Department of Health and Human Services
Health Care Financing Administration
Center for Health Plans and Providers
Medicare Managed Care
Operational Policy Letter #97.059
OPL97.059

Date: Dec 11 1997

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)

PROGRAM REQUIREMENTS

1998 Contract Year	**Sampling Frame/ Period**	**Medicare Contract in Place (NLT)**	**Minimum Sample Size**	**Market Area Analysis Reporting**
HEDIS73.0/98	Services delivered in CY 1997	12/31/97 with Medicare enrollees	Measure Specific	Yes
HOS	Members continuously enrolled 6 months prior to administration of survey	1/1/97	1000*	Yes
CAHPS	Members continuously enrolled 12 months prior to administration of survey	1/1/97	600*	Yes

*If the plans have fewer than this number, all members will be surveyed.

The sampling frame/period for each reporting activity and the minimum time frame for a Medicare contract to be in place is slightly different for each activity; this reflects differences in the measurement requirements of the three activities.

Market Area analysis will be performed by HCFA to determine how data shall be reported for each of the reporting categories. Plans required to report by Market Area will be notified by the end of 1997.

Plans going through acquisitions or mergers during the 1997 or 1998 contract year and requesting consolidated reporting should submit their requests to Steve Balcerzak/CHPP at his e-mail address Sbalcerzak@HCFA.gov. These requests will be handled on a case-by-case basis.

INTRODUCTION:

Effective January 1, 1997, HCFA began requiring Medicare managed care plans to report on performance measures from HEDIS7 3.0 relevant to the Medicare managed care population, and participate in an independently administered Medicare satisfaction survey, the Medicare version of the Consumer Assessments of Health Plans Study (Medicare CAHPS).

A. This OPL explains 1998 reporting requirements for HEDIS73.0/98 and CAHPS.

These reporting requirements apply to all section 1876 risk and cost health plans, and Social HMOs and Medicare Choice demonstrations. These requirements are consistent with our regulatory/statutory authority and contract terms with health plans to obtain the information necessary for the proper oversight of the program. 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 responsibilities.

HCFA continues to work closely with the American Association of Health Plans (AAHP), the National Committee for Quality Assurance (NCQA), as well as the Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control and Prevention (CDC), both of the Department of Health and Human Services, on developing initiatives that will help us implement these requirements.

B. This OPL addresses specific HCFA requirements regarding how health plans must implement HEDIS73.0/98 and CAHPS.

Important: The final HEDIS7 3.0/98 Volume 2, Technical Specifications is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy.

Please note that if there are differences between this policy letter and the HEDIS7 3.0/98 document, this OPL takes precedence for reporting data.

IMPLEMENTING HEDIS7 3.0/98 MEASURES AND MEDICARE CAHPS

A. Specifics Applicable to Both HEDIS7 3.0/98 and Medicare CAHPS

1. Plans Required to Participate

Regarding HEDIS7 3.0/98: All section 1876 risk and cost health plans with Medicare contracts in place by December 31, 1997 (with Medicare enrollees) must report those HEDIS7 3.0/98 measures in which specifications can be met, as detailed in the final HEDIS7 3.0/98 document. The sampling period is 1997, although some measures require data from earlier years as well. The HCFA recognizes that plans, whose initial contract began in 1997, will not be able to report all of the required HEDIS measures. The Medicare relevant measures in HEDIS7 3.0/98 which plans must report are listed in Attachment I.

Please note the following: Plans which have section 1876 risk contracts with cost enrollees remaining from previous contracts shall include only their risk members in calculating the performance measures. Plans which have expanded the service area of a given contract at any point during 1997 must include information regarding those beneficiaries from the entire contract service area who meet the sampling or denominator specifications for a given measure. For measures with a continuous enrollment requirement, enrollees who were receiving care through the health plan=s HCPP contract should not be counted for continuous enrollment purposes until the point they became enrolled in the health plan=s risk-based or cost-based section 1876 contract. Similarly, those who are current risk-based members, but previously were section 1876 cost-based members with the same plan should be excluded from the measure. Reporting requirements for those plans with mergers/acquisitions affecting membership in 1997 will be determined on a case by case basis. Plans should notify HCFA concerning these changes as soon as possible.

New Contractors: Plans whose initial contract is effective on or after January 1, 1998, will not report during 1998, since the HEDIS7 3.0/98 measures are for care provided in calendar year (CY)1997. However, these plans must have systems in place to collect HEDIS information so that they can provide reliable and valid HEDIS data in 1999, for the reporting year of 1998.

Regarding Medicare CAHPS and Health of Seniors Survey: All section 1876 risk and cost health plans whose Medicare contracts were in effect on or before January 1, 1997, must comply with these survey requirements during 1998.

Medicare CAHPS does not apply to plans which received a contract effective **after** January 1, 1997. However, such plans may be required to undertake an enrollee satisfaction survey during 1998 to comply with the HCFA regulations on physician incentive plans (Vol. 61, Federal Register, 13430, March 27, 1996). Plans may wish to use Medicare CAHPS for this purpose.

Please refer to paragraph C.3 (page 9) for more information on the relationship of CAHPS to the physician incentive regulations.

No Minimum Size Requirement: There is no minimum size requirement for plans to comply with reporting HEDIS 3.0/98 data and participating in Medicare CAHPS.

However, in determining whether to report a specific HEDIS measure, plan contracts must follow the *General Guidelines for Data Collection and Reporting* in the final HEDIS7 3.0/98 Volume 2, Technical Specifications. Discussion regarding the size of the denominator is found under *Specific Guidelines for Effectiveness of Care Measures, Access/Availability of Care Measures and Use of Services Measures.*

The HEDIS7 3.0/98 Volume 2, Technical Specifications clearly provides, for each measure, the following: *Description of the Measure*; and *Administrative Data Specification and Hybrid Method Specification*, both of which describe Calculation, Denominator and Numerator, where appropriate. Based on this information, plans can determine those measures which they must report.

Even though health plans do not meet specifications for all the measures, they must establish systems for collecting and reporting the data, and should be able to use the results of the measures for quality improvement purposes.

Demonstration Projects: Plans participating in either the Social HMOs or the Medicare Choices demonstrations must report HEDIS7 3.0/98 and participate in Medicare CAHPS if they are section 1876 risk or cost plans. They must also adhere to additional requirements contained in their demonstration agreements.

2. *Implications for Failure to Comply*

HCFA expects full compliance with the requirements of this OPL. Health plans must meet the time lines, provide the required data and give assurances that the data are accurate. Plans which do not comply may be subject to sanctions as provided for in section 1876(I) of the Social Security Act, as amended by Section 215 of P.L. 104-191.

3. Sampling and Reporting Unit

Plan contracts will be identified for sampling, collecting and reporting purposes, as AContract Reporting≅ or AMarket Area Reporting.≅ The latter category applies where the contract service area includes more than one Amarket area≅, that is, it covers more than one major community or city and each market area has at least 5,000 beneficiary enrollees. In these situations, plans will report two or more sets of data for a given contract. This approach will provide more meaningful information to beneficiaries, plans, and HCFA.

HCFA will assess all HMO contract service areas to determine whether the market area approach is appropriate. By the end of the year HCFA will notify those plans that must report by market area. If you do not receive notice, reporting for your plan will be by contract. The market area approach will apply to Medicare CAHPS and the HEDIS7 3.0/98 measures, including the Health of Seniors survey.

Attachment I identifies the HEDIS7 3.0/98 domains/measures by how plans will sample, collect and report summary data for their contracts. Specifically:

* There is one measure in the *Health Plan Stability Domain* which all plans will report *by legal entity*. (A legal entity is the licensed organization which contracts with HCFA. This entity submits the balance sheet and other financial reports, for the company, to HCFA as required by federal regulations). If a plan has more than one contract, data for **all** contracts will be aggregated in this measure.
* There are two measures in the Cost of Care Domain and one measure in the Health Plan Descriptive Information Domain which **all** plans will report *by contract.*
* All remaining measures will be reported *by contract* for plan contracts which are in the Contract Reporting Category, or *by Market Area* for plan contracts which are in the Market Area Reporting Category.

PLEASE NOTE THE FOLLOWING:

< There are no exceptions to reporting by contract/market area. Small contracts may not be combined.
< Table 8D, Data on Enrollment: Percent of Plan=s Total Member Months by Payer, Age and Sex must be submitted by contract/ market area. We will not accept reporting of commercial membership on a plan-wide basis.
< A plan with multiple Medicare contracts (even those with fewer than 5,000 or 10,000 Medicare enrollees in the combined contracts) must comply with HEDIS7 3.0/98 reporting requirements and CAHPS/Health of Seniors surveys for each 1876 risk and cost contract/ market area. Information used for beneficiaries= choice, plans= internal quality improvement activities, and HCFA oversight will be more pertinent as it relates to each specific contract.
< Some HMOs have a home and host plans. The home plan must report the data related to services received by its members when out of the plan=s service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan=s contract with HCFA. The home plan is responsible for assuring that the host plan fulfills the home plan=s obligations.

4. Use of Data

Data reported to HCFA under this requirement will be used in a variety of ways. The primary audience for the summary data is the Medicare beneficiary. These data will provide comparative information on health plans to beneficiaries to assist them in choosing among plans. Where

applicable, HCFA expects plans to use these data for internal quality improvement. Each plan=s summary HEDIS7 3.0/98 and Medicare CAHPS data will be arrayed and returned to them. These data should help the plans identify some of the areas where their quality improvement efforts need to be targeted. Further, these data will provide HCFA and the Peer Review Organizations, information useful for monitoring quality of, and access to, care provided by the plans. HCFA may target areas of plan-reported outcomes that warrant further review based on these data.

B. Specifics for Implementing HEDIS7 3.0/98

1. The Time Line for Reporting HEDIS 7 3.0/98 Measures to HCFA

Plans will be required to submit HEDIS7 3.0/98 measures and patient level data as described below by June 1, 1998.

Health plans must report summary data for all required HEDIS7 3.0/98 measures identified in Attachment I, except for the Health of Seniors measure (see discussion below at **B. 4.**). HCFA is committed to assure the validity of the summary data collected, before it is released to the public, and to make the data available in a timely manner for beneficiary information.

In addition, plans must provide patient level identifier data used to calculate the denominators and numerators for the summary data of each measure. Attachment II lists the clinical Effectiveness of Care process measures (excluding the Health of Seniors measure) and the Use of Services measures for which patient identifiers and member month contributions must be provided. Beneficiaries shall be identified by their individual health insurance claim (HIC) number. The HIC number is the number assigned by HCFA to the beneficiary when he/she signs up for Medicare. Health plans use this number for accretions/deletions**.** In addition, plans must also provide the member month contribution of each beneficiary to the calculation of the denominators. The specific information to be reported is described in Attachment II-2.

Analysis of data with patient level identifiers allows HCFA to match this database to other databases for special projects of national interest and research which, among other issues, could assess whether certain groups (e.g. ethnic, racial, gender, geographic) are receiving fewer or more services than others. These analyses will not be used for public plan-to-plan comparisons. We anticipate that project results (not plan specific data) will be disseminated to plans and as appropriate, plans could initiate quality improvement projects based on the results in a given geographic area, such as a region or nationally.

The patient level identifier data will be protected in accordance with the Privacy Act of 1974 as amended. There have been questions and concerns expressed about the provision of patient level data. Plans are accountable for providing the data, unless prohibited by state law. In such cases, plans must provide HCFA with appropriate documentation of the legal prohibition, for consideration.

2. Data Specifications and Where Data Should be Sent

The summary data and patient level data for all plan-generated HEDIS7 3.0/98 measures must be sent to NCQA, HCFA=s contractor for the collection of data. The specifications for both the summary data and for the patient level data will be provided to the plans by early April, 1998 by NCQA. NCQA is developing an Excel spreadsheet for the summary data, and plans to continue to use text files for the patient level data. Health plans must use the standardized data collection tool to report HEDIS7 3.0 /98 data. **Plans must retain data used for reporting for three years.**

3. Certification of Data Validity

Because of the critical importance of ensuring accurate data, there will be a process of external validation of the HEDIS measures before public reporting. In addition, the plan=s senior executive officer or its director of medical affairs will be required to provide written attestation to the validity of the plan-generated data. The attestation form will be sent with the data collection tool.

4. *How the Health of Seniors Measure is Different from Other Effectiveness of Care Measures*

The Short Form (SF) 36 supplemented with additional case-mix adjustment variables will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS7 3.0/98 functional status measure, Health of Seniors. This measure is the first Aoutcomes≅ measure for the Medicare population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by contract/market area. The Health of Seniors measure is **not** a substitute for assessment tools that plans are currently using for clinical quality improvement. In 1998, 1,000 beneficiaries per plan will be surveyed with a targeted response rate of at least 70 percent. If the plan has fewer than 1,000 eligible members, all will be surveyed.

All Section 1876 risk and cost health plans whose Medicare contracts were in effect on or before January 1, 1997, must comply with this survey requirement during 1998. Plans, **at their expense,** will be expected to contract with any of the NCQA certified vendors for administration of the survey. You may begin contracting with vendors as soon as they are selected by NCQA (approximately
December 1, 1997). Contracts are expected to be in place by February, 1998 to ensure survey implementation by the middle of April, 1998. Further details to be provided by NCQA, HCFA=s contractor, organizing the survey. To expedite the survey process, plans may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means. A process to ensure plans remain blinded to survey participants will be developed by HCFA and NCQA.

Since the Health of Seniors measure looks at health status over a two-year period, results from this survey will not be publicly released in 1998. The survey in 2000 will assess the same

beneficiaries= health status compared to two years prior. Beneficiaries will be categorized into those who are better, the same or worse over the two year period. Each contract/market area score (the percent of beneficiaries who are better, the same or worse), will be reported in late 2000. See Attachment III for additional information.

C. Specifics for Implementing Medicare CAHPS

1. Update on 1997 CAHPS

On September 29, HCFA awarded a contract for implementation of Medicare CAHPS to a contractor team of the Barents Group, Westat, the Picker Institute, and Data Recognition Corporation. All Section 1876 risk and cost health plans whose Medicare contracts were in effect on or before
January 1, 1996 will be included in this survey. Data collection is planned to begin in January. HCFA will forward to plans, under separate cover, a copy of the final 1997 CAHPS with beneficiary cover letters and instructions to plans on how to handle questions from enrollees on this effort. This material will be sent to plans before administration of the survey. This survey will meet the requirements of the physician incentive regulations for a survey of current enrollees for 1997.

For those health plans that are not eligible to participate in HCFA=s administration of this survey (i.e., those whose Medicare contracts were not in effect on or before January 1, 1996), the Medicare CAHPS survey, or similar survey chosen by the plan, may be administered by the plans themselves in order to meet the 1997 requirements of the physician incentive regulations for current enrollees. Plans may implement this survey any time they choose as long as they report results to HCFA by March 31, 1998. These results will not be included in HCFA=s public release of survey information, and plans may not represent the results as part of the Medicare national effort.

2. Information regarding 1998 CAHPS

All section 1876 risk and cost health plans whose contracts were in effect on or before January 1, 1997 are required to participate in this administration of the Medicare CAHPS survey. HCFA will have the survey administered for all eligible Medicare contracts (or market areas where applicable) by a single independent contractor in the fall of 1998. **HCFA will pay for the administration of this survey.**

HCFA will draw the sample for each contract (and market area where applicable). Each sample will include 600 plan members who have been continuously enrolled in the contract for one year by the time the survey is administered. For plans with fewer that 600 eligible members, all eligible members will be surveyed.

The Medicare CAHPS questionnaire will include 80-90 items. Plans may obtain a copy of the 1997 version of the questionnaire by calling 1-800-358-9295 and asking for publication number AHCPR 97-R051. The questionnaire includes the CAHPS core items, as well as a set of items developed specifically to address the health care concerns of Medicare beneficiaries in managed care plans. The 1998 version of the Medicare CAHPS questionnaire may include some changes

from the 1997 version. Further information will follow as soon as it is available.

In order to achieve a minimum 70 percent response rate, the survey will include two mailings with telephone follow-up of nonrespondents. Because HCFA does not have beneficiary telephone numbers, we will ask plans to provide us with an electronic transmission, to include the HIC and telephone number for beneficiaries. HCFA will provide a list of beneficiaries for whom telephone numbers are needed. The list will include beneficiaries in the CAHPS sample embedded within a larger list of beneficiaries enrolled in the plan. Plans may choose to provide telephone numbers only for the list of beneficiaries provided by HCFA or for all beneficiaries enrolled in the plan, whichever is easier for the plan.

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

It is also anticipated that the Medicare CAHPS survey will be useful for plan internal quality improvement purposes. Because of health plans= and HCFA=s interest in plan internal quality improvement activity, HCFA will return to each plan its own summary data, consistent with the Privacy Act (Title 5, USC, section 552a). Specifically, no data will be returned from which a plan can infer an individual beneficiary=s response.

3. Relationship to Physician Incentive Plan regulation

On March 27, 1996, HCFA published a final regulation regarding physician incentive plans in managed care settings. These regulations, codified at 42 CFR 417.479, require plans whose providers have been determined to be at substantial financial risk to conduct a survey of current and recently disenrolled (within the last 12 months) members.

The Medicare national administration of CAHPS survey will satisfy the Physician Incentive Plan (PIP) survey requirement for current enrollees **for those plans included in the administration**. The first fielding of the CAHPS survey in January 1998, includes those risk and cost plans whose contracts were in effect before January 1, 1996 and **will meet the PIP current enrollee survey** requirement for contract year **1997**. The second fielding of the CAHPS survey in the Fall of 1998, includes those plans whose contracts were in effect before January 1, 1997, and **will meet** the PIP **current enrollee survey** requirement for contract year **1998**.

Plans that are not eligible to participate in HCFA=s administration of the Medicare CAHPS survey but are still required to meet the PIP survey requirement (i.e., those whose Medicare contracts were not in effect before January 1, 1996 for the first survey or whose Medicare contracts were not in effect before January 1, 1997 for the second survey) may field any enrollee survey of their choice. However, we would recommend the CAHPS survey (with a sample size of 600 or 100% of their enrolled population, whichever is smaller). These plans may conduct their survey whenever they wish as long as they report results to HCFA **by the deadlines established by the PIP requirement**. These plan-administered survey results will not be included in HCFA=s public release of survey information and plans may not represent the results as part of the Medicare national effort.

In 1998, Medicare CAHPS will not contain a module for disenrolled members; a standardized disenrollment module will be available as part of Medicare CAHPS in 1999. In the meantime, in order to satisfy the physician incentive requirements for a survey of disenrollees, HCFA suggests a standardized disenrollment survey that plans may self-administer in 1998. For details, see HCFA letter of October 10, 1997 on physician incentive plan regulations, survey requirements. Plans not required to do a survey under the physician incentive regulations, but required to do Medicare CAHPS under the terms of this OPL, are not required to conduct a disenrollment survey in 1998.

Contacts:

For technical questions regarding HEDIS7 3.0/98 specifications on sampling, data collection and reporting, please contact the NCQA Technical Advice Line at 202-955-1737.

For technical questions regarding Medicare CAHPS, please contact Lori Teichman of HCFA=s Center for Beneficiary Services at 410-786-6684.

If you have other questions, please contact your plan manager in central office.

Attachment I

HEDIS7 3.0/98 Domains/Measures by Category of Reporting For Summary Data

ALL PLANS TO REPORT BY LEGAL ENTITY:

Health Plan Stability:

* Indicators of Financial Stability

ALL PLANS 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
* Inpatient Utilization - General Hospital/Acute Care
* Ambulatory Care
* Inpatient Utilization - Non-Acute Care
* Mental Health Utilization - Inpatient Discharges and Average Length of Stay
* Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
* Readmission for Specified Mental Health Disorders
* Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
* Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
* Readmission for Chemical Dependency
* 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)

Attachment II-1

Measures Which Require Patient-Level Identifiers

Plans must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. The HIC number is assigned by HCFA to the beneficiary when he/she signs up for Medicare, and health plans use this number for accretions/deletions. In addition to the patient identifier, plans also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

The list below includes five new Use-of-Services measures: Inpatient Utilization - General Hospital/Acute Care; Inpatient Utilization - Nonacute Care; Ambulatory Care; Mental Health Utilization - Inpatient Discharges and Average Length of Stay; and Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay. Attachment II-2 demonstrates the type of information required for each measure.

Effectiveness of Care:

X Breast Cancer Screening
X Beta Blocker Treatment After A Heart Attack
X Eye Exams for People with Diabetes
X Follow-up After Hospitalization for Mental Illness

Use of Services:

X Frequency of Selected Procedures
X Inpatient Utilization - General Hospital/Acute Care
X Ambulatory Care
X Inpatient Utilization - Nonacute Care
X Mental Health Utilization- Inpatient Discharges and Average Length of Stay
X Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
X Readmission for Specified Mental Health Disorders
X Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay
X Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
X Readmission for Chemical Dependency

To be useful, this patient-level data must match the summary data for the measures discussed here, *i.e.* the patient file should contain all beneficiaries enrolled in the plan at the time that the summary measures are calculated. To ensure an exact match, the plan should make a copy, or Afreeze,≅ its database when the summary measures are calculated. NCQA will provide plans with exact file specifications in sufficient time to allow plans to identify the best way to fulfill this requirement.

Attachment II-2

Description of Patient-Level Information

This attachment describes the type of patient-level information required for each measure. These charts are only meant to communicate the type of information HCFA requires. NCQA will provide plans with exact format specifications for submitting data.

The following examples use a fictional plan of 100 members, including beneficiaries HIC1, HIC2, HIC3, and HIC100, to depict the required information. For each plan member, the plan must provide three important pieces of information.

X HIC Number (Patient Identifier)
X Member Month Contribution
X Each Member=s Contribution (or lack thereof) to Each Measure.

This implies that information should be provided on <u>every</u> plan member for <u>every</u> measure, even if the beneficiary did not contribute to a specific measure. For example, for Breast Cancer Screening, the plan would indicate Ano≅ for male members for both the denominator and numerator.

Ultimately, plans will submit data in numeric form, such as a 1 for yes and a 0 for no. However, the examples below use text in order to better communicate the desired information. NCQA will provide plans with final file specifications in time for them to adequately extract the required data.

The charts below demonstrate how beneficiaries HIC1, HIC2, HIC3, and HIC100 would appear in a database. For example, HIC1 has a member month contribution of 12 months, was counted in the denominator for breast cancer screening, and received some ambulatory mental health care and several other ambulatory services.

Please consult the HEDIS Technical Specifications for a complete description of each measure.

1. Member Month Contribution

Plans must provide the member month contribution for each HIC number.

HIC Number	Member Month Contribution
HIC 1	12
HIC 2	12
HIC3	8
HIC 100	10

2. Effectiveness of Care Measures

Plans will need to provide numerator and denominator information for the Beta Blocker and Eye Exam Effectiveness of Care measures similar to the Breast Cancer Screening example below. For the Follow-up After Hospitalization for Mental Illness measure, plans should report the total number of valid discharges and follow-ups for each beneficiary. (Please see the HEDIS Technical Specifications to determine which discharges and follow-ups should be counted.)

HIC Number	Denominator Breast Cancer Screening	Numerator Breast Cancer Screening	Denominator Follow-up after Mental Illness	Numerator Follow-up after Mental Illness
HIC 1	Yes	No	2	1
HIC 2	Yes	Yes	0	0
HIC3	No	No	0	0
HIC 100	No	No	1	1

3. Use of Services - Frequency of Selected Procedures

Plans must provide the same numerator information for all the procedures listed under the Frequency of Selected Procedures Measure. Plans should report the total number of times a beneficiary received each procedure.

HIC Number	Numerator Frequency of Selected Procedures - CABG	Numerator Frequency of Selected Procedures - Total Knee Replacement
HIC 1	0	0
HIC 2	1	2
HIC3	0	0
HIC 100	0	1

4. Use of Services - Inpatient Utilization - General Hospital/Acute Care

Plans must report the total number of discharges and associated days for each beneficiary for each category. Note that HIC3 had 2 surgery discharges with a total of 12 associated days. Hypothetically, the first hospitalization may have lasted 4 days and the second may have lasted 8 days. Similarly, HIC3 also had 2 medical hospitalizations in the reporting year with a total of 4 associated days. Note that the total discharges (4) and days (16) for HIC3 is the sum of the discharges and days from the other three categories: surgery, medicine, and maternity.

HIC Number	Numerator Discharges - Total	Numerator Days - Total	Numerator Discharges - Surgery	Numerator Days - Surgery
HIC 1	0	0	0	0
HIC 2	2	8	1	5
HIC3	4	16	2	12
HIC 100	0	0	0	0

.... continuation of Inpatient Utilization - General Hospital/Acute Care

HIC Number	Numerator Discharges - Medicine	Numerator Days - Medicine	Numerator Discharges - Maternity	Numerator Days - Maternity
HIC 1	0	0	0	0
HIC 2	1	3	0	0
HIC3	2	4	0	0
HIC 100	0	0	0	0

5. Use of Services - Ambulatory Care

Plans must provide the total number of visits or stays for each beneficiary in each category.

HIC Number	Numerator Outpatient Visits	Numerator Emergency Room Visits	Numerator Ambulatory Surgery/ Procedures	Numerator Observation Room Stays Resulting in Discharge
HIC 1	4	1	2	0
HIC 2	0	0	0	0
HIC3	2	1	0	0
HIC 100	6	0	1	1

6. Use of Services - Inpatient Utilization - Nonacute Care

Plans must provide the total number of discharges and associated days for each beneficiary. Again, the number of reported days should be the total number of days associated with each discharge. For example, HIC3 might have had 10 days associated with each of his 3 discharges, for a total of 30 days.

HIC Number	Numerator Nonacute Discharges	Numerator Nonacute Days
HIC 1	0	0
HIC 2	1	17
HIC3	3	30
HIC 100	0	0

7. Use of Services - Mental Health Utilization and Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay

Plans must provide the total number of discharges and associated days for each beneficiary. Again, reported days should be the total number of days associated with the reported discharges. Like the Mental Health Utilization example below, plans must report inpatient discharges and

days for Chemical Dependency Utilization.

HIC Number	Numerator MH Inpatient Discharges	Numerator MH Inpatient Days
HIC 1	**0**	**0**
HIC 2	**0**	**0**
HIC3	**1**	**8**
HIC 100	**2**	**14**

8. Use of Services - Mental Health Utilization and Chemical Dependency Utilization-Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Care

Like the Mental Health Utilization example below, plans must indicate both whether a member had any Chemical Dependency Utilization and, if so, where they received that care: inpatient, day/night, or ambulatory. For both the Mental Health and Chemical Dependency Utilization measures, if any equals Ayes≅ then at least one of the three numerator columns (inpatient, day/night, ambulatory) should have a value of Ayes.≅

HIC Number	Numerator Mental Health Utilization - Any	Numerator Mental Health Utilization - Inpatient	Numerator Mental Health Utilization - Day/Night	Numerator Mental Health Utilization - Ambulatory
HIC 1	**Yes**	**No**	**No**	**Yes**
HIC 2	**Yes**	**No**	**Yes**	**No**
HIC3	**No**	**No**	**No**	**No**
HIC 100	**No**	**No**	**No**	**No**

9. Use of Services - Mental Health Readmission and Chemical Dependency Readmission

Like the Mental Health Readmission measure below, plans must indicate which members contribute to the denominator of the Chemical Dependency Readmission measure and to the numerator for Chemical Dependency Readmissions at 90 days and 365 days.

HIC Number	Denominator Readmission for MH Disorders	Numerator Readmission for MH Disorders - 90 Days	Numerator Readmission for MH Disorders - 365 Days
HIC 1	**No**	**No**	**No**
HIC 2	**Yes**	**Yes**	**Yes**
HIC3	**No**	**No**	**No**
HIC 100	**Yes**	**No**	**Yes**

ATTACHMENT III

HEDIS73.0/98:

1. How will HCFA release data for HEDIS73.0/98?

A. No patient level data will be released. Patient level data is protected in accordance with the Privacy Act of 1974 (The entire Privacy Act, Title 5, U.S.C., Sec.552.a will apply). This data will not be made public. The data will be used by HCFA and its representatives for research purposes and plan monitoring.

HCFA will release the summary data following validation. At that point, the data will be public. There will be nothing to preclude NCQA and others from using it in a variety of formats. It will be available to the public in such formats as the Internet, printed materials, and CD ROM. ICAs (Information, Counseling, and Assistance) of state offices of aging and other advocacy organizations will assist in reaching the beneficiary population.

HEALTH OF SENIORS:

1. Will the health plans have access to the members= data before 2000, as this could be key in quality improvement efforts?

A. Health of Seniors data will be plan-specific and in aggregate form (i.e., no patient-level information will be provided). Aggregate data will be provided after the 24 month follow-up survey in 2000. It has not yet been decided whether aggregate data will be provided after the first baseline survey in 1998. As part of a contract with NCQA, NCQA will convene a Health of Seniors technical expert panel which will suggest an approach for the release of aggregate data.

2. Do we have an estimate of the range of cost for the Health of Seniors survey?

A. Yes, the anticipated range is $20- $25 per completed survey.

3. Can you clarify the 1,000 cohort drawn for the Health of Seniors survey? In year two (1999) of the evaluation, will additional sampling be drawn if less than 1,000 enrollees can be contacted? And, will this occur again in 2000? When will the next cohort of 1,000 enrollees be drawn, in other words, will Health of Seniors reports come out each year after 2000 (e.g. requiring a new cohort be drawn in 1999 for reporting in 2001)? Due to the cost per survey, this is a particular budget issue for plans which may expect to pay for more than 1,000 surveys per year depending on the reporting schedule.

A. The diagram below indicates the current sampling strategy for the Health of Seniors measure. Replacement of the 1,000 persons surveyed at baseline will not be necessary, as the 24 month follow-up does not anticipate a 100% response rate (the goal is at least 70%). It is

anticipated that an entirely new cohort will be drawn every year so that the measure may be reported annually.

1998	**1999**	**2000**	**2001**
Baseline	Baseline	24 Month Follow-up	24 Month Follow-up
Cohort I- 1000	Cohort II - 1000	Cohort I	Cohort II
		New sample of 1,000 drawn for Cohort III	New sample of 1,000 drawn for Cohort IV

Since the technical expert panel will review the proposed specifications for the measure, this could change.

4. How will enrollee mortality be handled in reporting the results of the SF-36?

A. Beneficiaries who die between the baseline survey and 24 month follow-up are categorized in Aworse≅ condition for reporting purposes.

5. Will HCFA risk adjust in its surveys?

A. If approved by the technical expert panel, we anticipate that the Health of Seniors measure will be risk adjusted for age, race, sex, social support, co-morbid conditions, and normal expected decline in health status based on age.