Access/Availability of Care

Guidelines for   
Access/Availability of Care Measures

Continuous Enrollment

For some Access/Availability of Care measures, the eligible population includes individuals who were continuously enrolled for a specific period (e.g., during the measurement year). For these measures, follow the guidelines on continuous enrollment described in the *General Guidelines.*

Which Services Count

Report all services for Access/Availability of Care measures, whether or not the organization paid for them (e.g., report services paid for by a third party such as a community center, or services for which payment was denied because they were not properly authorized). Include all paid, suspended, pending and denied claims. Organizations are ultimately responsible for the quality of care they provide to members and for ensuring that certain services have been provided, even if another community practitioner provides the services.

To count services in the medical record, documentation in the medical record must indicate the date when the procedure was performed and the result or finding (when applicable).

Hybrid Methodology

Organizations that use the Hybrid Method for measures that include a hybrid specification must follow the guidelines pertaining to that method and substitution of medical records in the *Guidelines for Calculations and Sampling.*

## Adults’ Access to Preventive/Ambulatory Health Services (AAP)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

* Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
* Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Eligible Population

|  |  |  |
| --- | --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). | |
| Ages | 20 years and older as of December 31 of the measurement year. Report three age stratifications and a total rate. | |
| * 20–44 years. * 45–64 years. | * 65 years and older. * Total. |
| The total is the sum of the age stratifications. | |
| Continuous enrollment | *Medicaid and Medicare:* The measurement year.  *Commercial:* The measurement year and the two years prior to the measurement year. | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for  whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). | |
| Anchor date | December 31 of the measurement year. | |
| Benefit | Medical. | |
| Event/ diagnosis | None. | |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population (report each age stratification separately). |
| Numerator | *Medicaid and Medicare:* One or more ambulatory or preventive care visits during the measurement year.  *Commercial:* One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.  Use the following value sets to identify ambulatory or preventive care visits:   * Ambulatory Visits Value Set. * Other Ambulatory Visits Value Set. |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AAP-1/2/3: Data Elements for Adults’ Access to Preventive/Ambulatory  
Health Services

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *For each age stratification and total* |
| Numerator events by administrative data | *For each age stratification and total* |
| Reported rate | *For each age stratification and total* |
| Lower 95% confidence interval | *For each age stratification and total* |
| Upper 95% confidence interval | *For each age stratification and total* |

## Children and Adolescents’ Access to Primary Care Practitioners (CAP)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

* Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
* Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 12 months–19 years as of December 31 of the measurement year. Report four age stratifications:   * 12–24 months as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 1, 2013 and December 31, 2014). * 25 months–6 years as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between January 1, 2009 and November 30, 2013). * 7–11 years as of December 31 of the measurement year. * 12–19 years as of December 31 of the measurement year. |
| Continuous enrollment | *For 12–24 months, 25 months–6 years:* The measurement year.  *For 7–11 years, 12–19 years:* The measurement year and the year prior to the measurement year. |
| Allowable gap | *For 12–24 months, 25 months–6 years:* No more than one gap in enrollment of up to 45 days during the measurement year.  *For 7–11 years, 12–19 years:* No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.  To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment. |

|  |  |
| --- | --- |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | *For 12–24 months, 25 months–6 years:* One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.  *For 7–11 years, 12–19 years:* One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.  Count all members who had an ambulatory or preventive care visit to *any* PCP. Exclude specialist visits. |

*Note*

* *Refer to Appendix 3 for the definition of* PCP*.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CAP-1/2: Data Elements for Children and Adolescents’ Access to  
Primary Care Practitioners

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *For each age stratification* |
| Numerator events by administrative data | *For each age stratification* |
| Reported rate | *For each age stratification* |
| Lower 95% confidence interval | *For each age stratification* |
| Upper 95% confidence interval | *For each age stratification* |

## Annual Dental Visit (ADV)

Summary of Changes to HEDIS 2016

* Revised the upper age limit to 20 years of age to align with the EPSDT services guidelines, which include dental coverage for children under 21 who are enrolled in Medicaid.

Description

The percentage of members 2–20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization’s Medicaid contract.

Eligible Population

|  |  |  |
| --- | --- | --- |
| Product line | Medicaid. | |
| Ages | 2–20 years as of December 31 of the measurement year. Report six age stratifications and a total rate. | |
| * 2–3 years. * 4–6 years. * 7–10 years. * 11–14 years. | * 15–18 years. * 19–20 years. * Total. |
| The total is the sum of the age stratifications. | |
| Continuous enrollment | The measurement year. | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). | |
| Anchor date | December 31 of the measurement year. | |
| Benefit | Dental. | |
| Event/ diagnosis | None. | |

**Note:** Visits for many 1-year-olds will be counted because the specification includes children whose second birthday occurs during the measurement year.

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | One or more dental visits (Dental Visits Value Set) with a dental practitioner during the measurement year. |

*Note*

* *Refer to Appendix 3 for the definition of* dental practitioner.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ADV-1: Data Elements for Annual Dental Visit

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *For each age stratification and total* |
| Numerator events by administrative data | *For each age stratification and total* |
| Reported rate | *For each age stratification and total* |
| Lower 95% confidence interval | *For each age stratification and total* |
| Upper 95% confidence interval | *For each age stratification and total* |

## Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Summary of Changes to HEDIS 2016

* Added value sets to identify acute and nonacute inpatient discharges for step 1 of the event/diagnosis and for both numerators.

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

* *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
* *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Definitions

|  |  |
| --- | --- |
| Intake Period | January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD. |
| Index Episode | The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit during the Intake Period with a diagnosis of AOD.  *For ED visits that result in an inpatient stay*, the inpatient stay is the Index Episode. |
| IESD | Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.  *For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay),* the IESD is the date of service.  *For an inpatient (acute or nonacute) event,* the IESD is the date of discharge.  *For an ED visit that results in an inpatient event,* the IESD is the date of the inpatient discharge.  *For direct transfers*, the IESD is the discharge date from the last admission. |
| Negative Diagnosis History | A period of 60 days (2 months) before the IESD when the member had no claims/ encounters with a diagnosis of AOD dependence.  *For an inpatient event,* use the admission date to determine the Negative Diagnosis History.  *For ED visits that result in an inpatient event,* use the ED date of service to determine the Negative Diagnosis History.  *For direct transfers,* use the first admission to determine the Negative Diagnosis History. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Age | 13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate.   * 13–17 years. * 18+ years. * Total.   The total is the sum of the age stratifications. |
| Continuous enrollment | 60 days (2 months) prior to the IESD through 44 days after the IESD (105 total days). |
| Allowable gap | None. |
| Anchor date | None. |
| Benefits | Medical and chemical dependency (inpatient and outpatient).  **Note:** Members with detoxification-only chemical dependency benefits do not meet these criteria. |
| Event/ diagnosis | New episode of AOD during the Intake Period.  Follow the steps below to identify the eligible population, which is the denominator for both rates. |
| *Step 1* | Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:   * An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria: * IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set. * IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set. * IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set. * A detoxification visit (Detoxification Value Set). * An ED visit (ED Value Set) with a diagnosis of AOD (AOD Dependence Value Set). * An acute or nonacute inpatient discharge with either a diagnosis of AOD (AOD Dependence Value Set) or an AOD procedure code (AOD Procedures Value Set). To identify acute and nonacute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.   *For members with more than one episode of AOD,* use the first episode.  *For members whose first episode was an ED visit that resulted in an inpatient event,* use the inpatient discharge.  Select the IESD. |

|  |  |
| --- | --- |
| *Step 2* | Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (AOD Dependence Value Set) during the 60 days (2 months) before the IESD.  *For an inpatient IESD,* use the admission date to determine the 60-day Negative Diagnosis History period.  *For an ED visit that results in an inpatient event*, use the ED date of service to determine the 60-day Negative Diagnosis History period. |
| *Step 3* | Calculate continuous enrollment. Members must be continuously enrolled for 60 days  (2 months) before the IESD through 44 days after the IESD (105 total days), with no gaps. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator |  |
| *Initiation of AOD Treatment* | Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the IESD.  *If the Index Episode was an inpatient discharge,* the inpatient stay is considered initiation of treatment and the member is compliant.  *If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit,* the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a diagnosis of AOD, on the IESD or in the 13 days after the IESD (14 total days). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:   * An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.  * IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set. * IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set. * IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.   Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.  Exclude the member from the denominator for both indicators *(Initiation of AOD Treatment and Engagement of AOD Treatment)* if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year. |

|  |  |
| --- | --- |
| *Engagement of AOD Treatment* | Identify all members who meet the following criteria:   * Numerator compliant for the *Initiation of AOD Treatment* numerator ***and*** * Two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria: * An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute or nonacute inpatient admissions:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.  * IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set. * IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set. * IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.   *For members who initiated treatment via an inpatient admission,* the 29-day period for the two engagement visits begins the day after discharge.  Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying engagement of AOD treatment.  The time frame for engagement, which includes the initiation event, is 30 total days. |

*Note*

* *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and   
Other Drug Dependence Treatment

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (administrative) | ✓ |
| Eligible population | *For each age stratification and total* |
| Numerator events by administrative data | *Each rate, for each age stratification and total* |
| Reported rate | *Each rate, for each age stratification and total* |
| Lower 95% confidence interval | *Each rate, for each age stratification and total* |
| Upper 95% confidence interval | *Each rate, for each age stratification and total* |

## Prenatal and Postpartum Care (PPC)

Summary of Changes to HEDIS 2016

* Deleted the use of infant claims to identify deliveries.
* Clarified the tests that must be included to meet criteria for an obstetric panel in the hybrid specification.

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

* *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.
* *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Age | None specified. |
| Continuous enrollment | 43 days prior to delivery through 56 days after delivery. |
| Allowable gap | No allowable gap during the continuous enrollment period. |
| Anchor date | Date of delivery. |
| Benefit | Medical. |
| Event/ diagnosis | *Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Include women who delivered in any setting.  *Multiple births.* Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.  Follow the steps below to identify the eligible population, which is the denominator for both rates. |
| *Step 1* | Identify deliveries. Identify all women with a delivery (Deliveries Value Set) between November 6 of the year prior to the measurement year and November 5 of the measurement year. |
| *Step 2* | Exclude non-live births (Non-live Births Value Set). |
| *Step 3* | Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator |  |
| *Timeliness of Prenatal Care* | A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.  *Include only visits that occur while the member was enrolled.*  Follow the steps below to identify the numerator. |
| *Step 1* | Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.  For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3. |
| *Step 2* | Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester.*  For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3. |
| *Step 3* | Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).  *For women whose last enrollment started on or between 219 and 279 days before delivery,* proceed to step 4.  *For women whose last enrollment started less than 219 days before delivery,* proceed to step 5. |
| *Step 4* | Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit between the last enrollment start date and 176 days before delivery. |
| *Step 5* | Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit within 42 days after enrollment. |

Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester

|  |  |
| --- | --- |
| Decision Rule 1 | Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:   * A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated). * A visit for prenatal care (Stand Alone Prenatal Visits Value Set). |
| Decision Rule 2 | Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN or other prenatal care practitioner, meet criteria:   * A prenatal visit (Prenatal Visits Value Set) with an obstetric panel (Obstetric Panel Value Set). * A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set). * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set). * A prenatal visit (Prenatal Visits Value Set) with all of the following: * Toxoplasma (Toxoplasma Antibody Value Set). * Rubella (Rubella Antibody Value Set). * Cytomegalovirus (Cytomegalovirus Antibody Value Set). * Herpes simplex (Herpes Simplex Antibody Value Set). * A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO (ABO Value Set). * A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and Rh (Rh Value Set). * A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set). |
| Decision Rule 3 | Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:   * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an obstetric panel (Obstetric Panel Value Set). * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set). * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following: * Toxoplasma (Toxoplasma Antibody Value Set). * Rubella (Rubella Antibody Value Set). * Cytomegalovirus (Cytomegalovirus Antibody Value Set). * Herpes simplex (Herpes Simplex Antibody Value Set). |

|  |  |
| --- | --- |
|  | * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set). * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set). * A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set). * A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with an obstetrical history. * A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with risk assessment and counseling/education.   **Note:** For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits Value Set) **and** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim. |

Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester

Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

* A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
* A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
* A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
* A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

**Note:** For criteria that require a prenatal visit code (Prenatal Visits Value Set) **and** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.



|  |  |
| --- | --- |
| *Postpartum Care* | A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:   * A postpartum visit (Postpartum Visits Value Set). * Cervical cytology (Cervical Cytology Value Set). * A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).   ***Note*:** *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.* |

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year’s lowest product line-specific administrative rate of these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care* or the prior year’s lowest audited product line-specific rate for these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care*. |
| Numerator |  |
| *Timeliness of Prenatal Care* | A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| Medical record | Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.   * A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used). * Evidence that a prenatal care procedure was performed, such as: * Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or*** * TORCH antibody panel alone, ***or*** * A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or*** * Echography of a pregnant uterus. * Documentation of LMP or EDD in conjunction with *either* of the following. * Prenatal risk assessment and counseling/education. * Complete obstetrical history.   **Note:** For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy. |
| *Postpartum Care* | A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |

|  |  |
| --- | --- |
| Medical record | Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.   * Pelvic exam. * Evaluation of weight, BP, breasts and abdomen. * Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component. * Notation of postpartum care, including, but not limited to: * Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.” * A preprinted “Postpartum Care” form in which information was documented during the visit. |

*Note*

* *For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental*.
* *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
* *For women whose last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
* *For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
* *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.*
* *The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. The LMP may not be used to determine the first trimester.*
* *A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.*
* *The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.*
* *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
* *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal practitioners*.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PPC-1/2: Data Elements for Prenatal and Postpartum Care

|  |  |  |
| --- | --- | --- |
|  | **Administrative** | **Hybrid** |
| Measurement year | *For each of the 2 rates* | *For each of the 2 rates* |
| Data collection methodology (Administrative or Hybrid) | *For each of the 2 rates* | *For each of the 2 rates* |
| Eligible population | *For each of the 2 rates* | *For each of the 2 rates* |
| Number of numerator events by administrative data in eligible population (before exclusions) |  | *For each of the 2 rates* |
| Current year’s administrative rate (before exclusions) |  | *For each of the 2 rates* |
| Minimum required sample size (MRSS) or other sample size |  | *For each of the 2 rates* |
| Oversampling rate |  | *For each of the 2 rates* |
| Final sample size (FSS) |  | *For each of the 2 rates* |
| Number of numerator events by administrative data in FSS |  | *For each of the 2 rates* |
| Administrative rate on FSS |  | *For each of the 2 rates* |
| Number of original sample records excluded because of valid data errors |  | *For each of the 2 rates* |
| Number of employee/dependent medical records excluded |  | *For each of the 2 rates* |
| Records added from the oversample list |  | *For each of the 2 rates* |
| Denominator |  | *For each of the 2 rates* |
| Numerator events by administrative data | *For each of the 2 rates* | *For each of the 2 rates* |
| Numerator events by medical records |  | *For each of the 2 rates* |
| Reported rate | *For each of the 2 rates* | *For each of the 2 rates* |
| Lower 95% confidence interval | *For each of the 2 rates* | *For each of the 2 rates* |
| Upper 95% confidence interval | *For each of the 2 rates* | *For each of the 2 rates* |

## Call Answer Timeliness (CAT)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The percentage of calls received by the organization’s Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Definitions

|  |  |
| --- | --- |
| Call | Telephone contact initiated by an external caller connects with the organization’s Member Services call center. For calls transferred from other parts of the organization’s telephone system, measure time from after the call is transferred into the Member Services call center, the member chooses the option to speak to a Member Services representative and is placed in the call queue. |
| Member Services operating hours | Hours of live call-center operation indicated by membership materials (e.g., ID card, summary organization descriptions, enrollment materials). |
| Member Services representative | An employee at the organization’s Member Services call center responsible for answering calls regarding enrollment, benefits and claims processing. |
| Member Services call center | An entity within the organization or under contract with the organization that is responsible for handling the organization’s network Member Services inquiries regarding enrollment, benefits and claims processing. |
| Queue | A sequence of calls waiting to be handled by the Member Services representative. The wait time on a queued call is calculated by Automatic Call Distribution (ACD), which tracks incoming calls. |

Calculation

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately).  **Note:** Organizations that use the same systems, policies and procedures and staff to answer calls for all product lines may report the same rate for all product lines if they cannot report data by individual product line. |
| Denominator | The number of calls received by the Member Services call centers (during hours of operation) during the measurement year, where the member called directly into Member Services or selected a Member Services option and was put in the call queue. Exclude calls to a benefits contractor (e.g., mental health, dental, vision, pharmacy) that uses its own call center. |
| Numerator | The number of calls answered by a live voice within 30 seconds.  Time measured begins when the member is placed in the call queue to wait to speak with a Member Services representative.  **Note:** Calls abandoned within 30 seconds and calls sent directly to voicemail remain in the measure and are noncompliant for the numerator. |

|  |  |
| --- | --- |
| Formulas | *For an organization with one call center that answers all the organization’s calls and has the organization as its only client,* report the measure as specified.  *For an organization with one call center that answers all the* *organization’s calls and has multiple clients,* if the call center is unable to report timeliness data for the specific organization, report timeliness for the entire volume of calls the center handles.  *For an organization with multiple call centers, each of which answers a portion of the total calls for the organization and has the organization as its only client,* report the measure as a weighted average (see the formula below). |
| ***Definitions*** | Let N1 = The total number of Member Services calls received by call center 1.  Let N2 = The total number of Member Services calls received by call center 2.  Let PCAT1 = The rate for the *Call Answer Timeliness* HEDIS measure for call center 1.  Let PCAT2 = The rate for the *Call Answer Timeliness* HEDIS measure for call center 2. |
| ***Set-up calculations*** | Let W1 = The weight assigned to call center 1. This result is calculated by the formula W1 = N1/(N1+N2).  Let W2 = The weight assigned to call center 2. This result is calculated by the formula W2 = N2/(N1+N2). |
| ***Pooled analysis*** | The pooled result from the two rates is calculated as:  PCAT pooled = W1\*PCAT1+ W2\*PCAT2 |

*Note*

* *If an organization blocks calls during peak call periods (or regular business hours) by immediately giving members a busy signal and keeping the calls from reaching the call queue, the auditor assesses the percentage of blocked calls and its impact on the measure.*
* *If an organization’s phone system tracks members’ wait time and can call members back when it is their turn in the queue, include the call in the denominator; however, it will probably be noncompliant for the numerator because it is unlikely that the start of the call-back process would occur in the 30-second time frame.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CAT-1/2/3: Data Elements for Call Answer Timeliness

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

## Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Definitions

|  |  |
| --- | --- |
| Intake Period | January 1 through December 1 of the measurement year. |
| IPSD | Index Prescription Start Date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History. |
| Negative Medication History | A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions. |

Eligible Population

|  |  |  |
| --- | --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). | |
| Ages | 1–17 years as of December 31 of the measurement year. Report three age stratifications and a total rate: | |
| * 1–5 years. * 6–11 years. | * 12–17 years. * Total. |
| The total is the sum of the age stratifications. | |
| Continuous enrollment | 120 days (4 months) prior to the IPSD through 30 days after the IPSD. | |
| Allowable gap | None. | |
| Anchor date | IPSD. | |
| Benefit | Medical, mental health, pharmacy. | |
| Event | Follow the steps below to identify the eligible population. | |
| *Step 1* | Identify all members in the specified age range who were dispensed an antipsychotic medication (Table APP–A) during the Intake Period. | |
| *Step 2* | Test for Negative Medication History. For each member identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History. | |

|  |  |
| --- | --- |
| *Step 3* | Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. |
| *Step 4: Required exclusions* | Exclude members for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria:   * At least one acute inpatient encounter with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria: * BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Stand Alone Acute Inpatient Value Set ***with*** Bipolar Disorder Value Set. * BH Stand Alone Acute Inpatient Value Set ***with*** Other Psychotic Disorders Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Bipolar Disorder Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Other Psychotic Disorders Value Set. * At least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set. * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Bipolar Disorder Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Bipolar Disorder Value Set. * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Other Psychotic Disorders Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Other Psychotic Disorders Value Set. |

Table APP-A. Antipsychotic Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| First-generation antipsychotic medications | * Chlorpromazine HCL * Fluphenazine HCL * Fluphenazine decanoate * Haloperidol * Haloperidol decanoate * Molindone HCL | * Perphenazine * Pimozide * Haloperidol lactate * Loxapine HCL * Loxapine succinate | * Thioridazine HCL * Thiothixene * Trifluoperazine HCL |
| Second-generation antipsychotic medications | * Aripiprazole * Clozapine * Iloperidone * Lurasidone * Olanzapine | * Olanzapine pamoate * Paliperidone * Paliperidone palmitate * Quetiapine fumarate * Risperidone | * Risperidone microspheres * Ziprasidone HCL * Ziprasidone mesylate |
| Combinations | * Olanzapine-fluoxetine HCL (Symbyax) | * Perphenazine-amitriptyline HCL (Etrafon, Triavil [various]) | |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD. |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APP-1/2: Data Elements Access to Psychosocial Care for Children and   
Adolescents on Antipsychotics

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | For each age stratification and total |
| Number of required exclusions | For each age stratification and total |
| Numerator events by administrative data | For each age stratification and total |
| Reported Rate | For each age stratification and total |
| Lower 95% confidence interval | For each age stratification and total |
| Upper 95% confidence interval | For each age stratification and total |

**Experience of Care**

Experience of Care

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

Summary of Changes to HEDIS 2016

* This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures*.

Description

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

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Health Plan.
3. Rating of Personal Doctor.
4. Rating of Specialist Seen Most Often.

Seven composite scores summarize responses in key areas:

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

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

1. Health Promotion and Education.
2. Coordination of Care.

**Note:** Medicare member experience with the organization is assessed through the Medicare CAHPS survey. This measure is administered by the Centers for Medicare & Medicaid Services (CMS) on behalf of Medicare Advantage (MA) plans.

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

Summary of Changes to HEDIS 2016

* This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.*

Description

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

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Health Plan.
3. Rating of Personal Doctor.
4. Rating of Specialist Seen Most Often.

Five composite scores summarize responses in key areas:

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

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

1. Health Promotion and Education.
2. Coordination of Care.

## Children With Chronic Conditions (CCC)

Summary of Changes to HEDIS 2016

* This measure is collected using survey methodology. Detailed specifications and summary of changes for the measure are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.*

Description

This measure provides information on parents’ experience with their child’s commercial or Medicaid organization for the population of children with chronic conditions. Three composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions:

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

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

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