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HIPAA

Under the *Health Information Portability and Accountability Act (HIPAA)* privacy rule, data collection for HEDIS® is permitted and does not require patient consent or authorization. Our members’ personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers. All of the health plan providers’ records are protected by this law.

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

HEDIS data collection and release of information is permitted under *HIPAA* because the disclosure is part of quality assessment and improvement activities.
What is HEDIS?

HEDIS (HĒ·DIS)

Healthcare

Effectiveness

Data and

Information

Set

• HEDIS is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service.

• HEDIS is coordinated and administered by the National Committee for Quality Assurance (NCQA) and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.

• All managed care companies that are NCQA-accredited perform HEDIS reviews the same time each year.

• A subset of HEDIS measures will be collected and reported for the Marketplace (health care exchanges) product lines.

• HEDIS is a retrospective review of services and performance of care.
• Receiving all requested medical records helps ensure that our results are an accurate reflection of care provided.

• HEDIS results are audited by an independent, NCQA-certified auditor prior to being reported.

• Results are used to measure performance, identify quality initiatives and provide educational programs for providers and members.

• Results are reported as part of Medicare STARS, NCQA health plan ratings, and state and Marketplace report cards.
What is your role in HEDIS?

We appreciate your cooperation and timeliness in submitting the requested medical record information.

• You play a central role in promoting the health of our members.
• You and your office staff can help facilitate the HEDIS process improvement by:
  — Providing the appropriate care within the designated time frames.
  — Documenting all care in the patient’s medical record.
  — Accurately coding all claims. Providing accurate information on a claim may reduce the number of records requested.
  — **Responding to our requests for medical records within [5 to 7] business days.**

The records you provide during this process help us validate the quality of care provided to our members.
Annual HEDIS calendar

January to May
- Clinical Quality staff initiates medical record requests and collection from our providers.

June
- Results are reported to NCQA.

July to October
- NCQA releases Quality Compass® results nationwide.
  - July — commercial results
  - Sep. and Oct. — Medicaid and Medicare results.

Each year NCQA sets a deadline in May for health plans to complete HEDIS data collection.

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

HEDIS data is collected three ways:

1. **Administrative** — Data is obtained from our claims database.

2. **Hybrid** — Data is obtained from our claims database and medical record reviews.

3. **Survey** — Data is obtained from member and provider surveys.
• Medical record requests are sent to providers.
• The request includes a member list identifying assigned measures and the minimum necessary information needed.
• Data collection methods include: fax, mail, onsite for larger requests, remote EMR system access, and electronic data interchange via a secure site.
• Due to the shortened data collection time frame, a [five- to seven-day] turnaround is appreciated.

We recommend uploading records to our secure site to allow for optimal tracking of information submitted.
Hybrid HEDIS measures

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<tr>
<th>Acronym</th>
<th>HEDIS measure</th>
<th>Acronym</th>
<th>HEDIS measure</th>
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<td>IMA</td>
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<td>CBP</td>
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<td>CDC</td>
<td>Comprehensive Diabetes Care</td>
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<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
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<td>CIS</td>
<td>Childhood Immunization Status</td>
<td>W15</td>
<td>Well-Child Visits in the first 15 months of life</td>
</tr>
<tr>
<td>COA</td>
<td>Care for Older Adults (Medicare SNP* and MMP**)</td>
<td>W34</td>
<td>Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life</td>
</tr>
<tr>
<td>COL</td>
<td>Colorectal Cancer Screening</td>
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</tbody>
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* SNP = Special needs population
** MMP = Medicare-Medicaid programs
## Administrative HEDIS measures (cont.)*

<table>
<thead>
<tr>
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<td>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</td>
<td>FUH</td>
<td>Follow-Up after Hospitalization for Mental Illness</td>
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<td>ADD</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>IET</td>
<td>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</td>
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<tr>
<td>AMM</td>
<td>Antidepressant Medication Management</td>
<td>LBP</td>
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<td>ART</td>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
<td>MMA</td>
<td>Medication Management for People with Asthma</td>
</tr>
<tr>
<td>OMW</td>
<td>Osteoporosis Management in Women Who Had Fracture</td>
<td>SSD</td>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications</td>
</tr>
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* Note: List is not comprehensive.
### Q&A

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should I send the entire record?</td>
<td>No, we ask that you only provide the minimum necessary to meet our request.</td>
</tr>
<tr>
<td>Whom do I contact if I have questions about HEDIS requests?</td>
<td>Each medical record request includes contact information for the HEDIS Lead in Clinical Quality who is assigned to your office.</td>
</tr>
<tr>
<td>How do I improve scores for HEDIS measures?</td>
<td>Use correct diagnosis and procedure codes, submit claims and encounter data on time, ensure presence of all components required in the medical record documentation.</td>
</tr>
<tr>
<td>How are HEDIS rates communicated to physicians?</td>
<td>Educational articles are included in provider newsletters, which can be found on the health plan’s website.</td>
</tr>
<tr>
<td>Where can I get more information about NCQA and HEDIS?</td>
<td>More information can be found at <a href="http://www.ncqa.org">www.ncqa.org</a>.</td>
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</tbody>
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Appendix 1

HEDIS hybrid and administrative measures, required documentation
ABA – Adult BMI Assessment*

Members ages 18 to 74 who had an outpatient visit with a BMI documented during the measurement year or the year prior

*Medicare
Medicaid
Commercial

Documentation needed:
1. BMI — date and value
2. Weight — date and value

A height, weight and BMI percentile must be recorded for patients who are age 18 to 19 on the date of visit.

Common chart deficiencies:
• Height and/or weight are documented but there is no calculation of the BMI.
• Ranges and thresholds are not acceptable for this measure. A distinct BMI value or percentile is required.
APC – Adolescent Preventive Care*

Adolescents ages 12 to 17 who had at least one outpatient visit with a PCP or OB/GYN practitioner and required documentation during the measurement year.

* NY Quality Assurance Reporting Requirements (QARR)

Documentation needed:

Documentation in 2019 for the assessment or counseling or education on:

1. Risk behaviors associated with sexual activity and preventive actions.
2. Assessment for depression.
3. Risks of tobacco use.
4. Risk of substance abuse (including alcohol).

Common chart deficiencies:

- No documentation present in chart.
- Not all items are addressed during office visit.
AWC –
Adolescent Well-Care Visits*

Members 12 to 21 years old in the measurement year who have had at least one well-care visit with a PCP or OB/GYN (for example, school physical, Pap test, postpartum visit) during the measurement year.

Services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

* Medicaid and Commercial

Documentation needed:
1. Health history
2. Physical developmental history
3. Mental developmental history
4. Health education and anticipatory guidance

Preventive services may be rendered on visits other than well-child visits.

Common chart deficiencies:
- Lack of documentation of education and anticipatory guidance
- Adolescents being seen for sick visits only and no documentation related to well-child visits
CBP – Controlling High Blood Pressure*

Members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 Hg) during the measurement year (2018)

*Medicare Medicaid Commercial

Documentation needed:
1. At least two outpatient visits on different dates of service with a diagnosis of HTN during the measurement year [(2018)] or the year prior [(2017)]
2. The BP reading must occur on or after the date when the second diagnosis of hypertension occurs

Diagnosis can be from progress note, problem list, consult note, hospital admission or discharge (no longer need DX).

Common chart deficiencies:
• Rechecked elevated pressures during the same visit is not documented.
• Diagnosis date of hypertension is not clearly documented (no longer need DX).
CCS – Cervical Cancer Screening*

Female members 24 to 64 during the measurement time frame who had a cervical cancer screening

Female members ages 30 to 64 during the measurement time frame who had cervical cancer screening and HPV test

*Commercial and Medicaid

Documentation needed:
1. Date and result of cervical cancer screening test or
2. Date and result of cervical cancer screening test and date of HPV test on the same date of service or
3. Evidence of hysterectomy with no residual cervix

Common chart deficiencies:
• Lack of documentation related to women’s health present in PCP charts.
• Documentation related to hysterectomy is incomplete.
• HPV tests ordered due to positive Pap tests do not count.
CDC – Comprehensive Diabetes Care*

Members 18 to 75 with type 1 and 2 diabetes who received proper testing and care for diabetes during the measurement year

*Medicare
Medicaid
Commercial

Documentation needed:
1. Hemoglobin A1C*
2. Blood pressure*
3. Nephropathy: Urine rests, ACE/ARB prescription, or visits to nephrologists during the measurement year
4. Dilated retinal eye exam (during the measurement year or year prior)

Common chart deficiencies:
• Incomplete information from consultants in the PCP charts
• Incomplete information related to yearly lab testing and results

* Note: Date and result of last screening in the measurement year.
CIS – Childhood Immunization Status*

Percentage of children 2 years of age who had all of the required immunizations

*Medicaid and Commercial

Documentation needed:

Four each — diphtheria, tetanus, pertussis (DTP), pneumococcal conjugate vaccine (PCV)

Three each — Hepatitis B, Haemophilus influenza type B (HIB), inactivated polio vaccine (IPV)

Two or three — Rotavirus (RV) available in Rotarix (two dose) or Rota Teq (three dose)

Two — Influenza

One each — Hepatitis A; measles, mumps and rubella (MMR); varicella zoster virus (VZV) or had chickenpox

Please include this documentation if any immunizations are missing:

• Parental refusal
• Request for delayed immunization schedules
• Immunizations given at health departments
• Immunizations given in the hospital at birth
• Contraindications or allergies
CIS – Childhood Immunization Status (cont.)

Percentage of children 2 years of age who had all of the required immunizations

*Medicaid and Commercial

Common chart deficiencies:

- Immunizations received after the 2nd birthday
- Incomplete number of vaccines administered according to the recommended vaccine series
- PCP charts do not contain immunization records if received elsewhere
  - Health Departments
  - Immunizations that are given in the hospital at birth
- No documentation of contraindications/allergies
COA — Care of Older Adults*

The percentage of adults 66 and older who had each of the following during the measurement year

*Medicare SNP Medicare-Medicaid Programs (MMP)

Documentation needed:

1. Advance care planning
   Includes a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Examples include:
   • Advance directives.
   • Actionable medical orders.
   • Living will.
   • Surrogate decision maker.

2. Medication review:
   Includes at least one medication review conducted by a prescribing practitioner or clinical pharmacist in the measurement year and the presence of a medication list or includes notation that the member is not taking any medication.
COA — Care of Older Adults* (cont.)

The percentage of adults 66 and older who had each of the following during the measurement year

*Medicare SNP Medicare-Medicaid Programs (MMP)

Documentation needed:

3. Includes evidence of at least one functional status assessment and the date it was performed as documented by:
   - Instrumental Activities of Daily Living (IADL).
   - Activities of Daily Living (ADL).
   - Results of a standardized functional status assessment tool.
   - Notation that at least three of the following were assessed: notation of functional independence, sensory ability (includes hearing, vision, and speech-need all three), cognitive status, and ambulatory status.

4. Pain assessment:

   Includes evidence of a pain assessment using a standardized pain assessment tool and the date it was performed.
COL —
Colorectal Cancer Screening*

Members age 50 to 75 who had appropriate screening for colorectal cancer

* Medicare and Commercial

Documentation needed:
Date and result of one of these screenings:
• Colonoscopy (within last 10 years)
• Fecal occult blood testing (FOBT) in measurement year
  – FOBT tests performed in an office setting or on a digital rectal exam do not count
• Flexible sigmoidoscopy (within last five years)
• CT colonography (within last five years)
• Fecal immunochemical DNA test (FIT-DNA) a.k.a. Cologuard®, (within the last three years)

Patient reported data noted on a medical record is sufficient evidence with date and results noted.

Common chart deficiencies:
• Colorectal screenings are not consistently documented in health histories.
• Typically this information is included on health history forms; however, this information is not always provided as part of the record submissions.
IMA — Immunizations for Adolescents*

Adolescent members turning 13 in the measurement year who had these immunizations

*Medicaid and Commercial

Documentation needed:

1. Meningococcal — one dose on or between 11th and 13th birthdays.
2. Tdap — one dose on or between 10th and 13th birthdays.
3. HPV — two- or three-dose vaccine series administered between 9th and 13th birthdays.

If immunizations are missing, please include:
- Documentation of parental refusal
- Health Department records
- Patient contraindications/allergies

Common chart deficiencies:

- Immunizations are not administered during appropriate time frames.
- PCP charts do not contain immunization records if received elsewhere, such as local Health Departments.
LSC — Lead Screening in Children*

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

*Medicaid NY QARR

Documentation needed:
- A note indicating the date the test was performed
- The result or finding

Common chart deficiencies:
- Lead assessment does not constitute a lead screening
- Testing conducted outside of time frame
- Physician assumes that there is no exposure due to environment
MRP – Medication Reconciliation Post-Discharge*

The percentage of discharges from January 1 through December 1 of the measurement year for members 18 and older for whom medications were reconciled on or within 30 days of discharge

* Medicare

Documentation needed:

• Medication reconciliation completed by the prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge

• Need documentation that it was completed and the date

Any of the following evidence meets criteria:

• Notation that the medications prescribed upon discharge were reconciled with the current medication in the outpatient record

• A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications

• Notation that no medications were prescribed upon discharge

• Evidence that the member was seen for post-discharge follow-up with evidence of medication reconciliation or review
PPC —
Prenatal and
Postpartum Care*

Female members who had a live birth on or between November 6 of the year prior and November 5 of the measurement year

* Medicaid
Commercial

Documentation needed:
1. Prenatal care — Prenatal visit within 42 days of enrollment or during the first trimester
2. Postpartum care — Postpartum visit within 21 to 56 days of delivery

Common chart deficiencies:
• Incision check for post C-section alone does not constitute a postpartum visit.
• Office visit falls outside of time frame.
TRC — Transitions of Care*

The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation postdischarge

* Medicare (new measure for [2018])

Documentation needed:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Documentation of receipt of discharge information on the day of discharge or the following day
- Documentation of patient engagement after inpatient discharge (for example, office visits, home visits and telehealth) provided within 30 days after discharge
- Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 31 days after discharge
WCC — Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Members age 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN with the following components in the measurement year

* Medicaid Commercial

Documentation needed:

1. BMI percentile
   • BMI percentile and date
   • BMI values, ranges and thresholds do not meet the criteria for this measure
   • Weight and date
   • Height and date

2. Counseling for nutrition:
   Discussion on diet and nutrition, anticipatory guidance or counseling on nutrition

2. Counseling for physical activity:
   Discussion of current physical activities, counseling for increased activity or anticipatory guidance on activity
**WCC — Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** (cont.)

* Medicaid Commercial

**Common chart deficiencies:**

- BMI documented as a number versus percentile, which is based on height, weight, age and gender
- BMI growth chart not included in records submitted
- Anticipatory guidance does not specify what areas were addressed and are not age appropriate
- Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations
- Developmental milestones do not constitute anticipatory guidance or education for physical activity
- Preprinted forms do not address nutrition and physical activity
W15 – Well Child Visits in the First 15 Months of Life*

Services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure

Children who turned 15 months of age during the measurement year who had zero to six well-child visits

* Medicaid
Commercial

Documentation needed:
1. Health history
2. Physical developmental history
3. Mental developmental history
4. Physical exam
5. Health education/anticipatory guidance

Preventive services may be rendered on visits other than well-child visits.

Common Chart deficiencies:
- Lack of documentation of education and anticipatory guidance
- Children being seen for sick visits only and no documentation related to well-child visits
W34 — Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life*

Services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.
Children 3 to 6 years old in the measurement year that have had at least one “well-care” visit with a PCP during the measurement year

* Medicaid
Commercial

Documentation needed:
1. Health history
2. Physical developmental history
3. Mental developmental history
4. Physical exam
5. Health education/anticipatory guidance

Preventive services may be rendered on visits other than well-child visits.

Common chart deficiencies:
• Lack of documentation of education and anticipatory guidance
• Children being seen for sick visits only and no documentation related to well-child visits
HEDIS administrative measures
AAB – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*

The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

* Medicaid
Commercial

Dispensed prescription for antibiotic medications (listed in the HEDIS 2018 Medication List) on or three days after the index episode start date (IESD).

Intake period
January 1 through December 24 of the measurement year. The intake period captures eligible episodes of treatment.

Episode date
The date of service for any outpatient or ED visit during the intake period with a diagnosis of acute bronchitis.

This measure is reported as an inverted rate. A higher rate indicates appropriate treatment of adults with acute bronchitis. It describes the proportion for whom antibiotics were not prescribed.
AMM – Antidepressant Medication Management*

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment

*Medicare Medicaid Commercial

Two rates are reported:

• **Effective Acute Phase Treatment** — The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

• **Effective Continuation Phase Treatment** — The percentage of members who remained on an antidepressant medication for at least 180 days (six months).
ADD — Follow-Up Care for Children Prescribed ADHD Medication*

The percentage of children ages 6 to 12 who received an initial prescription for ADHD medication and had at least two follow-up visits within 270 days.

* Medicaid
Commercial

Two rates are reported:

- **Initiation Phase** — Received at least one follow-up visit with a practitioner with prescribing authority within 30 days of prescription.

- **Continuation and Maintenance Phase** — Remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits within 270 days after the initiation phase ended with a practitioner with prescribing authority.
ART — Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis *

The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD)

* Commercial Medicaid Medicare

Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year

There are two ways to identify members who received a DMARD:
1. Claim/encounter data
2. Pharmacy data
FUH — Follow-Up After Hospitalization for Mental Illness*

The percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

*Medicare
Medicaid
Commercial

Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days of discharge

2. The percentage of discharges for which the member received follow-up within seven days of discharge

Do not include visits that occur on the date of discharge.
**LBP – Use of Imaging Studies for Low Back Pain***

The percentage of members 18 to 50 years old with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

* Medicaid Commercial

**Intake period** — January 1 through December 3 of the measurement year. The Intake Period is used to identify the first outpatient or ED encounter with a primary diagnosis of low back pain.

**Index Episode Start Date (IESD)** The earliest date of service for an outpatient or ED encounter during the intake period with a principal diagnosis of low back pain.

This measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain. This indicates the proportion for whom imaging studies did not occur.
MMA – Medication Management for People with Asthma*

The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period

* Medicaid
  Commercial

Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.

2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.
OMW — Osteoporosis Management in Women Who Had Fracture*

The percentage of women 67 to 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

* Medicare

Intake period — A 12-month (one year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture.

IESD — The earliest date of service for any encounter during the intake period with a diagnosis of fracture. For an outpatient or ED visit, the IESD is the date of service. For inpatient encounters, the IESD is the date of discharge.

Negative DX history — A period of 60 days (two months) prior to the IESD when the member had no diagnosis of fracture.

For direct transfers, the first admission date should be used when determining the number of days prior to the IESD.
Appendix 2

HEDIS 2019 Physician Documentation Guidelines and Administrative Codes
HEDIS 2019
Physician Documentation Guidelines and Administrative Codes

This reference document includes HEDIS measures and the criteria (including ICD-10, CPT and HCPCS codes) required for your patient’s chart or claims review to be considered valid for HEDIS measurements.

To access this document on our provider website:
1. Please visit [www.anthem.com].
2. Select Providers.
4. Choose your state, then select View Medical Policies and UM Guidelines.
5. Under the Health and Wellness Tab, select Quality Improvement and Standards.
6. Select HEDIS Information.
Appendix 3

Survey data
Survey Data

There are measures that are collected using survey methodology.

CAHPS® Health Plan Survey 5.0H, Adult Version

• This measure provides information on the experiences of our members and indicates how well the organization meets their expectations for our Commercial and Medicaid populations.

• Medicare Advantage members are surveyed by each health plan using the Medicare Advantage CAHPS survey developed by CMS.

Medicare Health Outcomes Survey

• This measure provides a general indication of how well an organization manages the physical and mental health of its Medicare members by measuring their status at the beginning and the end of a two-year period.

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

CAHPS surveys represent an effort to accurately and reliably capture information from consumers about their experiences with health plans. The surveys assess our members’ experience with our health plan over the past 12 months for Commercial plans and the past six months for Medicaid and Medicare plans.

Health plans report survey results to NCQA, which uses the results to:
• Make accreditation decisions.
• Rate health plans.
• Create national benchmarks for care and service.

Health plans also use CAHPS survey data for internal quality improvement purposes.
Results reflect members rating the plan 8, 9 or 10 on a scale of 0 to 10 in the following areas:

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

CAHPS Health Plan Survey 5.0 H – Adult Version
Composite scores also summarize responses for these key areas:

1. Claims processing (commercial only)
2. Customer service
3. Getting care quickly
4. Getting needed care
5. How well doctors communicate
6. Shared decision making
7. Plan information on costs (commercial only)

There are two areas that are reported individually:

1. Health promotion and education
2. Coordination of care
Medicare Health Outcomes Survey

Provides a general indication of how well a Medicare organization manages the physical and mental health of its members at the beginning and the end of a two-year period. Scores are categorized and percentages reported as:

- Better than expected
- Same as expected
- Worse than expected
Thank you!

75099MUSENMUB 11/09/18