitioner (refer to Appendix 3 for the definition of “PCP”) or specialist if the specialist is providing a primary care service related to the condition being assessed, while taking a patient’s history. * The information is recorded, dated and maintained in the member’s legal health record. |

|  |  |
| --- | --- |
|  | * Obtain copies of the member’s legal health record from the practitioner who recorded the information. * The information meets the specific requirements of the measure.   All documents must meet the requirements for supplemental data and the measure to which they apply, and must be available for auditor review.  Organizations collecting member-reported information must have documents describing the policies and procedures for contacting members and for obtaining copies of legal health records.  Organizations *may not* conduct phone calls to members to collect information about services rendered.  **Note:** It is considered “best practice” to collect data directly from members for the Language Diversity of Membership and Race/Ethnicity Diversity of Membership measures. Member-reported data (without proof-of-service documents from the legal health record) are acceptable for only these measures.  ***Audit requirements.*** *Member-reported services must be accompanied by proof-of-service documents for every record, and the audit requires primary source verification annually.* |

### *Required Data Elements*

|  |  |
| --- | --- |
| Standard supplemental data | Organizations must have policies and procedures for using data files as standard supplemental data. Files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by measure specifications. If the measure has a hybrid specification, the supplemental data source must contain all data elements required by the hybrid specification regardless of the method (administrative or hybrid) the plan chooses to use when reporting the measure. |
| Nonstandard supplemental data | Nonstandard supplemental data files must have all data elements required to meet criteria specified by the measure specifications. If the measure has a hybrid specification, the supplemental data source must contain all data elements required by the hybrid specification.  **Electronic sources (i.e., portal, eMeasure module).** Data collected or reported from the practitioner who renders the clinical service must have evidence of accountability by the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/PIN data in each session or header record).  **Provider-abstracted forms.** Provider forms may not be simple “yes or no” responses as evidence of member compliance. Provider forms must have all necessary data elements required by the measure and are signed by the rendering practitioner, attesting to the accuracy of the information. |
| Member-reported services | Proof-of-service documents required for member-reported services must include all data elements required by the measure (i.e., date and place of service, procedure, prescription, test result or finding, practitioner type). If the measure has a hybrid specification, the proof-of-service documents must contain all data elements required by the hybrid specification. |

|  |  |
| --- | --- |
| All supplemental data | All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to *General Guideline 37* for date specificity requirements).  For all measures (including administrative-only measures), organizations must determine that a test or service was *performed* within the period specified, not merely ordered.  All supplemental data used to show eligibility for exclusions must follow the requirements for exclusions in each measure. |

### *Supplemental Data Timeline and Systematic Sample Requirements*

Supplemental data may be collected during the measurement year and into the beginning of the reporting year, but data collection for nonstandard and member-reported files must be completed by the March deadline listed in the Audit Timeline in *General Guideline 9*.

Supplemental data must follow the specifications for each measure. If the measure has a hybrid specification, the data elements used must comply with the hybrid requirements of the measure; however, supplemental data are used to calculate the administrative portion of the measure.

For hybrid measures, after the sample is pulled, organizations must follow the policies for collecting information for the systematic sample described in *General Guideline 35*. Supplemental data collection may not be targeted only at members selected for the systematic sample.

Data pulled from medical records for chart review for a hybrid measure may be used as supplemental data in *subsequent* HEDIS reporting years if they comply with the guidelines for data element requirements and audit review.

Refer to the Audit Timeline in *General Guideline 9* for additional deadline requirements.

### *Identifying and Validating Supplemental Data*

All supplemental data (standard, nonstandard and member-reported) must be identifiable. Because supplemental data can affect reporting and incentives, plans or vendors that use supplemental data for HEDIS reporting must mark the data files, regardless of the source. Auditors must be able to assess the contribution of each supplemental data source to the applicable components of the measure (numerator events or appropriate exclusions).

Auditors must review all supplemental data annually—there are no exceptions. At a minimum, the annual review includes the following for each supplemental data source:

* A completed current year’s Roadmap Section 5, including all attachments.
* Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data.)
* Primary source verification where required or requested by the auditor.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate HEDIS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

For additional information about audit requirements for supplemental data, refer to *Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures,* released each November.

35. Obtaining Information for the Systematic Sample

Organizations (and their contractors) that use the Hybrid Method are responsible for determining compliance with HEDIS measurement specifications. Information may be abstracted from the member’s legal health record by designated medical record review (MRR) staff. Abstraction of data for members in the systematic sample is performed by entities or vendors who adhere to training, policies and procedures, use of appropriate tools, oversight and all other audit components.

MRR abstractors count a service if the legal health record contains the date of the service and evidence that the service occurred. All services must be rendered and documented in the medical record by the deadline established in the measure (e.g., by the child’s second birthday, for the *Childhood Immunization Status* measure).

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward HEDIS compliance. Some EHRs record CPT codes when the practitioner enters a service order in the “order” screen. A CPT code found on the “order” list alone does not comply with the numerator criteria.

After the systematic sample is determined, supplemental data collection may not be used only for noncompliant members selected in the sample.

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard tests, are reviewed by the certified HEDIS Compliance Auditor.

|  |  |
| --- | --- |
| Data refresh for the systematic sample | Because NCQA requires that the systematic sample be stable and reproducible, organizations may not change the sample after it is created. If an organization refreshes the HEDIS repository after the sample is drawn and chart review is in progress, it should follow the guidelines below to use the newer administrative data for all hybrid measures.  **Note:** Organizations may elect to refresh data for administrative-only measures, but must apply the refresh to all applicable measures. |
| *Manually updating the sample* | Organizations may compare only the numerator-negative members in the sample to screen shots of the refreshed data; they are not required to update every measure manually or to reassess denominator compliance for every member in the sample.  Records used for numerator compliance are subject to medical record review validation. |
| *Automated updates to the sample* | Organizations may use an automated process that loads the entire sample for each measure and compares it to the refreshed data. All data must be used consistently in the samples.   * If recent data contradict numerator compliance, those data must be used. * If recent data exclude a member, those data must be used and the oversample must provide a substitute member. * If the oversample is exhausted, the organization must use the Sampling Guidelines to ensure a denominator of 411. * The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation. |

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

2 CPT codes copyright 2015 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

36. Measures That Require Results From the Most Recent Test

For measures that require the use of results from the most recenttest, search for medical record documentation that indicates a test was *performed,* not merely ordered*.* Medical record documentation indicating only that a test was ordered (and not performed) may not be included when identifying the most recent test. For example, documentation that the patient was sent to the lab or that a lab test was ordered does not mean a test was performed. These situations may not be included when identifying the most recent test.

Medical record evidence indicating that a test was performed (that should be included when identifying the most recent test) includes documentation of a numeric value, interpretation of a numeric value (e.g., within normal limits, average, high) or documentation that a test was performed but results could not be calculated. To determine numerator compliance for rates that require results to be at a certain level, documentation of a numeric result is required. Documentation that a result is “within normal limits” or “under control” would be considered a “missing” result and would not be compliant for rates that require results to be at a certain level.

If the organization uses a combination of administrative, supplemental, or hybrid data, the most recent test must be used, regardless of data source.

Multiple dates of service may be associated with a single lab test. For example, a laboratory test may have a collection date (i.e., the date when the specimen was drawn), a reported date (i.e., the date when results were calculated and reported) and a claim date (i.e., the date of service on the claim). Because of this, the “result” may not be associated with the most recent date. An organization may consider all events with dates no more than seven days apart to be the *same* test and may use the result associated with that event (even if it is not the most recent date of service). If there are two or more events with results, the most recent result must be used. The most recent date among all events must be in the timeframe specified by the measure and must be used for reporting. For example, a test with a collection date of December 1 and a reported date of December 8 may be considered the same test and the most recent date of December 8 must be used for reporting. Tests with dates more than seven days apart are considered different tests; the most recent must be used.

Undated lab results in medical records may not be used for HEDIS reporting. To be eligible for use, medical record documentation must include the collection date or the reported date.

37. Date Specificity

HEDIS requires that a date be specific enough to determine that an event occurred during the time frame established in the measure. For example, in the *Childhood Immunization Status* measure, members must receive three hepatitis B vaccines. Assume a member was born on February 5, 2013. Documentation in the medical record that the first hepatitis B vaccine was given “at birth” is specific enough to determine that it was given prior to the deadline for this measure (i.e., the child’s second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2015, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member’s second birthday.

There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the “measurement year or the year prior to the measurement year.” Terms such as “recent,” “most recent” or “at a prior visit” are not acceptable.

For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the *Childhood Immunization Status* measure, undated documentation on an immunization chart stating “chicken pox at age 1” is specific enough to determine that it occurred prior to the child’s second birthday. Similarly, for the *Breast Cancer Screening* measure, undated documentation on a problem list stating “bilateral mastectomy in 1999” is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.

38. Indicators That Require the Same Data Collection Method

Organizations must use the same data collection method (Administrative or Hybrid) to report the following indicators in the specified measure.

* *Comprehensive Diabetes Care:*
* HbA1c Testing.
* HbA1c Poor Control >9%.
* HbA1c Control <8%.
* HbA1c Control <7%.

39. Collecting Data for Measures With Multiple Numerator Events

The following measures require more than one event to satisfy the numerator:

* *Childhood Immunization Status.*
* *Well-Child Visits in the First 15 Months of Life.*
* *Human Papillomavirus Vaccine for Female Adolescents.*

For only the measures listed above, the organization may use a single data source or a combination of administrative data, which may include audited supplemental data, and medical record data to determine numerator compliance for members in the denominator. To avoid double counting events, when only assessing administrative data or when combining administrative and medical record data, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15. When combining administrative and medical record data, the dates of service must also be at least 14 days apart in order to count toward numerator compliance.

If the organization has one event from the medical record and one from administrative data but cannot determine if the dates are at least 14 days apart, it must use only the medical record event.

This rule does not apply when using only medical record data. For example, the organization may count two influenza vaccines identified through medical record data that are not 14 days apart.

40. Measures That Use Pharmacy Data

Some measures require the use of pharmacy data. The specifications include medication tables that must be referenced in conjunction with the National Drug Code (NDC) lists posted to NCQA’s Web site. The tables include a *Description* column that indicates the therapeutic category, and a *Prescription* column that includes all appropriate medications in their generic form. Organizations must use the NDC lists for each pharmacy-dependent measure. Final NDC lists for pharmacy-related measures will be posted to the NCQA Web site on November 2, 2015.

41. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Laboratory claims and data may be used only for the Lab Panel Value Set, the Obstetric Panel Value Set, the Pregnancy Tests Value Set, the Sexual Activity Value Set (which do not contain LOINC3 codes) and value sets that contain LOINC codes.

Claims data indicating a member had a laboratory test during a visit with a provider are not considered laboratory data. Laboratory data are claims or lab result data for the sole purpose of a laboratory test performed outside of a visit with a provider. Organizations determine how to differentiate between laboratory claims data and clinical/provider claims that may include a laboratory test. Diagnosis codes on pharmacy claims may not be used.

42. Member-Collected Samples and Biometric Values

Test results from member-collected samples may be used for FOBT, urinalysis testing and blood spots for HbA1c, LDL-C, glucose and total cholesterol. Member-collected samples must be sent to the laboratory or provider’s office for analysis.

Other member-collected biometric values (i.e., blood pressure [BP], body mass index [BMI], height and weight) may not be used for HEDIS reporting.

HEDIS Coding Conventions

43. Coding Systems Included in HEDIS

HEDIS includes codes from the following coding systems:

* CMS Place of Service (POS).
* Current Procedural Terminology (CPT).
* Medicare Severity Diagnosis-Related Group (MS-DRG).
* Healthcare Common Procedure Coding System (HCPCS) Level II.
* International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)**\***.
* International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)\*.
* International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)\*.
* Logical Observation Identifiers Names and Codes (LOINC).
* Uniform Bill (UB) revenue and Type of Bill (TOB).

**\*** Updates to the International Classification of Diseases diagnosis and procedure codes are released annually on October 1 by the American Hospital Association. Because HEDIS specifications are frozen with the release of the Technical Update, there is not enough time to review the appropriateness of ICD-9 codes released on the same date; therefore, they are not included in HEDIS value sets and may not be used for HEDIS reporting. This policy ensures consistency in reporting across organizations and reduces burden by minimizing updates to the technical specifications after the freeze date. The codes will be considered for the following HEDIS season.

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

Current Procedural Terminology © 2015 American Medical Association. All rights reserved.

3LOINC® is a registered trademark of the Regenstrief Institute.

44. Presentation of Codes in HEDIS Value Sets

Measure specifications reference value sets that must be used for HEDIS reporting. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). A **value set** is the complete set of codes used to identify the service or condition included in the measure. Only use the codes included in the value sets for HEDIS reporting.

Value sets used for HEDIS reporting are included in the Value Set Directory.

45. Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout HEDIS. Generally, a **principal diagnosis** or **primary diagnosis** is the diagnosis given at discharge and the one listed first on a claim form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is the **secondary diagnosis**. A claim form can contain multiple secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal or primary diagnosis must be used, any applicable diagnosis is used.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, the *Persistence of* *Beta-Blocker Treatment After a Heart Attack* measure specifies that any diagnosis of an AMI is eligible. If a member’s claim lists the principal diagnosis as “severe head injury trauma,” but an AMI is listed as a secondary diagnosis on the same claim form, the member is included in the *Persistence of* *Beta-Blocker Treatment After a Heart Attack* measure.

**On a UB-04 claim form,** the principal diagnosis is listed in Form Locator 67, *Principal Diagnosis Code,* and secondary diagnoses are listed in Form Locators 67A–Q, *Other Diagnosis Codes*. Do not include data in Form Locators 69, *Admitting Diagnosis Code* and 70a–c, *Patient’s Reason for Visit* in HEDIS reporting.

**On a CMS1500 claim form,** the primary diagnosis is listed in Item Number 21, line 1, and secondary diagnoses are listed in Item Number 21, lines 2–4.

46. CPT Code Modifiers

**CPT modifiers** are two- or five-digit extensions that, when added to CPT codes, provide additional information about a service or procedure. With the exception of mastectomies in the *Frequency of Selected Procedures* measure, the same procedure is never counted twice for the same date of service. Follow the guidelines below if procedure codes have modifiers (**xxxxx** denotes the five-digit CPT code).

* **xxxxx-26** indicates the professional component of a service (**xxxxx-TC** is used by some organizations to indicate the technical component of the same service). For a given procedure, count one or the other of these codes, but not both.
* **xxxxx-54** denotes surgical care only; **xxxxx-55** denotes postoperative management only; **xxxxx-56** denotes preoperative management only. For a given procedure, count only one of these codes.
* **xxxxx-80** and **xxxxx-82** indicate charges for surgical assistant services; **xxxxx-81** indicates a charge for minimum surgical assistant services. If the primary surgeon does not submit a claim for a given procedure, count only one of these codes. If a primary surgeon submits a claim, do not count any of these codes.

Unless otherwise specified, if a CPT code specified in HEDIS appears in the organization’s database with any modifier other than those specified above, the code may be counted in the HEDIS measure.

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

Current Procedural Terminology © 2015 American Medical Association. All rights reserved.

47. Uniform Bill Code Specificity

**Uniform Bill (UB)** codes, primarily type of bill and revenue codes, are used to identify services.

The HEDIS Value Set Directory specifies UB type of bill codes using four digits. The organization may also use the equivalent three-digit version of the code (which consists of the four-digit code without the leading zero); for example, to identify skilled nursing facility (SNF) encounters, use either 21x or 021x.

**Note:** The three-digit versions of the codes are not included in the Value Set Directory.

48. Mapping Proprietary or Other Codes

For all HEDIS measures, if the specified coding systems are not used, organizations must “map” the codes they use to the codes specified in HEDIS. Organizations may map proprietary codes, Level III and state-specific Level II HCPCS codes and NDC codes; it may not map standard codes or deleted codes to the codes used in the measures. When mapping codes, it is important to match the clinical specificity required for HEDIS. NDC code mapping must be linked to the generic name, strength/dose and route indicated in the HEDIS NDC lists posted on the NCQA Web site (www.ncqa.org).

For audit purposes, the organization documents the method used to map codes. At a minimum, documentation includes a crosswalk containing the relevant codes, descriptions and clinical information.

The organization documents the process for implementing codes. For Level III and state-specific Level II HCPCS mapping, the organization provides instructions for using state-specific codes. Auditors may request additional information.

49. Retiring Codes

NCQA annually tracks billing, diagnostic and procedure codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS measures. Obsolete codes are deleted from the HEDIS specifications one year after the look-back period is exhausted. For example, since the *Adult BMI Assessment* measure counts a BMI in the measurement year or the year prior to the measurement year, BMI codes, for this measure, have a two-year look-back period. A code that is designated obsolete effective January 1, 2014, is deleted from the specifications in HEDIS 2017 after the two-year look-back period (2015, 2016) plus one additional year (2014) is exhausted.

Obsolete NDC codes are phased out of the specifications three years after the look-back period, to allow pharmacies and organizations to use their inventory and change their systems. NCQA encourages organizations to update their information systems and to ensure that complete, accurate and consistent coding is used for all encounters and claims so that HEDIS specifications can be followed. This will help the industry move toward a uniform system of performance measurement.

50. Table Names

Measure specifications contain two types of tables: one to present specification requirements and one used by organizations to submit data. Tables use a standardized naming system. Table names begin with a measure’s three-character abbreviation; for example, *Comprehensive Diabetes Care* tables begin with “CDC.”

|  |  |
| --- | --- |
| Specification tables | Tables that are part of the specifications (i.e., medication tables) begin with the measure abbreviation and end with a hyphen (**-**) and a capital letter to distinguish them in the measure’s specifications. |

|  |  |
| --- | --- |
| Reporting tables | Data element tables begin with the measure abbreviation. Each product line is assigned a number; for example:   * **CDC-1** (Medicaid). * **CDC-2** (commercial). * **CDC-3** (Medicare).   If more than one table will be reported for a product line, the table is assigned a lowercase letter. For example*,* the Medicaid tables for *Enrollment by Product Line* are ENP-1a (Total Medicaid) and ENP-1b (Medicaid/Medicare Dual-Eligibles). |

Measures Reportable With a Partial Year of Data

If an organization licenses a new product or product line during the measurement period, a number of HEDIS measures may be reported with a partial year of data. In general, a measure without a continuous enrollment requirement is reportable with less than a full measurement period of data. The organization must present a written request for approval to the PCS system at <http://my.ncqa.org>.

Guidelines for Calculations   
and Sampling

## 

Guidelines for Calculations and Sampling

This section contains guidelines for calculating rates based on the Administrative and Hybrid Methods, as well as specifications for sampling when using the Hybrid Method. Organizations that use the Hybrid Method must follow the systematic sampling methodology described in this section or receive written authorization from NCQA for an alternative sort or sampling method; written authorization from NCQA is required annually. Proper use and implementation of these methods is assessed as part of NCQA’s HEDIS Compliance Audit™.

How to Use the Administrative Method

|  |  |
| --- | --- |
| *Step 1* | Identify the eligible population and remove all required exclusions. All required exclusions must be removed from the final eligible population. |
| *Step 2* | Search administrative systems to identify numerator events for all members in the eligible population. |
| *Step 3* | If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured.  **Note:** This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions. |
| *Step 4* | Exclude from the eligible population, members from step 3 for whom administrative system data identified an exclusion to the service or procedure being measured. |
| *Step 5* | Calculate the rate. |

Guidelines for the Hybrid Method

Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:

* *Membership-dependent denominator—*Defined by membership data only (e.g., women between   
  24 and 64 years of age for *Cervical Cancer Screening*), ***or***
* *Claims-dependent denominator*—Defined by membership and claims data (e.g., members who were diagnosed with hypertension for *Controlling High Blood Pressure*).

|  |  |
| --- | --- |
| Drawing the sample prior to the reporting year | Organizations are strongly encouraged to draw samples no earlier than January 2016 for the 2015 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.  Organizations must adhere to the following guidelines if samples are drawn prior to January 2016. |

|  |  |
| --- | --- |
| Membership-dependent denominators | The eligible population for the following measures is determined through membership data. Do not draw the sample prior to December 1 of the measurement year.   * *Childhood Immunization Status.* * *Immunizations for Adolescents.* * *Human Papillomavirus Vaccine for Female Adolescents.* * *Lead Screening in Children.* * *Cervical Cancer Screening*. * *Colorectal Cancer Screening.* * *Care for Older Adults.* * *Well-Child Visits in the First 15 Months of Life* (Medicaid only). * *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* (Medicaid only). * *Adolescent Well-Care Visits* (Medicaid only).   An organization that draws its sample on or between December 1 and December 31 of the measurement year must perform the following tasks.   * Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year. * On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria. * For example,for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday). * Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group. |
| Claim-dependent denominators | The eligible population for the following measures is determined through membership data and claims data. Do not draw the sample before the end of the measurement year.   * *Medication Reconciliation Post-Discharge.* * *Weeks of Pregnancy at Time of Enrollment.*   To be drawn from a complete eligible population, the sample must be selected no earlier than January of the reporting year. Allow claims incurred through December 31 to be captured in administrative systems before identifying the eligible population and drawing the sample.  The eligible population for the following measures is determined through membership data and claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year. If an organization draws the sample on or between December 1 and December 31 of the measurement year, it must perform the tasks included in the “Membership-dependent denominators” section above (i.e., oversample as necessary and verify that members remain eligible on or after December 31 of the measurement year).   * *Adult BMI Assessment.* * *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.* * *Controlling High Blood Pressure.* * *Comprehensive Diabetes Care.* * *Prenatal and Postpartum Care.* * *Frequency of Ongoing Prenatal Care.* |
| Determining the required sample size | Using the Hybrid Method to collect and report a measure requires a sample to be drawn from the eligible population. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year’s audited result can be used to reduce the current year’s sample size.  Use Table 2 if the prior year’s rate is used to determine the current year’s sample. The organization may use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization’s rate improves; for example, the organization calculates a 77 percent administrative rate for the commercial product line for a new measure and decides to implement the Hybrid Method.  Instead of using a sample size of 411, the organization reduces the sample size for this measure for its commercial product line by using the 77 percent administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. |
| Population definition | In some cases, the size of the eligible population for a measure may be smaller than the required sample size. In this case, the organization must use its entire eligible population and report the data with a 95 percent confidence interval.  *Why use a 95 percent confidence interval when the entire eligible population is included?* When these data are used to make decisions, an inference is made about expected future performance on a group of potential members. The confidence interval provides an indication of the variability in the data. In either case, the user is interested in the “process of care,” which goes beyond an organization’s performance in a single year for a static product line. It is therefore appropriate to consider the organization’s entire eligible population for a measure as a sample from the universe of “all years” or “all populations.” |
| Finite population correction | Because HEDIS views organization enrollment as a sample from a larger potential population (see above), and the use of the finite population correction (FPC) decreases the power to detect differences between organizations, it is *not appropriate* to use the FPC for public reporting of HEDIS measures. |
| Organization responsibility for chart review | An organization that uses the Hybrid Method for a measure should attempt to pursue charts for all noncompliant members in the systematic sample, to preserve the integrity of the sample and its representative rate.  After the systematic sample is generated and chart pursuit has started, the sample  may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternative sampling |

|  |  |
| --- | --- |
|  | method, and the organization must submit a request for approval to PCS at <http://my.ncqa.org> that includes the reason for not completing chart review, and the auditor’s approval showing that the members to be removed are distributed systematically across the larger sample and the hybrid results from the reduced sample are reportable. |
| Calculating the 95 percent confidence interval | The formula for calculating the 95 percent confidence interval around an organization’s HEDIS rate is: |
|  | where *p* = the organization’s rate and *n* = the sample size.  For example, suppose the organization has a sample size of 96 eligible members for its *Adult BMI Assessment* rate. Of these, 50 had a BMI documented during the measurement year or the year prior to the measurement year. The calculation would proceed as follows: | |
|  | |
| Thus, the user can be 95 percent certain that the organization’s true adult BMI rate is between 41.5 percent and 62.5 percent. | |

*Note*

* *For rates near 0 percent, the lower limit may be negative. If this occurs, replace the lower limit with   
  0 percent. For rates near 100 percent, the upper limit may exceed 100 percent. If this occurs, replace the upper limit with 100 percent. The IDSS automatically calculates these percentages.*
* *There are more complex confidence interval calculations with better properties at extreme values. This formula is provided because it performs adequately over a wide range of percentages and is simple to compute.*

|  |  |
| --- | --- |
| Statistical assumptions for sample size | Sample size is calculated assuming a two-tailed test of significance between two proportions (α = .05, 80 percent power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50 percent expected value was assumed.  The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not a burden for data collection and it is not so small as to be “swamped” by nonsampling error. |

### 

### Table 1: Sample Size Information for Hybrid Measures

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Measure | Medicaid | Commercial | Medicare | Prior Year’s Rate May Be Used to Reduce MY 2015 Sample Size1 |
| **Effectiveness of Care** | | | | |
| Adult BMI Assessment | 411 | 411 | 411 | Y |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | 411 | 411 | NA | Y2 |
| Childhood Immunization Status | 411 | 411 | NA | Y3 |
| Immunizations for Adolescents | 411 | 411 | NA | Y3 |
| Human Papillomavirus Vaccine for Female Adolescents | 411 | 411 | NA | Y |
| Lead Screening in Children | 411 | NA | NA | Y4 |
| Cervical Cancer Screening | 411 | 411 | NA | Y |
| Colorectal Cancer Screening | NA | 411 | 411 | Y |
| Care for Older Adults | NA | NA | 411 | Y2 |
| Controlling High Blood Pressure | 411 | 411 | 411 | Y |
| Comprehensive Diabetes Care | 548 | 548 | 411 | Y5 |
| Medication Reconciliation Post-Discharge | NA | NA | 411 | Y |
| **Access/Availability of Care** | | | | |
| Prenatal and Postpartum Care | 411 | 411 | NA | Y6 |
| **Utilization and Risk Adjusted Utilization** | | | | |
| Frequency of Ongoing Prenatal Care | 411 | NA | NA | Y6 |
| Well-Child Visits in the First 15 Months of Life | 411 | NA | NA | Y7 |
| Well-Child Visits in the 3rd, 4th, 5th and 6th Years  of Life | 411 | NA | NA | Y |
| Adolescent Well-Care Visits | 411 | NA | NA | Y |
| **Health Plan Descriptive Information** | | | | |
| Weeks of Pregnancy at Time of Enrollment | 411 | NA | NA | N |

1 Refer to *Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured* in this section to determine the minimum required sample size.

2 If reducing the sample size based on the current year’s administrative rate or the prior year’s product line-specific rate for this measure*,* the lowest rate from all the indicators must be used.

3 If reducing the sample based on the current year’s administrative rate or the prior year’s product line-specific rate for either the *Childhood Immunization Status* or *Immunizations for Adolescent* measure, the lowest rate must be used.

4 If a separate sample from the *Childhood Immunization Status* measure is used for *Lead Screening in Children*, the organization can reduce the sample based on the product-line specific current measurement year’s administrative rate or the prior year’s reported rate for *Lead Screening in Children*.

5 If reducing the sample size based on the product-line-specific rate for *Comprehensive Diabetes Care*, the organization must first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) and then reduce using the lowest rate among all the reported CDC indicators.

6 If reducing the sample size based on the product-line-specific current measurement year’s administrative rate or the prior year’s reported rate, the lowest of the three rates for *Timeliness of Prenatal Care, Postpartum Care* and the rate for women who received 81 percent or more of expected prenatal care visits must be used for both *Prenatal and Postpartum Care* and *Frequency of Ongoing Prenatal Care*.

7 If reducing the sample size based on the product-line-specific current measurement year’s administrative rate or the prior year’s reported rate for *Well-Child Visits in the First 15 Months of Life*, the rate for children who received six or more well-child visits must be used.

### Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured

Organizations may use a rate calculated from the current year’s administrative rate or the prior year’s reported rate to determine the sample size. Table 1: Sample Size Information for Hybrid Measures must be used first to determine if a prior year’s rate can be used to reduce the sample size for a particular measure.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If the Current Year’s Administrative Rate or the Prior Year’s Reported Rate Is… | …the Sample Size Is: |  | If the Current Year’s Administrative Rate or the Prior Year’s Reported Rate Is… | …the Sample Size Is: |
| ≤50% | 411 | 73% | 328 |
| 51% | 411 | 74% | 321 |
| 52% | 410 | 75% | 313 |
| 53% | 410 | 76% | 305 |
| 54% | 409 | 77% | 296 |
| 55% | 407 | 78% | 288 |
| 56% | 405 | 79% | 279 |
| 57% | 403 | 80% | 270 |
| 58% | 401 | 81% | 260 |
| 59% | 398 | 82% | 250 |
| 60% | 395 | 83% | 240 |
| 61% | 392 | 84% | 229 |
| 62% | 388 | 85% | 219 |
| 63% | 384 | 86% | 207 |
| 64% | 380 | 87% | 196 |
| 65% | 376 | 88% | 184 |
| 66% | 371 | 89% | 172 |
| 67% | 366 | 90% | 159 |
| 68% | 360 | 91% | 147 |
| 69% | 354 | 92% | 134 |
| 70% | 348 | 93% | 120 |
| 71% | 342 | 94% | 106 |
| 72% | 335 | ≥95% | 100 |

*Note*

* *Truncate the decimal portion of the rate to obtain a whole number.*
* *For the commercial and Medicaid product lines, the Comprehensive Diabetes Care sample size is 548. The intent of this sample size is to achieve a sample of at least 411 for the HbA1c Control <7.0% for a Selected Population denominator after the required exclusions are applied. The organization may reduce the sample size using the lowest rate among the 7 indicators calculated from the current year’s administrative rate or the prior year’s reported rate, but it must maintain the applicable sample size listed in Table 2 in the HbA1c Control <7.0% for a Selected Population denominator after the required exclusions are applied. For example, if the organization’s lowest audited CDC rate reported in the prior year is 70 percent, the sample size may not fall below 348 for all 7 indicators (including the HbA1c Control <7% for a Selected Population indicator, after removing required exclusions).*

Systematic Sampling Methodology

NCQA implemented a systematic sampling scheme for the Hybrid Method. Proper utilization and implementation of this method ensures ongoing integrity of HEDIS data and supports increasing requests for audited data. Complete the following steps for each hybrid measure.

|  |  |
| --- | --- |
| *Step 1* | Determine the eligible member (EM) population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable). An organization that reports on combined HMO/POS or HMO/POS/PPO/EPO products must include all EMs from all products. |
| *Step 2* | Determine the minimum required sample size (MRSS) from Table 1 or Table 2. This number becomes the denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to *Determining the required sample size* for instructions.) If the  EM is ≤ MRSS, proceed to step 4.  **Note:** The MRSS may only be the appropriate value from Table 1 or Table 2.  To use a larger MRSS, an organization must provide written rationale to NCQA through the PCS system at <http://my.ncqa.org>. |
| *Step 3* | Determine the final sample size (FSS).The FSS includes the MRSS (from step 2) plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the MRSS is met; keep substitution criteria in mind.  Written approval from NCQA must be obtained to use an oversampling rate larger than 20 percent. Refer to *Oversample requests to NCQA* for details.  The FSS is calculated by the following formula:  FSS = MRSS + (MRSS × oversampling rate)  (round *up* to the next whole number), where MRSS = the minimum required sample size (step 2).  For example, if the MRSS is 411 and a 10 percent oversample is needed,  FSS = 411 + (411 × 0.10) = 453. |
| *Step 4* | If EM >FSS, go to step 5.If EM ≤MRSS, all eligible members are included in the sample. If MRSS <EM ≤FSS, proceed to step 8. |
| *Step 5* | Sort the list of EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). If the organization reports on combined products (i.e., HMO/POS or HMO/POS/PPO/EPO), it must alphabetize the combined EM population from both products.  Sort EMs from A to Z in even measurement years and from Z to A in odd measurement years. For example, for HEDIS 2016 (2015 measurement year), sort the list of EMs from Z to A. For HEDIS 2017 (2016 measurement year), sort the list from A to Z.  **Note:** Sort order applies to all components. For HEDIS 2016, sort all fields by descending order (i.e., last name descending, first name descending, date of birth descending, event descending). |

|  |  |
| --- | --- |
| *Step 6* | Calculate N = EM/FSS. Round *down* to a whole number.  Determine N, which is used in the formula to determine which member will start your sample.  N is calculated using the equation:  N = EM/FSS  where EM = the eligible member population (step 1) and FSS = the final sample size (step 3). |
| *Step 7* | Calculate START = (RAND × N).Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.  In October 2015, NCQA will release a Random Number (RAND) table that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.  Calculate the number from which to start drawing the final sample as follows:  START = (RAND × N)  (round per the .5 rule to the nearest whole number greater than 0), where RAND = the random number for each respective measure identified from Volume 2 *Technical Update,* released in October 2015*.* |
| *Step 8* | Select the sample, choosing every ith member using the formula:  ith member = START + [(i-1) x (EM/FSS)]  (rounding [(i-1) x (EM/FSS)] per the .5 rule to the nearest whole number greater than 0).  For i = 2,3,4, …, FSS where EM = the eligible member population (step 1). FSS = the final sample size (step 3).  Starting with the member corresponding to the number START, choose every ith member until the MRSS is met. This becomes the primary list of sampled members.  Continue choosing every ith member until the FSS is met. This set of members becomes the auxiliary list of sampled members (i.e., the oversample).  Stop when the FSS is achieved or use all members in the primary and auxiliary list.  **Note:** From step 4, if MRSS < EM ≤ FSS, sort the EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). Choose the first MRSS EMs as the primary sample and the remaining EMs as the auxiliary sample. |

If the oversample was calculated correctly, the majority of members in the auxiliary list are ultimately used to replace exclusions. All exclusions must be documented because they may be subject to audit.

|  |  |
| --- | --- |
| Oversample requests to NCQA | Any oversampling rate larger than 20 percent must be approved by NCQA annually. Organizations submit a formal request with the rationale to NCQA through the PCS system at <http://my.ncqa.org>.  NCQA provides written notification of approval or disapproval within seven business days. The organization must maintain the documentation for the HEDIS Compliance Audit™. |

|  |  |
| --- | --- |
| Oversampling methodology | For hybrid measures, the starting sample size must be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member was incorrectly identified as a diabetic through administrative data or meets exclusion criteria for the measure.  To adjust for this, divide the sample size by the percentage of charts expected to  be inappropriate for review. Suppose 10 percent of charts are expected to be inappropriate for the measure.  FSS (rounded *up* to the next whole number) = 411 + (411 × 0.10) = 452.1 (rounded *up* to 453).  The recommended methodology for substitution is:   * Replace the member’s chart with that of the first member in the auxiliary list. * Continue replacing each ineligible member with the next consecutive member of the auxiliary list.   If the initial oversample was underestimated and all auxiliary members have been exhausted without satisfying the MRSS, the organization must contact NCQA through the PCS system at <http://my.ncqa.org> to determine next steps.  Some organizations may calculate rates on their sample and oversample combined. They will have no substitutions because the oversample is included in the denominator. An organization that uses this type of reporting must include the entire oversample, regardless of its numerator compliance.  Organizations that report measures using the oversample and the sample must do so consistently across all measures.  **Note:** Many factors must be considered when determining the initial sample size and oversampling percentage—such as previous years’ data, frequency of exclusions and claims lag. |

Example 1

The eligible population for the commercial product line for *Adult BMI Assessment* is 9,000. Reduce the minimum required sample size using the commercial rate from the prior year’s HEDIS submission, which was 77 percent. Based on experience, estimate a 5 percent oversample rate. Follow the systematic sampling scheme.

|  |  |
| --- | --- |
| *Step 1* | EM = 9,000. |
| *Step 2* | From Table 2, the MRSS is 296. |
| *Step 3* | FSS = 296 + (296 × .05) = 310.8 (the next whole number *above* is 311, so FSS = 311). |
| *Step 4* | Because 9,000 > 311, go to step 5. |
| *Step 5* | Sort the list alphabetically and in this order: last name, first name, date of birth. |
| *Step 6* | N = 9,000/311 = 28. |
| *Step 7* | For this example, assume that RAND = 0.66, so START = 0.66 x 28 = 18.48.   * Rounding using the .5 rule, START = 18. * The 18th sorted member is chosen *first.* * The 2nd member chosen is the 18 + [(2-1) x (9,000/311)] = 18 + 29 = 47th sorted member, after rounding the term [(2-1) x (9,000/311)] to 29, using the .5 rule. |
|  | | * The 3rd member chosen is the 18 + [(3-1) x (9,000/311)] = 18 + 58 = 76th sorted member. * The 296th member (the last one in the primary list) is the 18 + [(296-1) x (9,000/311)] =  18 + 8,537 = 8,555th sorted member. * The last member in the auxiliary sample is the 18 + [(311-1) x (9,000/311)] = 18 + 8,971 = 8,989th sorted member. |

Example 2

The eligible member population for *Colorectal Cancer Screening* is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling scheme.

|  |  |
| --- | --- |
| *Step 1* | EM = 389. |
| *Step 2* | From Table 1, the MRSS is 411. Since 389 <411, skip to step 4. |
| *Step 3* | *Skip this step.* |
| *Step 4* | Include all 389 members in your primary list. |

Example 3

The eligible member population for *Childhood Immunization Status* is 436. The sample size will not be adjusted using this year’s administrative rate. Based on experience with this population, about 10 percent of the members from the primary sample will have to be excluded. Follow the systematic sampling scheme.

|  |  |
| --- | --- |
| *Step 1* | EM = 436. |
| *Step 2* | From Table 1, the MRSS is 411. |
| *Step 3* | FSS = 411 + (411 × .10) = 452.1 (the next whole number *above* is 453, so FSS = 453). |
| *Step 4* | Because 411 <436, skip to step 6. |
| *Step 5* | *Skip this step.* |
| *Step 6* | Sort the list and choose the first 411 as the primary list. The remaining 25 members become the auxiliary list. |

Complex Probability Sampling

|  |  |
| --- | --- |
| Organization responsibility | Properly applied, other techniques (e.g., stratified sampling, cluster sampling and other complex probability approaches) can improve precision and increase sampling efficiency. To use a probability sampling approach different from the one specified, submit a written rationale and documentation of the approach to NCQA through the PCS system at http://my.ncqa.org. The organization must demonstrate that the sampling approach is auditable and does not introduce bias against specific members. A committee of statisticians and health policy experts staffed by NCQA reviews the approach. Written notification of NCQA approval or disapproval is provided within 10 business days.  If complex sampling methods are used, report the estimated rate, in addition to any information required to perform a valid test of significance between that rate and another organization’s rate. |

|  |  |
| --- | --- |
|  | Report the sample size (if different from the HEDIS recommendation) and document the method used in the calculation (including software used, if applicable). Consult a statistician before implementing a complex sampling methodology. |

Substituting Medical Records

|  |  |  |
| --- | --- | --- |
| Acceptable circumstances for substitution: | Organizations must specify the number of substituted records. Members who are noncompliant because they refused the service or because the organization cannot access their chart may not be substituted. Unless otherwise noted in the specifications for a particular measure, members or events may not be dropped from the sample or substituted, except under the three circumstances described below. | |
| *1. Errors in sampling data* | Chart review reveals that a member or event does not meet the eligibility criteria for inclusion in the sample. Data errors can be caused by incorrect member or clinical information. Examples of valid data errors:   * A member selected for the *Childhood Immunization Status* sample is found to be 22 years old. * A member in the *Comprehensive Diabetes Care* sample has a diagnosis in the chart showing that a prescription for oral hypoglycemics was not related to diabetes. * A member in the sample for any measure has a notation entered by the deadline established for the measure, explaining the reason for the erroneous inclusion and stating the member does not have the condition.   The medical record must have evidence that a member does not meet the criteria  for the measure. A chart that does not contain a notation that substantiates or refutes the diagnosis is not evidence that the member does not have the condition being measured. | |
| *2. Optional exclusion to treatment being measured* | A member has a valid, optional exclusion to the treatment being measured. For example,a diagnosis of colorectal cancer or total colectomy is a valid, optional exclusion in the denominator for the *Colorectal Cancer Screening* measure*.*  Valid, optional exclusions are included in the measure specifications. If members meet optional exclusion criteria, exclude onlymembers for whom administrative data or medical record data do not show that the service or procedure was rendered within the appropriate period specified. The organization must verify that the exclusion occurred by the deadline established for the measure.  All exclusions must be available for auditor review. |
| *3. Employee/ dependent was selected for the sample* | An employee of the organization or the vendor, or the employee’s dependent, was selected for the sample, and the medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*. |

Hybrid Method: Three Approaches

There are three approaches to conducting the Hybrid Method; they differ only in the timing for identifying individuals in the denominator who have a valid, optional exclusion. The first two approaches allow organizations to first select the sample and then search for valid, optional exclusions. The third allows organizations to search for valid, optional exclusions on the entire eligible population prior to selecting the sample. Organizations may use any of the three approaches.

|  |  |
| --- | --- |
| **Approach 1** | Remove members that meet the optional exclusion criteria after the sample is drawn by searching the administrative systems prior to beginning medical record review. Substitute excluded members with members from the oversample population. |
| **Approach 2** | Remove members that meet the optional exclusion criteria during or after the medical record review. Substitute excluded members with members from the oversample population. |
| **Approach 3** | Remove members that meet the optional exclusion criteria from the eligible population by searching administrative systems prior to selecting the sample. |

References

Deming, W.E. On the interpretation of censuses as samples. 1941. *Journal of the American Statistical Association.* 36: 45–9.

Fleiss, L. *Statistical Methods for Rates and Proportions.* 2nd Ed. (New York: John Wiley & Sons, Inc.): 38–42.