March 20, 1998

NOTE TO: All Medicare Contracting HMOs and CMPs

SUBJECT: Addendum to Operational Policy Letter #59

This note transmits the first addendum to OPL #59, *Reporting Requirements for Medicare Health Plans in 1998: HEDIS 3.0/98 Measures and the Medicare Consumer Assessment of Health Plans Study (CAHPS).* In addition to clarifications to OPL #59, this addendum requires that health plan HEDIS data be audited by a HCFA contractor prior to submission.

As stated in OPL 59, it is critical to HCFA=s mission that we collect and disseminate information that will help beneficiaries choose among health plans, contribute to improved quality of care through identification of quality improvement opportunities, and assist HCFA in carrying out its oversight responsibilities. Thus the purpose of the audit is to understand for all plans the accuracy and completeness of the data submitted prior to use of this data.

It is critical that your health plan staff who are involved in HEDIS implementation receive this information as soon as possible. This addendum addresses the audit and change in submission dates, as well as clarifying information on HEDIS and updates on the Health of Seniors and CAHPS surveys. As with last year=s submission of HEDIS data, the importance of reporting complete and accurate HEDIS data is important to HCFA=s commitment to publish this data.

In addition to the actual rate, HCFA will release the audit findings for each 1997 HEDIS measure audited. This is a change in policy from last year, when not all plans were audited and HCFA specified that audit findings would not be released. HCFA also is considering whether any additional information about the audits would be helpful in analyzing the HEDIS data and providing useful information to consumers, and thus should be released. You will be notified about the details of HCFA=s release of audit information as soon as a decision is made. Information concerning individual patients, of course, would be kept confidential.

/s/
Kathleen A. Buto
Acting Director
Center for Health Plans and Providers

Attachment
cc:
Center for Beneficiary Services
Office of Clinical Standards and Quality
Regional Administrators, Regions I-X
All Managed Care Contacts, Regions I-X
NCQA HEDIS Contacts
Island Peer Review Organization

Department of Health and Human Services
Health Care Financing Administration
Center for Health Plans and Providers
Medicare Managed Care
Addendum to Operational Policy Letter # 59
OPL97.059

Date: March 20, 1998

Subject: Reporting Requirements for Medicare Health Plans in 1998: Health Plan Employer Data and Information Set Measures (HEDIS7 3.0/98) and the Medicare Consumer Assessment of Health Plans Study (CAHPS)

Note: This addendum provides additional information on HEDIS reporting, particularly the mandatory audit of all contracts prior to submission of the summary data. This audit activity will be at HCFA=s expense. In addition, changes to and clarifications of specific issues covered by the December 11, 1997 OPL #59 are provided. Specifically, reporting requirements for cost health plans, and updates related to Health of Seniors and CAHPS surveys are covered. Each element will be addressed separately.

HEDIS REPORTING:

AUDIT

HCFA=s contract for auditing HEDIS7 3.0/98 data will call for a pre-submission audit of all reporting health plan contract markets (i.e., reporting units) submitting HEDIS data in 1998. To accommodate this, the due date for summary data submission to the National Committee for Quality Assurance (NCQA) has been changed to July 30. Other dates related to the audit program are discussed below.

OPL #59 stated that there would be a process of validation of the HEDIS measures before public reporting. The audit of the 1996 HEDIS data, which included in-depth analysis at a sample of plans, identified problem areas related to accuracy and completeness in HEDIS reporting. We expect the report to be available this Spring. In order to ensure greater public confidence in public reporting, the audit of 1997 HEDIS data will be expanded to include all contracts and additional systems and processes. HCFA is building on the 1997 validation effort which was carried out by Island Peer Review Organization, Inc. (IPRO, the New York PRO) under contract to HCFA. We are working with

IPRO to audit the validity and accuracy of the 1997 HEDIS data. This validation will provide both HCFA and health plans with insights into data strengths and weaknesses, identify areas for improvement, and improve accuracy of data prior to submission.

The audit program will consist of an offsite pre-visit review of health plan documentation followed by an onsite visit by an audit team. The audit will also include a review of medical records to validate measures produced using the hybrid method. In addition, there will be a pilot to determine the accuracy of coding at the point of entry into the system (i.e., the point at which the service is provided). Prior to submission of HEDIS data to NCQA (HCFA=s agent), IPRO will send a report of the audit to each health plan to allow it to make corrections and to resubmit corrected data. IPRO will conduct telephone follow-up, as necessary, with each health plan related to the resubmitted data.

The tentative schedule at this point is that health plans will be notified, by the end of March, of the agreed upon audit activity and time frames. In addition, a hard copy template for submission of summary data, and necessary instructions, will be provided. We expect onsite audit activity to begin by mid-to-late April. All site visits will be completed by the third week in June. By June 5, plans must identify to IPRO the medical records which they have used to compute their performance rates. This will allow IPRO to move forward on the medical record review activity. **After June 5, only corrections due to the audit activity will be permitted; additional administrative and medical record data may not be added to modify the calculation of the performance rates.**

At this point, we expect the Medicare measures subject to this audit will include: 1) Effectiveness of Care domain: breast cancer screening, beta blocker treatment after a heart attack, and eye exams for people with diabetes; and 2) Use of Services domain: frequency of selected procedures which include angioplasty (PTCA), prostatectomy, coronary artery bypass graft, hysterectomy, cholecystectomy, cardiac catheterization, reduction of fracture of the femur, total hip replacement, total knee replacement, partial excision of large intestine, and carotid endarterectomy. These are generally the same measures which were part of the audit program last year. In addition, the audit will include certain non-clinical measures (provider turnover, board certification, access to prevention/ambulatory health services). The measures to be **reported** by risk plans are detailed in Attachment I of the December 1997 OPL, and for cost plans in Attachment I of this addendum.

The process used to audit this year=s Medicare HEDIS data will be consistent with NCQA=s HEDIS Compliance Audit9 Standards and Guidelines for HEDIS 3.0/1998. We are cognizant that a number of

health plans will be using NCQA-licensed auditing firms to audit their commercial HEDIS data. Health plans also may contract for an NCQA Compliance Audit of their Medicare data. It should be noted that having either commercial or Medicare data audited will not exempt health plans from an onsite visit by IPRO. However, plans that choose to have their Medicare data audited by an NCQA-licensed organization using NCQA-certified auditors will have the opportunity to allow IPRO to use the results of the audit if the same measures are audited, thereby reducing health plans= burden. While an audit of commercial HEDIS data will not be accepted as a substitute, health plans that have been through a commercial audit will gain some efficiencies from having already compiled much of the required audit documentation.

In the interest of public accountability and advancing performance measurement as a critical tool in consumer choice and continuous quality improvement in care and services, HCFA will release the actual rates and the audit findings for each 1997 HEDIS measure audited. HCFA also is considering whether any additional information about the audits would be helpful in analyzing the HEDIS data and providing useful information to consumers, and thus should be released. You will be notified about the details of HCFA=s release of audit information as soon as a decision is made. Information concerning individual patients, of course, would be kept confidential.

DUE DATES

Health plans must report **final audited summary** Medicare HEDIS data by **July 30** to NCQA. Health plans will **not** be given an extension.

Upon receipt of each health plan=s HEDIS file, IPRO will verify that the agreed upon rates have been reported for the audited measures. NCQA will print a hard copy and return this to the health plan for correction of errors. Since many of the clinical measures will have been audited, with the opportunity for correction by the health plans, prior to submission to NCQA, we anticipate minimal errors. Please keep in mind that changes due to additional administrative and/or medical record information will **not** be accepted.

Patient level data will be due **August 31**. As stated in OPL #59, the patient level data **must** match the summary data. Specifically, those individual members who were in the denominator and those in the numerator for each measure reported must be identified (please see page 6 and Attachment II). NCQA anticipates issuance of patient-level specifications by the end of March.

SECTION 1876 COST PLANS

For cost plans subject to OPL #59, HCFA has modified the measures

to be reported. Cost plans will **not** report the Use of Services inpatient measures. The measures to be reported are listed on Attachment I.

This change has been necessary for inpatient (e.g., hospitals, SNFs) measures because cost-based health plans are not always aware of the inpatient stays of their members if the member chooses to go out of plan and not seek authorization from the plan. Thus, HCFA and the public would not know to what degree the data for these measures are incomplete.

Cost plans will provide patient level data for all the Effectiveness of Care and the Use of Services measures mentioned above.

GENERAL

1. We expect that NCQA will provide the data submission tool to health plans by early May. Health plans must use this submission tool.

2. This year, for the Effectiveness of Care measures, as well as Access/Availability of Care and Use of Services measures, if the denominator used to calculate a measure is smaller than 30, health plans shall provide the number of people who do meet the specifications as the denominator and the number of people who received the treatment or service of interest as the numerator. This is different from last year when this rule applied only to Access/Availability of Care and Use of Services measures.

   This is discussed in HEDIS7 3.0/98 Volume 2, Technical Specifications, under Guidelines for Data Collection and Reporting on page 24 for Effectiveness of Care, on page 25 for Access/Availability of Care, and on page 30 for Use of Services.

3. Regarding mergers and acquisitions, HCFA has determined that the surviving entity shall report both summary and patient level data only for the four condition-specific Effectiveness of Care measures related to the former members of the non-surviving contract(s) [i.e., those contract(s) which have been terminated due to the merger]. This reporting by the surviving entity shall apply only if the non-surviving contract was in effect for any part of 1997. Members of the non-surviving contract(s) will not be surveyed under CAHPS and Health of Seniors.

   The purpose for such reporting is to provide a more complete data base for HCFA and other researchers related to issues of national interests. HCFA will **not** use information

relating to non-surviving contract(s) for plan-to-plan comparisons since they are no longer in effect and thus not available for beneficiary selection. We recognize that beneficiaries and affiliated providers may be associated with the surviving entity=s contract. However, HCFA believes that HEDIS measures based on the combined 1997 membership and providers of both contracts could be misleading since the management, systems and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care available under the surviving contract.

The surviving contract(s) must comply with all aspects of OPL #59 for all members it had in 1997.

4. If there is a discrepancy between what is in the HEDIS 3.0/98 Technical Specifications and OPL #59, the OPL takes precedence. Specifically, for the Flu Shots for Older Adults and Advising Smokers to Quit, health plans shall **NOT** report these measures to HCFA. The CAHPS survey captures this information. For those health plans for which HCFA is not administering the CAHPS survey, due to cutoff dates for identifying the 1997 samples, this smoking cessation and flu shot information will not be available as part of HEDIS under the requirements of this OPL.

5. For continuous enrollment measures, Medicare beneficiaries are counted as continuously enrolled if part of the time period included membership while they were covered by an employer. The assumption is that the health plan has health care services data related to that individual for the entire time period. This applies to Aage-ins.≅ This is established by the first bullet under Specific Guidelines for Effectiveness of Care in the HEDIS7 3.0/98 Technical Specifications. Although this bullet is not under the section on Continuous Enrollment, HCFA has spoken to NCQA and they agree that it does apply there also for purposes of Medicare reporting.

6. Regarding Table 8D, Enrollment: Percent of Plan=s Total Member Months by Payer, Age and Sex, health plans must report commercial and Medicaid enrollment by contract and report Medicare enrollment by contract/market area (as appropriate). Any variation of this must be justified in your submission. This modifies the instructions on page 5 of the December 11, 1997 OPL 59.

7. In OPL #59, we stated on page 3 that risk plans which have cost enrollees remaining from previous contracts shall

include only their risk members in calculating performance measures. In selecting the samples for the CAHPS and Health of Seniors surveys, cost members will not be included.

8. Health plans will be accountable to provide data as required. If there are problems encountered, health plans must provide an explanation as to why the reporting will not be complete. HCFA may take this under consideration.

9. We would like to call your attention to OPL #64 related to submission of hospital encounter data as required by the Balanced Budget Act (BBA) of 1997. The documentation needed to submit encounter data to HCFA should improve health plans= ability to provide accurate and complete data for HEDIS performance measures. We anticipate that certain information system efficiencies can be achieved.

CAHPS

HCFA is covering the costs of the 1996 and 1997 CAHPS surveys which are being administered by HCFA for Medicare contracts effective on January 1, 1996 and January 1, 1997. It is anticipated that each year HCFA will administer the CAHPS, or another appropriate beneficiary satisfaction survey. By the time this addendum is released, health plans with contracts effective January 1, 1996 will have been notified of the CAHPS survey which is being administered in mid-February. We expect the CAHPS survey related to health plans= **contracts in effect on January 1, 1997,** will be administered in late 1998 [please note that there was an error (related to the eligibility date) on page 9, second and third paragraphs of section 3 in OPL #59].

Use of Data

Selected summary results of this survey will be released as public information. To ensure the validity of these comparisons, only data gathered through HCFA=s independent administration of the survey will be publicly released.

HEALTH OF SENIORS

NCQA, as agent to HCFA, oversees the Health of Seniors measure. Seven vendors were recently selected; health plans have been notified by NCQA as to whom they are and the process health plans must engage in to select a vendor. Although health plans will pay for the survey, HCFA will draw the sample. We expect that the survey will be sent out by the certified vendors in mid-May. A technical expert panel (with MCO representation)has developed an instruction manual for the vendors, and will continue to decide operational issues. This panel will continue to ensure that technical issues raised by this measure are addressed. The draft Health of Seniors survey is on the NCQA website at

www.NCQA.org under the researchers section.

FUTURE REQUIREMENTS

At this time, we wish to alert health plans to possible future requirements related to HEDIS and the surveys.

1. HEDIS audit:
   After this year, we anticipate that HCFA will require health plans themselves to arrange to have an independent audit of their HEDIS data. Thus, the cost of auditing may not be borne by HCFA. HCFA will be working with appropriate organizations to create a pool of Acertified≅ auditors with whom health plans would contract.

2. Surveys:
   CAHPS: It is anticipated that HCFA will continue to cover the costs of administering the Medicare beneficiary satisfaction survey after this year.

   Health of Seniors: Health plans will continue to be required to select and contract with a vendor certified to administer this functional status survey.

   For both surveys, HCFA plans to continue to select the samples and provide them to the respective vendors.

3. The BBA requires HCFA to provide every November, beginning in 1999, written plan-to-plan comparative information on quality and satisfaction. In order to meet this requirement, HCFA needs health plans= performance data by May of each year. To allow health plans sufficient time to collect the data and to have them audited prior to submission, HCFA is considering what changes are necessary in the reporting year and/or the submission dates. We are working with NCQA and the Committee on Performance Measurement.

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Attachment I

For Cost Contractors Only

HEDIS7 3.0/98 DOMAINS/MEASURES BY CATEGORY OF REPORTING FOR SUMMARY DATA

TO REPORT BY LEGAL ENTITY:

Health Plan Stability:

* Indicators of Financial Stability

TO REPORT BY CONTRACT

Cost of Care:

* High-Occurrence/High-Cost DRGs
* Rate Trends

Health Plan Descriptive Information

* Provider Compensation

CONTRACT REPORTING CATEGORY TO REPORT BY CONTRACT;
MARKET AREA REPORTING CATEGORY TO REPORT BY MARKET AREA

Effectiveness of Care

* Breast Cancer Screening
* Beta Blocker Treatment After A Heart Attack
* Eye Exams for People with Diabetes
* Follow-up After Hospitalization for Mental Illness
* The Health of Seniors

Access to/Availability of Care

* Adults= Access to Prevention/Ambulatory Health Services
* Availability of Primary Care Providers
* Availability of Mental Health/Chemical Dependency Providers
* Availability of Language Interpretation Services, Parts I & II

Health Plan Stability

* Years in Business/Total Membership
* Disenrollment
* Provider Turnover

Use of Services

* Frequency of Selected Procedures
* Ambulatory Care
* Outpatient Drug Utilization (for those with a Drug Benefit)

Health Plan Descriptive Information

* Board Certification/Residency Completion
* Total Enrollment
* Enrollment by Payer (Member years/Months)