Health Plan Descriptive Information

## Board Certification (BCR)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The percentage of the following physicians whose board certification is *active* as of December 31 of the measurement year:

|  |  |  |
| --- | --- | --- |
| * Family medicine physicians. * Internal medicine physicians. | * Pediatricians. * OB/GYN physicians. | * Geriatricians. * Other physician specialists. |

**Board certification** refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association. Report each product separately as of December 31 of the measurement year.

|  |  |  |
| --- | --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). | |
| Physicians | This measure applies to independent physicians or group of physicians who provide care for members. | |
| *Organizations must* include: | * Physicians who have an independent relationship with the organization. An **independent relationship** exists when an organization selects and directs its members to see a specific physician or group of physicians.An independent relationship is not synonymous with an “independent contract.” Physicians may contract with the organization directly or indirectly (e.g., physicians contract with an IPA). * Physicians who are listed in the organization’s directory. * Physicians who see members outside of the inpatient hospital setting or outside of free-standing facilities. * Physicians who are hospital based and who see members as a result of their independent relationship with the organization; for example: * Anesthesiologists with pain management practices. * Hospital-based cardiologists. * Hospital-based faculty (who meet the criteria above). | |
| *Organizations must* exclude: | * Physicians who practice exclusively within the inpatient hospital setting and who provide care for members only as a result of members being directed to the hospital; for example: | |
| * Pathologists. * Radiologists. * Anesthesiologists. | * Hospitalists. * Neonatologists. * ED physicians. |
|  | * Chiropractors. * Podiatrists. | |

|  |  |
| --- | --- |
|  | * Physicians who practice exclusively within free-standing facilities and who provide care for members only as a result of members being directed to the facility; for example: * Mammography centers. * Urgent care centers. * Surgicenters. * Dentists who do not provide care under the organization’s medical benefits; for example: * Endodontists. * Oral surgeons. * Periodontists. * Dentists who provide primary dental care under a dental plan or rider. |
| Categories | Use Table BCR-A to identify physicians. |

Table BCR-A: Identifying Physicians

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Product Line | Family Medicine | Internal Medicine | Pediatricians | OB/GYN | Geriatricians | Other Physician Specialists |
| Commercial | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicaid | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Definitions

|  |  |
| --- | --- |
| Family medicine physician | A physician who provides preventive and diagnostic health care services for individuals and families. Report general practitioners in the *Family Medicine* category. |
| Internal medicine physician | A physician who provides long-term and comprehensive care and manages common and complex illness of adolescents, adults and the elderly. |
| Pediatrician | A physician who provides preventive and diagnostic health care services for infants, children and adolescents. |
| OB/GYN physician | A physician who provides medical and surgical care relating to the female reproductive system and associated disorders. |
| Geriatrician | A family medicine or internal medicine physician who has special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly. |
| Other physician specialist | Any other physician specialist or physician subspecialist not mentioned above. |

Calculation of Board Certification

|  |  |
| --- | --- |
| Number of physicians in each practice area | Refer to Table BCR-1/2/3. For each product line, identify the number of physicians (with active or inactive board certification) in each practice area, by type and number, with whom the organization contracted as of December 31 of the measurement year.  Physicians are assumed to practice in the clinical area or areas in which they are listed in an organization’s *internal* directory or classification system. Count physicians listed under more than one category as many times as they are listed, and in each area of practice. For example, count a family medicine physician who also practices as a geriatrician in both the *Family Medicine* category and the *Geriatrician* category.  Physicians do not have to be listed in the organization’s external provider directory to be included in the measure. |
| Board certification number | Count the number of physicians in each practice area with active board certification. For example, to be reported as a board-certified geriatrician, a physician must have a specialty certification in geriatric medicine.  *Count as board certified:* A physician with recent board certification who has not completed a residency/fellowship.  *Do not count as board certified:* A physician for whom there is confirmation by the appropriate certifying body that the physician is eligible for and has applied to a board-certification program. |
| Board certification percentage | For each type of physician, calculate the percentage whose board certification is active by dividing the board certification number by the number of physicians in each practice area.  First, determine the number of areas of specialization and board certification status for each physician; then determine how to count them in the denominator (i.e., number of physicians in each practice area) and the numerator (i.e., number of active board-certified physicians) of the calculation.  *A physician with only one specialty who is not board certified in the specialty* counts as 1 in the denominator and 0 in the numerator.  *A physician with only one specialty whose board certification is active in the specialty* counts as 1 in the denominator and 1 in the numerator.  *A physician with more than one specialty counts as 1 in the denominator for each specialty.* Count in the numerator the number of specialty areas in which the physician has active board certification. |
| *Example* | A physician listed under both hematology and medical oncology counts as 2 in the denominator for *Other Physician Specialists*.  *A physician whose board certification is active in both hematology and medical oncology* counts as 2 in the numerator.  *A physician whose board certification is active in only one of these two areas* counts as 1 in the numerator.  *A physician whose board certification is not active in either area* counts as 0 in the numerator. |

*Note*

* *The physician definitions for this measure are based on the American Board of Medical Specialties (ABMS) definitions for physician specialties.*
* *The numbers in the column “Number of Physicians in Each Practice Area” might not be the same as the* *organization’s actual number of physicians because some physicians might practice in more than one area and will be counted in the denominators of several percentages.*
* *Reporting in the "Pediatrician” category is expected to be rare for the Medicare product line.*

Table BCR-1/2/3: Board Certification

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Physician | Number of Physicians in  Each Practice Area | Active Board Certification | |
| Number | Percentage |
| Family medicine |  |  |  |
| Internal medicine |  |  |  |
| Pediatrician |  |  |  |
| OB/GYN |  |  |  |
| Geriatrician |  |  |  |
| Other physician specialist |  |  |  |

## Enrollment by Product Line (ENP)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The total number of members enrolled in the product line, stratified by age and gender.

Calculations

|  |  |
| --- | --- |
| Product lines | Report the following tables for each applicable product line, stratified by age and gender:   * Table ENP-1a Total Medicaid. * Table ENP-1b Medicaid/Medicare Dual-Eligibles. * Table ENP-1c Medicaid—Disabled. * Table ENP-1d Medicaid—Other Low Income. * Table ENP-2 Commercial—by Product or Combined HMO/POS. * Table ENP-3 Medicare. |
| Member months | For each product line, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* in *Guidelines for Use of Services Measures* for more information*.* |

Medicaid Beneficiary Category Assignment

The organization assigns Medicaid members to beneficiary categories based on a state-provided list of all payment-rate categories used by the state and the organization in their contract. The state should use the algorithm provided below (described in Categories A–D) to assign each payment-rate category it uses to one of the three beneficiary categories, and provide this categorization of rate categories to the organization. The organization should then report Medicaid members using the state’s categories. The state should classify beneficiaries according to the hierarchy below, beginning with Category A.

This algorithm addresses variables most likely to influence utilization patterns:

* The presence of a Medicare benefit.
* The presence of a disability.
* A restricted benefits package:
* This last group is not reported separately because of its anticipated small numbers, but is included in the total count of Medicaid members.

|  |  |
| --- | --- |
| Category A |  |
| *Total Medicaid—Table ENP-1a* | Include all Medicaid members enrolled in the organization who receive Medicaid benefits, including those who receive a restricted benefits package smaller in scope than the other Medicaid members enrolled in the same organization.  A **restricted benefits package** meets one of the following criteria:   * Pregnant women whose Medicaid eligibility is based on poverty-related coverage and whose Medicaid benefits are restricted to services related to pregnancy and other conditions that may complicate pregnancy. * Other members whose benefits are limited (e.g., emergency services).   Include members in either of these two groups in this category. Total Medicaid also includes the sum of Categories B–D.  Go to Category B if a member does not meet the criteria for Category A. |
| Category B |  |
| *Medicaid/Medicare Eligible— Table ENP-1b* | Include all Medicaid members (including children) entitled both to the state’s full Medicaid benefit for which the organization has contracted *and* to Medicare Part  A or B benefits.  Qualified Medicare Beneficiaries (QMB), other specified low-income Medicare beneficiaries, Qualified Disabled and Working Individuals (QDWI) and Qualified COBRA Continuation Beneficiaries whose Medicaid benefit is limited to the payment of a premium for Medicare or commercial coverage are not included in this category because they do not receive the Medicaid benefit package.  Go to Category C if a member does not meet the criteria for Category B. |
| Category C |  |
| *Disabled— Table ENP-1c* | Include all Medicaid members who do not meet the criteria for Category B *and* who receive Medicaid benefits wholly or in part because of physical or mental disability. This category includes supplemental security income (SSI) beneficiaries, SSI-related beneficiaries and other disabled, medically needy beneficiaries.  Go to Category D if a Medicaid member does not meet the criteria for Category B and does not receive Medicaid based on a disability (Category C). |
| Category D |  |
| *Other Low Income— Table ENP-1d* | Include all nondisabled, non-Medicare, low-income Medicaid members who do not meet the criteria for Category B or Category C. |

*Note*

* *NCQA recognizes that most* *organizations do not serve Medicaid beneficiaries in all categories. Not many serve the few individuals with a restricted benefits package (see Category A).*

Table Instructions

Use Table ENP-1/2/3 to report the organization’s enrollment by product line for the most recent calendar year, based on member months.

|  |  |
| --- | --- |
| Medicaid  (Tables 1a-1d) | *Use the definitions* in *Medicaid Beneficiary Category Assignment* to assign Medicaid beneficiaries to Categories A–D.  *Report* the number of member months by age and gender, including subtotals, by eligibility category.  *Calculate the subtotal percentages* in each eligibility category by dividing the total subtotal member months into total member months by gender (e.g., [X member months of enrolled Medicaid disabled males, 0–19/Y member months for all Medicaid disabled males, 0–90+ and age unknown] x 100 = Z percent of member months for Medicaid disabled males, 0–19 years of all male Medicaid disabled member months). |
| Commercial (Table 2) | *Report* the number of member months by age and gender, including subtotals, for the commercial product line.  *Calculate the subtotal percentages* in the commercial product line by dividing the total subtotal member months into total member months by gender (e.g., [X member months of enrolled commercial product males, 0–19/Y member months for all commercial product males, 0–90+ and age unknown] x 100 = Z percent of member months for commercial product males, 0–19 years of age of all male commercial product member months). |
| Medicare (Table 3) | *Report* the number of member months by age and gender, including subtotals,for the Medicare product line.  *Calculate the subtotal percentages* in the Medicare product line by dividing the total subtotal member months into total member months by gender (e.g., [X member months of enrolled Medicare males 0–19/Y member months for all Medicare males, 0–90+ and age unknown] x 100 = Z percent of member months for Medicare males, 0–19 years of age of all male Medicare member months). |

Table ENP-1/2/3: Member Months of Enrollment by Product Line

|  |  |  |  |
| --- | --- | --- | --- |
| Age | Male | Female | Total |
| <1 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1-4 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5-9 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10-14 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 15-17 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 18-19 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 0-19 Subtotal: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 0-19 Subtotal (%): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% |
| 20-24 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 25-29 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 30-34 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 35-39 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 40-44 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 20-44 Subtotal: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 20-44 Subtotal (%): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% |
| 45-49 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 50-54 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 55-59 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 60-64 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 45-64 Subtotal: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 45-64 Subtotal (%): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% |
| 65-69 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 70-74 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 75-79 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 80-84 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 85-89 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ≥90 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ≥65 Subtotal: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ≥65 Subtotal (%): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% |
| Age unknown | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Total*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Enrollment by State (EBS)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The number of members enrolled as of December 31 of the measurement year, by state.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Anchor Date | December 31 of the measurement year. |

Calculation

Calculate enrollment by state using the address on record for members on December 31 of the measurement year, to be determined according to the organization’s administrative processes. Report by categories (states and territories) listed in Table EBS-1/2/3. If the member’s address is unknown or does not match, report as “Other.” If a child’s address is not captured, the organization may use the address of the policyholder, parent or caretaker.

Report on total unduplicated membership as of December 31 of the measurement year. If the organization assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to avoid double-counting members.

Table EBS-1/2/3: Member Enrollment by State

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| State | Number | State | Number | State | Number |
| Alabama | \_\_\_\_\_\_\_\_\_\_\_\_ | Michigan | \_\_\_\_\_\_\_\_\_\_\_\_ | Utah | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Alaska | \_\_\_\_\_\_\_\_\_\_\_\_ | Minnesota | \_\_\_\_\_\_\_\_\_\_\_\_ | Vermont | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Arizona | \_\_\_\_\_\_\_\_\_\_\_\_ | Mississippi | \_\_\_\_\_\_\_\_\_\_\_\_ | Virginia | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Arkansas | \_\_\_\_\_\_\_\_\_\_\_\_ | Missouri | \_\_\_\_\_\_\_\_\_\_\_\_ | Washington | \_\_\_\_\_\_\_\_\_\_\_\_ |
| California | \_\_\_\_\_\_\_\_\_\_\_\_ | Montana | \_\_\_\_\_\_\_\_\_\_\_\_ | West Virginia | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Colorado | \_\_\_\_\_\_\_\_\_\_\_\_ | Nebraska | \_\_\_\_\_\_\_\_\_\_\_\_ | Wisconsin | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Connecticut | \_\_\_\_\_\_\_\_\_\_\_\_ | Nevada | \_\_\_\_\_\_\_\_\_\_\_\_ | Wyoming | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Delaware | \_\_\_\_\_\_\_\_\_\_\_\_ | New Hampshire | \_\_\_\_\_\_\_\_\_\_\_\_ | American Samoa | \_\_\_\_\_\_\_\_\_\_\_\_ |
| District of Columbia | \_\_\_\_\_\_\_\_\_\_\_\_ | New Jersey | \_\_\_\_\_\_\_\_\_\_\_\_ | Fed. Sts. of Micronesia | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Florida | \_\_\_\_\_\_\_\_\_\_\_\_ | New Mexico | \_\_\_\_\_\_\_\_\_\_\_\_ | Guam | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Georgia | \_\_\_\_\_\_\_\_\_\_\_\_ | New York | \_\_\_\_\_\_\_\_\_\_\_\_ | Cmnwlth. of N. Marianas | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Hawaii | \_\_\_\_\_\_\_\_\_\_\_\_ | North Carolina | \_\_\_\_\_\_\_\_\_\_\_\_ | Puerto Rico | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Idaho | \_\_\_\_\_\_\_\_\_\_\_\_ | North Dakota | \_\_\_\_\_\_\_\_\_\_\_\_ | Virgin Islands | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Illinois | \_\_\_\_\_\_\_\_\_\_\_\_ | Ohio | \_\_\_\_\_\_\_\_\_\_\_\_ | Other | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Indiana | \_\_\_\_\_\_\_\_\_\_\_\_ | Oklahoma | \_\_\_\_\_\_\_\_\_\_\_\_ | ***Total:*** | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Iowa | \_\_\_\_\_\_\_\_\_\_\_\_ | Oregon | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Kansas | \_\_\_\_\_\_\_\_\_\_\_\_ | Pennsylvania | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Kentucky | \_\_\_\_\_\_\_\_\_\_\_\_ | Rhode Island | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Louisiana | \_\_\_\_\_\_\_\_\_\_\_\_ | South Carolina | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Maine | \_\_\_\_\_\_\_\_\_\_\_\_ | South Dakota | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Maryland | \_\_\_\_\_\_\_\_\_\_\_\_ | Tennessee | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Massachusetts | \_\_\_\_\_\_\_\_\_\_\_\_ | Texas | \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

## Language Diversity of Membership (LDM)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |

Calculations

|  |  |
| --- | --- |
| Table instructions | Report the number and percentage of members for whom the organization has information about spoken language preferred for health care and for written materials for each product population. If any of these data are unknown or unavailable, report as “Unknown.”  Report total unduplicated membership during the measurement year. |
| Data source | Report the percentage of members for whom data have been collected from each data source for each of the three indicators: spoken language preferred for health care, preferred language for written materials, and other language needs. Data sources include data the organization has collected directly from its members (e.g. enrollment forms, surveys, health risk assessments, disease management registries) or from enrollment information furnished by state Medicaid agencies or other third-party sources. |
| Spoken language preferred for health care | Enter the percentage of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for preferred language for health care, unknown and declined in Table LDM-B-1/2/3.  **Data collection guidance.** This information can be gathered through questions such as:  *What language do you feel most comfortable speaking with your clinician or health care provider?*  *What language do you feel most comfortable speaking with your doctor or nurse?*  *In what language do you prefer to receive your medical care?*  *In what language do you want us to speak to you?*  *What language do you prefer to speak when you come to the medical center?*  *What language do you feel most comfortable speaking?* |

|  |  |
| --- | --- |
| Preferred language for written materials | Enter the percentage of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for preferred language for written materials, unknown and declined in Table LDM-B-1/2/3.  **Data collection guidance.** This information can be gathered through questions such as:  *In which language would you feel most comfortable reading health care information?*  *In which language would you feel most comfortable reading medical or health care instructions?*  *What language should we write [to] you in?*  *What is your preferred written language?*  *In what language do you prefer to read health-related materials?*  *What language do you prefer for written materials?* |
| Other language needs | Enter the percentage of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for any “Other Language Needs,” “Unknown” and “Declined” in Table LDM-B-1/2/3.  **Data collection guidance.** This category captures data collected from questions that cannot be mapped to any of the categories above, such as:  *What is the primary language spoken at home?* |

*Note*

* *It is considered “best practice” to collect data directly from members because this method reflects members’ self-identification. If data collected directly are not available, third-party data collected directly by another entity (e.g., the state or CMS) are desired.*
* *Indirect data may not be used when reporting this measure*. *Table LDM-B-1/2/3 is reported using the total unduplicated count of members; report any data not collected using a direct method in the “Unknown” category.*
* *When multiple sources of data are used, there may be disagreements in the data collected. In such a case, use a logical process that considers the relative accuracy of each data source to resolve the difference. For example, one way to use a stepwise logic for any data disagreement is to:*
* *Select specific categories over non-specific categories.*
* *Select the most frequently or consistently reported category over less frequently reported categories.*
* *Data sources might also be prioritized after an analysis of the reliability of the different data sources.*

Table LDM-A-1/2/3: Percentage of Members With Language Value From Each Data Source

|  |  |  |  |
| --- | --- | --- | --- |
|  | Health Plan Direct | CMS/State Databases | Other Third-Party Source |
| Spoken language preferred for health care | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Preferred language for written materials | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Other language needs | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_% |

**Note:** Include members who decline to provide language information. The “Declined” category is included because it indicates that the organization asked about the member’s language needs.

Table LDM-B-1/2/3: Preferred Language Data

|  |  |  |
| --- | --- | --- |
| Spoken Language Preferred for  Health Care | Number | Percentage |
| English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Non-English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Unknown | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Declined | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| ***Total:\**** | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Language Preferred for Written Materials | Number | Percentage |
| English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Non-English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Unknown | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Declined | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| ***Total:***\* | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Other Language Needs | Number | Percentage |
| English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Non-English | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Unknown | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| Declined | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |
| ***Total:\**** | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_% |

**\***The *Total* will sum to 100%.

## Race/Ethnicity Diversity of Membership (RDM)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |

Calculations

|  |  |
| --- | --- |
| Table instructions | Report the number and percentage of members by race/ethnicity for the product population. If a member’s race or ethnicity is unknown or unavailable, report as “Unknown.”  Report the total unduplicated membership during the measurement year. |
| Data source | Report the percentage of members for whom data have been collected from each data source for race and ethnicity. Data sources include data collected directly from members (e.g. surveys, health risk assessments, disease management registries, CMS/state databases); from enrollment information furnished by state Medicaid agencies, or supplemented through indirect methods (e.g. surname analysis, geo-coding). When using the combined race/ethnicity data format for collection or if using CMS as the data source, refer to Table RDM-A-1 and Table RDM-A-2 for a crosswalk of reporting categories.  Table RDM-D reports the percentage of each race (e.g., White, Black or African American) within each ethnicity (e.g., Hispanic or Latino, Not Hispanic or Latino) category. |

Race Reporting Category Definitions

|  |  |
| --- | --- |
| White | People whose origins are in any of the original peoples of Europe, the Middle East or North Africa; including people who indicated their race or races as White or wrote entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab or Polish. |
| Black or African American | People whose origins are in any of the Black racial groups of Africa; including people who indicated their race or races as Black, African American or Negro, or wrote entries such as African American, Afro-American, Nigerian or Haitian. |
| American Indian and Alaska Native | People whose origins are in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment; including people who indicated their race or races by marking this category or writing in their principal or enrolled tribe, such as Rosebud, Sioux, Chippewa or Navajo. |

|  |  |
| --- | --- |
| Asian | People who are Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese and “Other Asian,” which may include people who are Burmese, Hmong, Pakistani, Thai or from two or more Asian subgroups. |
| Native Hawaiian and Other Pacific Islander | People whose origins are in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands; including Carolinian, Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese) and Yapese. |
| Some Other Race | People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census “Race” categories. |
| Two or More Races | People with any combination of races, including “Some Other Race.” |
| *Ethnicity reporting category:* Hispanic or Latino | People of Spanish, Mexican, Puerto Rican or Cuban origin. |

*Note*

* *It is considered “best practice” to collect data directly from members because this method reflects members’ self-identification. If data collected directly by the health plan are not available, third-party data collected directly by another entity (e.g., the state or CMS) are desired.*
* *When multiple sources of data are used, there may be disagreements in the data collected. In such a case, use a logical process that considers the relative accuracy of each data source to resolve the difference. For example, one way to use a stepwise logic for any data disagreement is to:*
* *Select specific categories over nonspecific categories.*
* *Select the most frequently or consistently reported category over less frequently reported categories.*

*Data sources might also be prioritized based on an analysis of the reliability of the different data sources.*

* *NCQA encourages collecting and reporting race and Hispanic ethnicity as defined by the Office of Management and Budget (OMB). Because some health plans, CMS and state agencies may have varying classification schemes for race and ethnicity, refer to Table RDM-A for HEDIS reporting.*
* *If detailed ethnicity information is collected, these data must be aggregated and reported in the OMB categories provided. If a combined race/ethnicity category question is used to collect data, data must be disaggregated and race and ethnicity categories must be reported separately.*
* *If race information is received from one data source and ethnicity information from a different data source, count the member in both sources. If the same category of information is received from two different data sources, prioritize data sources based on the second bullet above.*

Table RDM-A-1: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity

|  |  |  |
| --- | --- | --- |
| CMS Category | HEDIS/OMB Race | HEDIS/OMB Ethnicity |
| White | White | Unknown |
| Black | Black | Unknown |
| American Indian/Alaska Native | American Indian/Alaska Native | Unknown |
| Asian/Pacific Islander | Asian | Unknown |
| Hispanic | Unknown | Hispanic/Latino |
| Other | Some Other Race | Unknown |
| Unknown | Unknown | Unknown |
| (No equivalent category) | Native Hawaiian and Other Pacific Islander | Unknown |
| (No equivalent category) | Two or more races | Unknown |

Table RDM-A-2: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

|  |  |  |
| --- | --- | --- |
| Race/Ethnicity Combined Category | HEDIS/OMB Race | HEDIS/OMB Ethnicity |
| White | White | Not Hispanic/Latino |
| Black | Black | Not Hispanic/Latino |
| American Indian/Alaska Native | American Indian/Alaska Native | Not Hispanic/Latino |
| Asian | Asian | Not Hispanic/Latino |
| Native Hawaiian and Other Pacific Islander | Native Hawaiian and Other Pacific Islander | Not Hispanic/Latino |
| Hispanic/Latino/White | White | Hispanic/Latino |
| Hispanic/Latino /Black | Black | Hispanic/Latino |
| Other | Some Other Race | Unknown |
| Multiple races marked | Two or more races | Unknown |
| Unknown | Unknown | Unknown |

**Note:** NCQA recommends this mapping strategy based on research on the sensitivity and specificity of CMS data, expert input and lessons from data collection learning initiatives. This crosswalk is a guide only. If organizations have more accurate race or ethnicity information, they may overwrite these data and code race or ethnicity to the more accurate categories.

Table RDM-B-1/2/3: Race/Ethnicity Information by Data Collection Method

|  |
| --- |
| Total Unduplicated Membership During the Measurement Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Note:** The total unduplicated count of members in the organization is the denominator for calculating all percentages in Table RDM-C-1/2/3.

Table RDM-C-1/2/3: Percentage of Members for Whom the Organization Has Race/Ethnicity Information by Data Collection Method

|  |  |  |  |
| --- | --- | --- | --- |
|  | Direct Data Collection Method | Indirect Data  Collection Method | Unknown |
| Race | Direct Total \_\_\_\_\_\_\_\_\_%  Health Plan Direct \_\_\_\_\_\_\_\_\_%  CMS/State Databases \_\_\_\_\_\_\_\_\_%  Other \_\_\_\_\_\_\_\_\_% | Indirect Total \_\_\_\_\_\_\_\_\_% | Total \_\_\_\_\_\_\_\_\_% |
| Ethnicity | Direct Total \_\_\_\_\_\_\_\_\_%  Health Plan Direct \_\_\_\_\_\_\_\_\_%  CMS/State Databases \_\_\_\_\_\_\_\_\_%  Other \_\_\_\_\_\_\_\_\_% | Indirect Total \_\_\_\_\_\_\_\_\_% | Total \_\_\_\_\_\_\_\_\_% |

*Note*

* *Percentages include the sum of all race and ethnicity response options, which does not include “Unknown.” The “Declined” response option is included in the Direct Data Collection Method percentages because it indicates that the organization asked about the member’s race/ethnicity. “Unknown” includes members for whom the organization did not obtain race/ethnicity information using the direct or indirect data collection method or for whom the organization did not receive a “Declined” response.*
* *Percentages for the race and ethnicity total rows equal the organization’s total unduplicated membership count (Direct Total + Indirect Total + Unknown Total). However, because the indirect method is typically based on a percentage of members instead of on a member count, rounding can cause minor discrepancies between the total membership count and the sum for all Total categories in Table RDM-C.*
* *Prioritize data sources as specified in the measure.*

Table RDM-D-1/2/3: Race/Ethnicity Categories Reported

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Race | HISPANIC OR LATINO | | NOT HISPANIC OR LATINO | | UNKNOWN ETHNICITY | | DECLINED ETHNICITY | | TOTAL | |
| Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage |
| White | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Black or African-American | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| American-Indian and Alaska Native | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Asian | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Native Hawaiian and Other Pacific Islander | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Some other race | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Two or more races | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Unknown | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| Declined | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |
| ***Total*** | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_ | \_\_\_\_\_% |

**Note:** The numbers and percentages reported in this table are based on the total unduplicated membership count, which is reported in the Total-Total cell of this table.

## Weeks of Pregnancy at Time of Enrollment (WOP)

Summary of Changes to HEDIS 2016

* Deleted the use of infant claims to identify deliveries.

Description

The percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization, according to the following periods:

* Prior to pregnancy (280 days or more prior to delivery).
* The first 12 weeks of pregnancy, including the end of the 12th week (279–196 days prior to delivery).
* The beginning of the 13th week through the end of the 27th week of pregnancy (195–91 days prior to delivery).
* The beginning of the 28th week of pregnancy or after (≤90 days prior to delivery).
* Unknown.

Eligible Population

|  |  |
| --- | --- |
| Product line | Medicaid. |
| Age | None specified. |
| Continuous enrollment | None. |
| Anchor date | Date of delivery. |
| Benefit | Medical. |
| Event/ diagnosis | *Delivered a live birth during the measurement year.* Include women who delivered in any setting.  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) during the measurement year. |
| *Step 2* | Exclude non-live births (Non-live Births Value Set). |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. Report this number under *Total* in Table WOP-1. |
| Numerator | The number of women who enrolled in the organization at the following times:   * Prior to 0 weeks (280 days or more prior to delivery). * 1–12 weeks (279–196 days prior to delivery). * 13–27 weeks (195–91 days prior to delivery). * 28 or more weeks of pregnancy (≤90 days prior to delivery). * Unknown.   The organization uses enrollment and delivery data to determine how many weeks prior to delivery each member enrolled.  Estimate the weeks of pregnancy at time of enrollment using administrative systems. This can sometimes be estimated by using the delivery date. In other cases, either the most recent EDD noted in the patient’s prenatal care record or the gestational age of the fetus obtained from the patient’s delivery records must be used in following these steps: |
| *Step 1* | Prior to pregnancy. Identify all women whose most recent date of enrollment in the organization was more than 40 weeks (280 days or more prior to delivery) prior to the delivery date. These women will be included in the *≤0 weeks* row of Table WOP-1. Include women even if they had a premature birth. |
| *Step 2* | Premature births. For women with a delivery date ≤40 weeks (fewer than 280 days prior to delivery) after enrollment in the organization, identify deliveries that resulted in a premature birth (Premature Births Value Set).  For women who had a premature birth, the organization may use sources other than administrative data (e.g., delivery or prenatal care records) to identify the EDD or gestational age of the fetus or the last menstrual period noted to estimate the weeks of pregnancy at enrollment in the organization. If these are not available, include these women in the *Unknown* category. |
| *Step 3* | Assume a full-term pregnancy for all remaining women (i.e., those not enrolled in the organization more than 40 weeks prior to the delivery date, and for whom there is no indication of a premature birth). For these women, the weeks of pregnancy at enrollment is determined by subtracting the number of weeks of enrollment in the organization prior to delivery from 40 weeks. Calculate the number of women in each remaining category:   * 1–12 weeks of pregnancy (279–196 days prior to delivery). * 13–27 weeks of pregnancy (195–91 days prior to delivery). * 28 or more weeks of pregnancy (≤90 days prior to delivery). |

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. The sample size serves as the total and the denominator for all percentage calculations in Table WOP-1. |
| Numerators | The number of women who enrolled in the organization at the following times:   * Prior to 0 weeks (280 days or more prior to delivery). * 1–12 weeks (279–196 days prior to delivery). * 13–27 weeks (195–91 days prior to delivery). * 28 or more weeks of pregnancy (90 days or fewer prior to delivery). * Unknown. |
| *Administrative* | Refer to *Administrative Specification* to identify the correct reporting category for each woman. |
| *Medical record* | Estimate the weeks of pregnancy at time of enrollment. This can sometimes be estimated by using the delivery date. In other cases, either the most recent EDD noted in the patient’s prenatal care record or the gestational age of the fetus obtained from the patient’s delivery records must be used.  *If EDD data are used,* count the number of weeks that elapsed between the enrollment date and EDD and subtract this number from 40 (weeks). The result gives an estimate of the weeks of pregnancy at time of enrollment in the organization.  *If gestational age is used,* count the number of weeks elapsed between the enrollment date and the delivery date. Subtract this number from the gestational age of the fetus (in weeks) at the time of delivery. The result is the number of weeks of pregnancy at time of enrollment in the organization. This will be a negative number if a woman enrolls prior to pregnancy. |

*Note*

* *For consistency with the* Prenatal and Postpartum Care *measure in the Access/Availability of Care domain, this measure examines only enrollment of women who have live births.*
* *“Stage of pregnancy at enrollment” refers to the estimated weeks of pregnancy on the first date for which capitation payment provides coverage (for the most recent enrollment period).*

Table WOP-1: Data Elements for Weeks of Pregnancy at Time of Enrollment

|  |  |  |
| --- | --- | --- |
| Weeks of Pregnancy | Number | Percentage |
| **Measurement Year** | | |
| ≤0 weeks (280 days or more prior to delivery) | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| 1-12 weeks (279-196 days prior to delivery) | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| 13-27 weeks (195-91 days prior to delivery) | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| 28 or more weeks (≤90 days prior to delivery) | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Unknown | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Total all pregnancies*** | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |

***Total Membership (TLM)***

Summary of Changes to HEDIS 2016

* Added the EPO product.
* Added the Marketplace product line.
* Clarified that Medicare-Medicaid Plans (MMP) are included in the Medicare count.
* Clarified that this measure is reported for an organization in its entirely.

Description

The number of members enrolled as of December 31 of the measurement year.

Calculation

For each product the organization offers (i.e., HMO, POS, PPO, EPO or FFS), report the number of members enrolled as of December 31 of the measurement year by product line (i.e., commercial, Medicaid, Medicare, Marketplace or other). The total category must equal the organization’s total membership as of December 31 of the measurement year. Complete this measure once and report the information for each HEDIS submission.

Include all products and product lines, even if they were not part of a HEDIS submission:

* Special Needs Plans (SNP) and Medicare-Medicaid Plans (MMP) in the Medicare count.
* ASO members in either the commercial HMO, POS, PPO, EPO count, as appropriate.
* CHIP members in the Medicaid product line.

This measure is reported for an organization in its entirety (i.e., the number of members for each product and product line will be the same for all HEDIS submissions).

Table TLM-1/2/3: Total Membership\*

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Product/Product Line | Total Number of Members | Product/Product Line | Total Number of Members |
| **HMO** | | **POS** | |
| Medicaid | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Commercial | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Commercial | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicare | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicare | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marketplace | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marketplace | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Total HMO*** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | ***Total POS*** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PPO** | | **FFS** | |
| Medicaid | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Commercial | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Commercial | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicare | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicare | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marketplace | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| ***Total PPO*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Total FFS*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Total number of members in each category as of December 31 of the measurement year.

Table TLM-1/2/3: Total Membership\* *continued*

|  |  |  |  |
| --- | --- | --- | --- |
| Product/Product Line | Total Number of Members | Product/Product Line | Total Number of Members |
| **EPO** | |  | |
| Commercial | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Marketplace | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| ***Total EPO*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| ***Total*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

\*Total number of members in each category as of December 31 of the measurement year.

Measures Collected Using

Electronic Clinical Data Systems

## Guidelines for Measures Collected Using Electronic Clinical Data Systems (ECDS)

**Note:** New domain in HEDIS for health plan measures requiring structured electronic clinical data to be shared between clinicians and plans for automated quality reporting.

Description

NCQA has been strongly encouraged to explore new approaches to HEDIS measures that assess whether health plans promote care practices that lead to improved outcomes. Moving health plan measurement and HEDIS toward this future will require leveraging new data and a new quality reporting process.

Phased Implementation of Data Collection Method

This new data collection method represents a step forward in adapting HEDIS to leverage new sources of data available through health information technology. By introducing measures into this new domain over time, NCQA can work closely with innovative plans to pilot requirements, with a focus on further refinement of measure, audit and software certification specifications. To follow the progress of the pilot implementation of the new domain, go to <http://ncqa.org/ECDS>.

Definitions

|  |  |
| --- | --- |
| ECDS | Electronic clinical data system. A structured, electronic version of a patient’s comprehensive medical experiences, maintained over time, that may include some or all key administrative clinical data relevant to care (e.g., demographics, progress notes, problems, medications, vital signs, past medical history, social history, immunizations, laboratory data, radiology reports).  The ECDS provides automated access to comprehensive information and can create data files for quality reporting (e.g., QRDA 1, C-CDA, CCD). The ECDS may also support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management and outcome reporting.  **To qualify for this measure, ECDS data must be automated data that is accessible by the health care team at the point of care** (e.g.,electronic health records, registries and case management or disease management systems to which any provider interacting with the member has access to the clinical interface). For specific requirements on allowable ECDS data, refer to <http://ncqa.org/ECDS>. |

Overview

ECDS HEDIS measures report the organization’s total eligible population as defined by specific measure criteria. The measurement period aligns with the traditional 12-month measurement year, although process orientation may operate in reverse order from the traditional HEDIS administrative approach. For example, because data for ECDS HEDIS is generated directly from a patient’s history, some data elements specified in the technical specifications may extend beyond the measurement period.

Guidelines

1. Eligible Population

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

**Inclusion in ECDS rate.** For the duration of the ECDS HEDIS reporting pilot phase, organizations are required to submit a data coverage rate for each measure submitted.

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

2. Data Collection Methods

Measures in the ECDS HEDIS domain are specified for one data collection method. For additional information on data collection requirements and the pilot implementation of ECDS HEDIS measures, go to <http://ncqa.org/ECDS>.

### Electronic Clinical Data Systems

|  |  |
| --- | --- |
| Electronic Method | Transactional data from a number of sources are used to identify the eligible population. The reported rate is based on all members who meet the eligible population criteria (after exclusions, if applicable). |
| Allowable  data | To calculate ECDS HEDIS measures, organizations may use sources other than EHRs to collect data about their members and about delivery of health services to their members. |
| Standard ECDS 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:   * Laboratory result files. * Current or historic transactional files in a standard electronic format. * Transactional data from behavioral healthcare vendors. * EHR vendor systems. * Transactional data from case management, disease management or wellness vendors. |
| How ECDS data differ from supplemental data | Unlike supplemental data currently used in HEDIS, ECDS HEDIS data are expected to be used to report all elements included in the measure specification, including:   * Eligible population diagnosis/event criteria. * Denominator events. * Identifying exclusions for clinical conditions. * Numerator qualifying events. |
| *Audit requirements* | ECDS measures will not be part of the HEDIS Compliance Audit for HEDIS 2016. For information on the rollout of audit requirements for measures in the HEDIS ECDS domain, go to NCQA’s Web site (<http://ncqa.org/ECDS>). |

3. Qualifying Data

Organizations must have policies and procedures for using data files as ECDS data. Files must:

* Have standard file layouts referring to structured, standard data fields.
* Include all elements required by measure specifications.
* Be accessible by the practitioner or practitioner group that is accountable for the clinical service.

NCQA recommends adherence to the Health Level Seven International (HL7) Clinical Document Architecture (CDA) Release 2—Continuity of Care Documents (CCD) specifications to support data exchange between personal health records managed by insurance plans (i.e., “Plan to Plan Personal Health Record” documents [P2PPHR]).

## Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)

**Summary of Changes to HEDIS 2016**

* First-year measure.

**Note**: This measure uses a new reporting methodology for electronic clinical data. For the most up-to-date information go to <http://ncqa.org/ECDS>.

Description

The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who have a PHQ-9 or PHQ-A tool administered at least once during a four-month period. Two rates are reported.

1. **Inclusion in ECDS Rate.** The percentage of members 12 and older with a diagnosis of major depression or dysthymia, who are included in an electronic clinical data system (ECDS).
2. **Utilization of PHQ-9 Rate.** The percentage of PHQ utilization. Members with a diagnosis of major depression or dysthymia who are covered by an ECDS and, if they had an outpatient encounter, have *either* a PHQ-9 or a PHQ-A score present in their record.

Definitions

|  |  |
| --- | --- |
| ECDS | Electronic clinical data system. A structured, electronic version of a patient’s comprehensive medical experiences, maintained over time, that may include some or all key administrative clinical data relevant to care (e.g., demographics, progress notes, problems, medications, vital signs, past medical history, social history, immunizations, laboratory data, radiology reports).  The ECDS provides automated access to comprehensive information and can create data files for quality reporting (e.g., QRDA 1, C-CDA, CCD). The ECDS may also support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management and outcome reporting.  **To qualify for this measure, ECDS data must be automated data that is accessible by the healthcare team at the point of care** (e.g.,electronic health records, registries and case management or disease management systems to which any provider interacting with the member has access to the clinical interface). For specific requirements on allowable ECDS data, refer to <http://ncqa.org/ECDS>. |
| IESD | Index Episode Start Date. The first date of an outpatient encounter in *each* assessment period, where an active diagnosis of depression starts before or occurs during the encounter. |
| Measurement period | The measurement year is segmented to establish regular utilization of the PHQ assessment tool in the management of depression. The first qualifying encounter in each period determines the denominator events for the performance measure. The measurement year is divided into three assessment periods with specific dates of service:   * *Assessment Period One.* January 1–April 30 of the measurement year. * *Assessment Period Two.* May 1–August 31 of the measurement year. * *Assessment Period Three.* September 1–December 31 of the measurement year. |

Eligible Population

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| Product line | Commercial, Medicare, Medicaid (report each product line separately). | |
| Ages | 12 years and older as of January 1 of the measurement year.  Report four age stratifications and a total rate: | |
|  | * 12–17 years. * 18–44 years. * 45–64 years. | * 65+ years. * Total. |
| Continuous enrollment | The measurement year. | |
| Allowable gap | No more than one gap in enrollment 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 | Medical. | |
| Event/ diagnosis | Follow the steps below to identify the eligible population. | |
| *Step 1* | Identify all members in claims with an active diagnosis of major depression or dysthymia (Major Depression and Dysthymia Value Set) that starts before the beginning of the measurement year or during the measurement year. | |
| *Step 2* | Identify all members in step 1 with an active diagnosis of depression that starts before or occurs during an outpatient encounter (Depression Encounter Value Set) during the measurement year. | |
| *Step 3* | Determine continuous enrollment. For all members identified in step 2, identify members continuously enrolled in the health plan for the measurement year, with no more than a 45-day gap in enrolment. | |
| *Step 4: Required Exclusions* | Exclude members with an active diagnosis from any of the following value sets, at any time during the measurement year:   * Bipolar disorder (Bipolar Disorder Value Set; Bipolar Disorder ECDS Value Set; Other Bipolar Disorder Value Set). * Personality disorder (Personality Disorder Value Set). * Psychotic disorder (Psychotic Disorders Value Set). * Autism spectrum disorder (Pervasive Developmental Disorder Value Set). | |

*Rate 1:* Inclusion in ECDS

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| Denominator | The eligible population. |
| Numerator | Identify all members for whom a plan can receive HEDIS measure ECDS data. |

*Rate 2:* Utilization of PHQ-9

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| Denominator | Count the IESD from each of the three assessment periods (members may have an IESD in any or all the three assessment periods, thus members may appear in the denominator 1-3 times based on the presence of an IESD in each of the different assessment periods). Members need only have one event in any assessment period to be counted. Follow the steps below to determine denominator events. |
| *Step 1* | For all members from the inclusion in ECDS numerator, identify all outpatient encounters (Depression Encounter Value Set) during the measurement year where an active diagnosis of depression starts before or during the encounter. |
| *Step 2* | For each outpatient encounter in step 1, identify the date of service and classify each encounter in one of the three assessment periods. |
| *Step 3* | For each assessment period, count only the first qualifying encounter for each member. These are the IESD. Each member may have up to three IESDs (one from each assessment period) for the measurement year. |
| *Step 4* | Count the number of IESDs for each member. The denominator is the sum of all IESDs across all of the members. |
| Numerator | A PHQ-9 or PHQ-A total score in the patient’s record during the same assessment period in which an IESD occurred. Follow the steps below to determine numerator events. |
| *Step 1* | For each IESD, identify if a PHQ questionnaire was completed during the same assessment period as the IESD. The presence of a PHQ total score indicates completion of a PHQ assessment tool and counts as a qualifying PHQ. In addition, completion of a PHQ can be identified by codes in the PHQ Administered Value Set. The PHQ assessment does not need to occur during an encounter; for example, it can be completed over the telephone or through a Web-based portal. |
| *Step 2* | For each assessment period where a member had an IESD, count only the first qualifying PHQ. Each member may have up to three qualifying PHQs (one from each assessment period) for the measurement year. |
| *Step 3* | Sum the qualifying PHQs across the three periods to report the Rate 2 numerator. |
| *Step 4* | To calculate the performance rate, divide the sum of the qualifying PHQs across the three assessment periods (step 3) by the sum of the IESDs across the three assessment periods. |

Data Elements for Reporting

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

### Table DMS-1/2/3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

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|  | **Electronic Clinical Data** |
| Measurement year | *Each of the 2 rates* |
| Data collection methodology (Electronic Clinical Data) | *Each of the 2 rates* |
| Eligible population | *For each of the 2 rates for each age stratification and total* |
| Number of required exclusions | *For each of the 2 rates for each age stratification and total* |
| Numerator events | *For each of the 2 rates for each age stratification and total* |
| Reported rate | *For each of the 2 rates for each age stratification and total* |
| Lower 95% confidence interval | *For each of the 2 rates for each age stratification and total* |
| Upper 95% confidence interval | *For each of the 2 rates for each age stratification and total* |