

Attachment 1: HEDIS 1999 Reporting Set Measures

Effectiveness of Care

- Childhood Immunization Status
- Adolescent Immunization Status
- Advising Smokers to Quit
- Flu Shots for Older Adults
- Breast Cancer Screening
- Cervical Cancer Screening
- Prenatal Care in the First Trimester
- Low Birth-Weight Babies
- Check-Ups After Delivery
- Beta Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Events
- Eye Exams for People with Diabetes
- Comprehensive Diabetes Care
- Follow-Up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- The Health of Seniors

Access/Availability of Care

- Adults -- Access to Preventive/Ambulatory Health Services
- Children's Access to Primary Care Practitioners
- Initiation of Prenatal Care
- Low Birth-Weight Deliveries at Facilities for High-Risk Deliveries and Neonates
- Annual Dental Visit
- Availability of Language Interpretation Services

Satisfaction with the Experience of Care

- HEDIS/CAHPS 2.0H Survey (Adult Medicaid, Commercial)
- HEDIS/CAHPS 2.0H Child (Medicaid, Commercial)
- HEDIS/CAHPS 2.0, Medicare

Health Plan Stability

- Disenrollment
- Practitioner Turnover
- Years in Business/Total Membership
- Indicators of Financial Stability

Use of Services

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
- Adolescent Well-Care Visits

- Frequency of Selected Procedures
- Inpatient Utilization
- General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization
- Non-Acute Care
- Discharge and Average Length of Stay
- Maternity Care
- Cesarean Section Rate
- Vaginal Birth After Cesarean Rate
- Births and Average Length of Stay
- Mental Health Utilization
- Inpatient Discharges and Average Length of Stay
- Mental Health Utilization
- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Chemical Dependency Utilization / Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization / Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Outpatient Drug Utilization

Cost of Care

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

Health Plan Descriptive Information

- Board Certification/Residency Completion
- Practitioner Compensation
- Arrangements with Public Health, Educational and Social Service Organizations
- Total Enrollment
- Enrollment by Payer
 - Unduplicated Count of Medicaid Members
 - Cultural Diversity of Medicaid Membership
 - Weeks of Pregnancy at Time of Enrollment in the Health Plan

Attachment 2: NCQA Preliminary National and Regional Benchmarks

National Committee
for Quality Assurance

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Washington, DC 20036

Main: 202/955-3500
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NCQA

A. MEMORANDUM

To: Persons Interested in Accreditation '99

From: Phyllis Torda
Vice President, Policy and Product Development

Date: March 12, 1999

Re: Preliminary HEDIS Effectiveness of Care Benchmarks and Thresholds for Accreditation '99

This document reports preliminary national benchmarks and national and regional thresholds for HEDIS Effectiveness of Care measures required for NCQA's Accreditation '99 for the commercially insured and Medicare populations. These preliminary benchmarks and thresholds are based on HEDIS 3.0/1998 data reported to NCQA. Although NCQA will use HEDIS 1999 results to determine the benchmarks and thresholds for Accreditation '99 scoring, these benchmarks and thresholds based on HEDIS 3.0/1998 data provide an indication of what they will be. The information presented in this document represents the best indication we can provide, but benchmarks and thresholds may change based on HEDIS 1999 results reported by June 15, 1999. We do not yet have survey results from the new CAHPS - 2.0H survey to use to establish benchmarks and thresholds for the survey results. NCQA will publish final benchmarks and thresholds for required Effectiveness of Care and HEDIS/CAHPS 2.0H results by July 30, 1999.

ACCREDITATION '99 SCORING

As described in the *Accreditation '99 Standards* and in the *Accreditation '99 Surveyor Guidelines*, NCQA is requiring managed care organizations (MCOs) accredited after July 1, 1999 to submit specified HEDIS Effectiveness of Care and HEDIS/CAHPS 2.0H Survey Results. Between July 1, 1999 and June 30, 2000 these results may count for 25 percent of a plan's accreditation score. NCQA incorporated several features into Accreditation '99 scoring to take into account concerns about using HEDIS data in this new way:

- During this first year, July 1, 1999 and June 30, 2000, NCQA will score plans going through full accreditation surveys both by taking into account performance on standards and HEDIS results and by taking into account performance on standards alone. NCQA will base accreditation decisions on whichever scoring method results in a better outcome.
- NCQA will determine the HEDIS portion of the score by comparing a plan's results to a national benchmark (the 90th percentile of national results) and to regional and national thresholds (the 75th, 50th and 25th percentiles) and averaging the points based on comparison to the regional and national thresholds. (NCQA will compare consumer survey results only to national thresholds since variation in this data is not as great by region.)
- To take into account inherent sampling variation, NCQA will add five points to each Effectiveness of Care result prior to scoring.

Beginning July 1, 2000 NCQA will base accreditation decisions for all plans going through full accreditation surveys since July 1, 1999 on both performance on standards and HEDIS results. Plans going through full accreditation surveys between July 1, 1999 and June 30, 2000 will submit updated HEDIS results in June 2000 and again in 2001, and NCQA will use those results to redetermine accreditation status.

Please consult the *Accreditation '99 Standards* or *Accreditation '99 Surveyor Guidelines* for further details about required HEDIS results and scoring.

MEDICARE

Preliminary benchmarks and thresholds are available for Effectiveness of Care measures relevant to the Medicare population, except for Follow-Up After Hospitalization for Mental Illness. HCFA did not audit or release data for this measure. Data for two measures, Advising Smokers to Quit and Flu Shots for Older Adults, comes from the CAHPS survey fielded by an independent vendor in 1997 on behalf of HCFA.

MEDICAID NOT YET AVAILABLE

We are providing preliminary benchmarks and thresholds for the commercially insured and Medicare populations only at this time. NCQA does not yet have sufficient HEDIS results for the Medicaid population to calculate preliminary benchmarks and thresholds. We are hopeful that by next year, we will have sufficient results to do so and are working with HCFA and states to create this database.

USE OF AUDITED, UNAUDITED RESULTS

All of the preliminary *national* benchmarks and thresholds provided in this document are based solely on audited data. Regional thresholds are based on audited results if NCQA's database contained 20 or more audited rates. Where the database included fewer than 20 reported audited rates for a region, the preliminary thresholds are based on audited and unaudited rates. No preliminary thresholds are provided for regions with fewer than 19 reported rates. Differences between benchmarks and thresholds calculated from audited and unaudited data are small, based on the data in our database. (This indicates that, for the data in our database, errors detected by audits are not biased in a systematic direction.)

ADDITIONAL CONSIDERATIONS

Please keep in mind the following issues related to the data used to determine the benchmarks and thresholds:

- The database includes data voluntarily reported to NCQA reflecting performance of 490 products nationwide (331 HMO and 159 POS).
- Because MCOs voluntarily reported these results for the commercial population, the results may not be totally representative of performance by plans accredited by NCQA. The distributions of results may change this year as additional plans submit the results required for accreditation. The Accreditation 1999 scoring system takes this into account by: basing accreditation outcomes in this first year on scores with or without HEDIS results, whichever is higher; weighting disproportionately results at or above the 50th percentile (results in the 50th-75th percentile receive .85 points out of 1.25); and recognizing that all rates could be up to five percentage points higher due to sampling variation.
- There is currently significant variation by region in reported data. After much internal and external debate, NCQA decided to recognize this by scoring on the basis of both regional and national thresholds.
- Once NCQA publishes final benchmarks and thresholds based on HEDIS 1999 results, we plan to hold these constant for at least two years so that plans receive credit for improving their rates.
- NCQA will closely monitor the distributions of results to ensure that individual measures are providing information meaningful for plan-to-plan comparison. If, for example, results indicate strong performance on a specific measure by the vast majority of plans, it may be appropriate to consider less frequent reporting of the measure.

We hope you find this information helpful. Please call our Technical Inquiry Line (202-955-5697) with any questions.

**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
BETA BLOCKER TREATMENT AFTER A HEART ATTACK**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	23	NA	96	93	84
2	All	36	NA	83	70	58
3	All	32	NA	88	84	67
4	All	35	NA	81	73	63
5	All	57	NA	83	77	64
6	All	20	NA	75	60	45
7			NA			
8			NA			
9			NA			
10			NA			
NATIONAL	Audit	99	93	88	78	64

REGIONS

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
BREAST CANCER SCREENING**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	33	NA	81	75	70
2	All	59	NA	74	69	63
3	Audit	20	NA	73	70	65
4	Audit	26	NA	76	74	69
5	Audit	26	NA	79	72	69
6	Audit	30	NA	72	68	65
7	All	38	NA	73	71	68
8	Audit	20	NA	73	70	62
9	All	30	NA	76	71	64
10	All	25	NA	79	75	70
NATIONAL	Audit	180	81	76	72	67

REGIONS

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
CERVICAL CANCER SCREENING**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	33	NA	83	73	68
2	All	59	NA	78	70	64
3	Audit	20	NA	75	73	66
4	Audit	27	NA	74	72	68
5	Audit	23	NA	75	70	61
6	Audit	32	NA	74	72	67
7	All	38	NA	78	73	70
8	Audit	20	NA	75	72	66
9	All	30	NA	76	71	66
10	All	27	NA	78	74	70
NATIONAL	Audit	178	81	76	72	67

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
CHECK-UPS AFTER DELIVERY**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	33	NA	83	78	64
2	All	57	NA	74	64	54
3	Audit	20	NA	86	75	56
4	Audit	25	NA	84	80	69
5	All	90	NA	84	77	63
6	Audit	29	NA	73	64	46
7	All	33	NA	78	68	35
8			NA			
9	All	30	NA	77	67	59
10	All	23	NA	73	64	39
NATIONAL	Audit	159	86	80	71	53

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
EYE EXAMS FOR DIABETICS**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	33	NA	56	47	40
2	All	56	NA	52	40	30
3	Audit	20	NA	47	39	33
4	Audit	24	NA	44	36	30
5	Audit	25	NA	36	33	27
6	Audit	31	NA	42	36	27
7	All	37	NA	39	34	23
8	All	19	NA	45	37	28
9	All	28	NA	44	39	30
10	All	24	NA	53	41	37
NATIONAL	Audit	176	56	48	37	30

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	30	NA	86	77	69
2	All	40	NA	77	69	55
3	All	51	NA	77	69	63
4	All	60	NA	72	62	49
5	All	74	NA	83	72	63
6	All	35	NA	78	71	65
7	All	30	NA	76	69	56
8			NA			
9	All	19	NA	83	78	52
10			NA			
NATIONAL	Audit	130	87	80	73	61

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
PRENATAL CARE IN FIRST TRIMESTER**

HHS REGION	AUDIT OR ALL	PLAN S	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	33	NA	96	92	83
2	All	56	NA	89	84	78
3	All	58	NA	93	89	84
4	Audit	26	NA	92	90	86
5	Audit	20	NA	91	89	79
6	Audit	30	NA	90	87	79
7	All	33	NA	93	89	84
8	All	21	NA	91	80	73
9	All	30	NA	92	87	79
10	All	22	NA	88	84	74
NATIONAL	Audit	168	95	90	88	77

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
ADOLESCENT IMMUNIZATION MMR RATE**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	32	NA	88	79	65
2	All	54	NA	68	59	45
3	All	50	NA	67	59	47
4	Audit	23	NA	59	45	41
5	Audit	23	NA	57	38	25
6	Audit	27	NA	55	47	43
7	All	34	NA	65	42	9
8	All	22	NA	67	46	36
9	All	22	NA	56	38	25
10	All	20	NA	64	51	37
NATIONAL	Audit	162	80	65	49	36

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
CHILDHOOD IMMUNIZATION COMBO RATE 2**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	All	27	NA	85	84	66
2	All	50	NA	80	71	61
3	All	43	NA	79	69	61
4	Audit	25	NA	68	67	57
5	Audit	23	NA	72	66	55
6	Audit	25	NA	63	58	49
7	All	35	NA	71	67	62
8	Audit	20	NA	64	57	39
9	All	28	NA	66	60	55
10	All	24	NA	75	63	57
NATIONAL	Audit	161	83	73	64	55

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**HEDIS 3.0/1998
COMMERCIAL PRODUCT LINE
ADVISING SMOKERS TO QUIT**

HHS REGION	AUDIT OR ALL	PLANS	PERCENTILES			
			90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1	Vendor	23	NA	77	72	65
2	Vendor	40	NA	72	69	63
3	Vendor	42	NA	68	63	60
4	Vendor	47	NA	67	61	59
5	Vendor	73	NA	70	66	62
6	Vendor	25	NA	66	60	56
7	Vendor	28	NA	65	63	56
8			NA			
9			NA			
10	Vendor	20	NA	70	64	59
NATIONAL	Vendor	323	74	70	64	60

Note: This measure was collected by independent survey vendors through the HEDIS Member Satisfaction Survey.

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**HEDIS 3.0/1998
MEDICARE PRODUCT LINE
BETA BLOCKER TREATMENT**

HHS REGION	PLANS	PERCENTILES			
		90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1		NA			
2		NA			
3		NA			
4		NA			
5		NA			
6		NA			
7		NA			
8		NA			
9	29	NA	89	79	70
10		NA			
NATIONAL	29	95	88	79	67

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**HEDIS 3.0/1998
MEDICARE PRODUCT LINE
BREAST CANCER SCREENING**

HHS REGION	PLANS	PERCENTILES			
		90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1		NA			
2	21	NA	81	75	70
3	21	NA	80	76	70
4	35	NA	81	73	69
5	29	NA	76	71	62
6	19	NA	75	71	60
7		NA			
8		NA			
9	52	NA	80	73	65
10	21	NA	81	74	70
NATIONAL	198	84	80	73	67

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**HEDIS 3.0/1998
MEDICARE PRODUCT LINE
EYE EXAMS FOR DIABETICS**

HHS REGION	PLANS	PERCENTILES			
		90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1		NA			
2	24	NA	68	62	53
3	23	NA	63	54	47
4	39	NA	61	49	39
5	32	NA	56	42	34
6	27	NA	54	46	41
7		NA			
8		NA			
9	52	NA	61	52	43
10	23	NA	61	53	34
NATIONAL	220	69	62	52	41

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**HEDIS 3.0/1998
MEDICARE PRODUCT LINE
FLU SHOTS FOR OLDER ADULTS**

HHS REGION	PLANS	PERCENTILES			
		90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1		NA			
2	21	NA	78	68	65
3		NA			
4	33	NA	71	69	65
5	21	NA	79	72	69
6	23	NA	78	72	68
7		NA			
8		NA			
9	49	NA	76	74	69
10	24	NA	82	76	73
NATIONAL	171	82	78	73	69

Note: This measure was collected through the CAHPS survey by an independent survey vendor on behalf of HCFA.

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**HEDIS 3.0/1998
 MEDICARE PRODUCT LINE
 ADVISING SMOKERS TO QUIT**

HHS REGION	PLANS	PERCENTILES			
		90th (1.25 points)	75th (1.10 points)	50th (0.85 points)	25th (0.50 points)
1		NA			
2	21	NA	69	63	57
3		NA			
4	33	NA	65	60	59
5	21	NA	68	60	57
6	23	NA	63	59	53
7		NA			
8		NA			
9	49	NA	64	58	52
10	24	NA	65	61	54
NATIONAL	171	71	65	60	55

Note: This measure was collected through the CAHPS survey by an independent survey vendor on behalf of HCFA.

REGIONS

- 1 =Connecticut, Maine, Rhode Island, Massachusetts, New Hampshire, Vermont
- 2 =New Jersey, New York, Puerto Rico, Virgin Islands
- 3 =Delaware, Maryland, Virginia, District of Columbia, Pennsylvania, West Virginia
- 4 =Alabama, Georgia, Mississippi, South Carolina, Florida, Kentucky, North Carolina, Tennessee
- 5 =Illinois, Michigan, Ohio, Indiana, Minnesota, Wisconsin
- 6 =Arkansas, New Mexico, Texas, Louisiana, Oklahoma
- 7 =Iowa, Missouri, Kansas, Nebraska
- 8 =Colorado, North Dakota, Utah, Montana, South Dakota, Wyoming
- 9 =American Samoa, California, Hawaii, Arizona, Guam, Nevada
- 10=Alaska, Oregon, Idaho, Washington

Attachment 3: CAHPS Core Questionnaire Topics

Enrollment/Coverage

- Covered by (name of) health plan
- Insurance used for all care
- Length of coverage

Access

- Problem of finding a doctor
- Problem of getting a referral
- How often received help by phone
- Get routine appointment as soon as wanted
- See doctor for illness/injury as soon as wanted
- Problem in getting necessary care
- Problem with care delayed due to approval
- Wait more than 15 minutes in doctor's office
- Doctor spent enough time

Provider Relationship

- Specialist same as personal doctor

Overall Rating

- Rating of personal doctor
- Rating of specialist
- Rating of health care
- Rating of health insurance plan

Utilization

- Times visited emergency room
- Times visited doctor's office for care

Communication/Interaction

- Doctor's staff courteous and respectful
- Doctor's staff helpful
- Doctor listens carefully
- Doctor explained things clearly
- Doctor respected your comments

Plan Administration

- Problem to find or understand information in written material

Attachment 3 ? cont?d

- Problem to get help from customer service
- Problem with paperwork

Health Status

- Rate overall health

Demographics

- Age
- Male or female
- Highest grade level completed
- Hispanic or Latino
- Race

Verification

- Received help completing survey
- How did that person help you

Attachment 4: HIPAA Implementation Checklist

A HIPAA Checklist

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) called for standards on electronic health information to be developed. While HCFA has proposed standards for Medicare and Medicaid programs, the final standards are still being developed. The following proposed standards were published in the *Federal Register* in response to the HIPAA mandate:

- May 7, 1998 -- the proposed standards for the healthcare provider identifier and electronic transactions
- June 16, 1998 -- the proposed national standard for the employer identifier
- August 12, 1998 -- the proposed security and electronic signature standards

Every indication shows that the final rules will not be published until the end of 1999. Once they are published, large health plans will have 24 months to comply and smaller health plans will have 36 months. The overall goal is administrative simplification, but implementation within an organization will be anything but simple. As healthcare professionals await final regulations, what can organizations do to prepare? Following is an organizational checklist to assess your readiness and develop your plan.

General

- Assign responsibility for tracking the progress of regulations as they develop
- Continue to inform key internal stakeholders about HIPAA and its impact on your information systems and processes
- Seek current information on the industry's approach to HIPAA compliance
- Develop resources (publications, seminars, Web sites, professional networking, etc.) to facilitate development of your approach to HIPAA requirements
- Plan internal educational programs to describe HIPAA requirements to those responsible for implementing the changes
- Obtain and read copies of the proposed rules from the *Federal Register*, which can be accessed via HCFA's Web site at <http://www.hcfa.gov>
- Read the reports and recommendations from the National Committee on Vital and Health Statistics (NCVHS). The NCVHS serves as the statutory public advisory body to the Secretary of Health and Human Services in the area of health data and statistics (The reports and recommendations can be accessed via the NCVHS Web site at <http://aspe.os.dhhs.gov/ncvhs> through NCVHS Reports and Recommendations.)

- Obtain and read a copy of the Internet Security Policy from HCFA's Web site
- Meet with key staff in information services to discuss the requirements, identify the people who need to be involved, and develop a plan of action Share sections of the *Federal Register* with individuals who need to be involved in preparing for the regulations
- Perform a gap analysis of your existing policies and procedures compared to the requirements of the proposed standards
- Have individuals who need to be involved send you copies of their policies and procedures that address the requirements
- Develop a checklist to help identify those policies and procedures that you will need

Standardization of Code Sets

- Monitor payer compliance with official coding guidelines
- Perform regular coding quality control studies
- Provide feedback on documentation issues that have an impact on the quality of coded data
- Routinely train coding staff on current coding practice
- Provide access to resources available on coding guidelines and best practices.
- Efficiently update the ICD-9-CM codes in October and the CPT-4 codes (for both transaction and analysis systems) in January

Healthcare Identifiers

- Become familiar with the Notice of Proposed Rule Making for the employer identifier number (EIN), the taxpayer identification number for employees that is assigned by the Internal Revenue Service
- Read the Notice of Proposed Rule Making for the national provider identifier (NPI)
- Assess the quality of the master person index (MPI)
- Perform required cleanup and eliminate duplications in the MPI
- Institute procedures to maintain the integrity of the MPI

- Train staff on the importance of data quality in an MPI
- Make necessary data quality improvements in registration systems
- Assign responsibility for the maintenance of MPI data integrity
- Perform routine data integrity checks on the provider database
- Develop effective procedures to maintain provider tables
- Integrate or interface provider tables with necessary systems
- Monitor data quality for unique personal identification numbers (UPINs) on billing documents
- Provide easy access to UPIN tables
- Maintain current, complete payer tables
- Perform data quality checks on payer data entry
- Develop feedback loops from the billing process to data collection processes regarding payer data

Claims Transactions

- Maintain effective communication regarding claims processing with all affected parties
- Perform routine maintenance on the charge master
- Utilize electronic claims processing and electronic data interchange
- Explore the feasibility of converting to electronic claims processing or outsourcing that function
- Have comprehensive documentation of claims processing
- Routinely monitor remittance information against claims data
- Have an effective process for handling rejected claims
- Aggregate data about rejected claims to improve claims processing
- Become familiar with transaction standards and standards development organizations

Information Security

- Review the proposed standards and assess your organization's level of compliance by performing a gap analysis

- Become familiar with the information security standards and standards development organizations
- Identify existing organizational structures to aid development and implementation of an information security program
- Ensure that policies exist to control access to, and release of, patient-identifiable health information
- Ensure that users of electronic health information have unique access codes
- Ensure that each user's access is restricted to the information needed to do his or her job
- Outline physician responsibilities for protecting the confidentiality of health information in the medical staff bylaws or rules and regulations
- Outline employee responsibilities for protecting the confidentiality of health information in the employee handbook
- Train everyone with access to health information about confidentiality and their responsibilities regarding confidentiality
- Review vendor contracts for outsourcing of health information to ensure that they include provisions regarding confidentiality and information security
- Ensure that system managers, network managers, and programmers do not have unlimited and unrecorded access to patient information
- Monitor access to information and put corrective action plans in place for violation of organization policy
- Perform risk assessments to prioritize and continually improve the security of the systems
- Maintain current knowledge of information security issues and industry response to these issues (read books, publications, attend seminars, etc.)

Electronic Signature

- Identify the use of the electronic signature in your organization
- Perform a gap analysis for electronic signature applications to assess compliance with proposed standards for electronic signatures
- Become familiar with the electronic signature standards and standards development organizations
- Discuss the proposed requirements with current vendors who may be supporting your organization's information systems

- Familiarize yourself and employees with new and emerging information security technologies
- Research various certificate authorities to determine costs and identify a potential candidate

Resource List

Web Sites

- AHIMA -- www.ahima.org
- Computer-based Patient Record Institute -- <http://www.cpri.org>
- HCFA -- <http://www.hcfa.gov>
- NCVHS -- <http://aspe.os.dhhs.gov/ncvhs>
- Posting of law, process, regulations, and comments -- <http://aspe.os.dhhs.gov/admnsimp/>
- Posting of X12 implementation guides -- <http://www.wpc-edi.com/hipaa>

Listserv

To receive e-mail notification on publication of documents related to HIPAA regulations, send an e-mail to listserv@list.nih.gov, and include "Subscribe HIPAA-REGS your name" in the body of the message.

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</map/publications.hpindex.2a.map/map/publications.hpindex.2a.map>

Attachment 5: PEIA/Medicaid Effectiveness of Care Measures

Measure	Source	Historical/National Performance
B. Effectiveness of Care		
Advising Smokers to Quit	HEDIS Quality Compass	61%
Beta Blocker Treatment	HEDIS Quality Compass	61.9%
Cervical Cancer Screening	HEDIS Quality Compass	70.4%
Breast Cancer Screening	HEDIS Quality Compass	70.4%
Childhood Immunizations	HEDIS Quality Compass	65.3%
Prenatal Care in First Trimester	HEDIS Quality Compass	84.5%
Asthma Screening/Care	Delmarva Methodology	TBD
Diabetes Screening/Care	Delmarva Methodology	TBD
Follow-up after Hospitalization for Mental Illness (PEIA only)	HEDIS 3.0	72%
C. Use of Services		
Well-Child Visits in the First 15 Months of Life	Medicaid HEDIS/HEDIS 3.0	TBD
Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life	Medicaid HEDIS/HEDIS 3.0	TBD
Adolescent Well-Care Visits	Medicaid HEDIS/HEDIS 3.0	TBD
Inpatient Utilization - Non-Acute Care	HEDIS 3.0	TBD
Inpatient Utilization - General Hospital	HEDIS 3.0	TBD
Emergency Room Utilization	MEDICAID HEDIS	TBD
D. Health Plan Stability		
Provider Turnover	HEDIS 3.0	TBD
Medical Loss Ratio	TBD	TBD
Administrative Expense		
E. Satisfaction with Care		
Member Satisfaction Survey - selected measures	PEIA Satisfaction Survey	TBD

E. Effectiveness of Care

A. Advising Smokers to Quit

This measure estimates the percentage of adult smokers or recent quitters age 18 and older who received advice to quit smoking from a health professional in the Plan.

Smoking is the leading preventable cause of death in the U.S., causing more than 400,000 deaths each year. Clinical trials have demonstrated the effectiveness of clinical smoking-cessation programs, and advice to quit from a health care professional is associated with a 30% increase in the number of people who quit.

The national average performance for managed care organizations, as reported in the NCQA Quality Compass report, is 61%.

B. Beta Blocker Treatment After a Heart Attack

This measure estimates the number of plan members who were discharged from a hospital after a heart attack (who did not show evidence that beta blockers might have negative side effects) and were dispensed a prescription for beta blockers.

The American Heart Association estimates that the total annual cost of medical care and lost productivity due to heart attacks is \$12 billion to \$24 billion. About 1.5 million Americans annually experience a heart attack, roughly a third of them die from it. In West Virginia, the rate of heart disease as well as the rate of Chronic Pulmonary Disease exceeds the national average and those of its neighboring states (Ohio, Maryland, Pennsylvania, Tennessee, Virginia and North Carolina). The use of beta-blockers lowers blood pressure and reduces the risk of additional heart attacks.

The NCQA Quality Compass reports the national average for beta-blocker treatment to be 61.9%.

C. Cervical Cancer Screening

This measure is the percentage of women in the health plan, age 21 - 64, who have had a Pap smear performed within the last three years.

About 13,000 new cases of cervical cancer are diagnosed annually. The Pap smear is highly effective in detecting cancer early on -- when treatment is most likely to be successful. West Virginia ranks among its neighboring states as the state with the highest new cancer cases and it far exceeds the national average.

The NCQA Quality Compass reports the national average for cervical cancer screening to be 70.4%.

D. Breast Cancer Screening

This measure is the percentage of women aged 52 - 69 who have had a mammogram within the last two years.

The National Cancer Institute estimates that approximately one in nine American women will develop breast cancer before the age of 85. Breast cancer is the second most common type of cancer among American women (after skin cancer). Regular mammography screening can reduce morbidity by as much as 23 percent.

The NCQA Quality Compass reports the national mammography-screening rate to be 70.4%.

E. Childhood Immunization Status

This measure is the percentage of children who by age two have received appropriate immunizations.

Childhood immunizations help prevent serious illnesses and their potentially harmful effects. The Children's Defense Fund estimates that providing immunizations yields a 10:1 economic return on investment in terms of reduced medical expenditures.

The NCQA Quality Compass reports the national childhood immunization rate to be 65.3% (using the most current immunization recommendations).

F. Prenatal Care in the First Trimester

This measure estimates the percentage of women in the health plan who delivered a live baby that received prenatal care during the first trimester.

For maximum impact on outcomes, prenatal care such as healthy diet, vitamin supplementation, and identification of maternal risk factors must begin in the early stage of pregnancy.

The NCQA Quality Compass reports the national average to be 84.5%.

G. Asthma Screening/Care

This measure estimates the percentage of members diagnosed with Asthma who subsequently referred for, and receiving, follow-up care/case management.

Delmarva is the external quality review organization with which DR contracts to monitor performance in the Medicaid program. The ultimate benchmarks established therefore will be specific to West Virginia.

H. Diabetes Screening/Care

This measure estimates the percentage of members diagnosed with Diabetes who subsequently referred for, and receiving, follow-up care/case management.

Delmarva is the external quality review organization with which DHHR contracts to monitor performance in the Medicaid program. The ultimate benchmarks established therefore will be specific to West Virginia.

I. Follow-Up After Hospitalization for Mental Illness

This measure estimates the rate of enrollees age 6 years and older at the time of discharge who were hospitalized with a diagnosis indicating a major affective disorder and who had a follow-up visit with a mental health provider within 30 days after hospital discharge.

Major mental affective disorders are among the most common mental health conditions. An ambulatory visit by a patient during the 30 days following discharge enables providers to detect early post-discharge reactions and to evaluate compliance with medication instructions. Follow-up after discharge reduces the potential for repeat hospitalizations

The NCQA Quality reports the national average rate for follow-up after mental hospitalization is 72.3%.

F. Use of Services

A. Well Child Visits in the First 15 Months of Life

This measure estimates the percentage of children enrolled in the Plan whose 15 month birthday during the reporting year who were continuously enrolled in the plan from 31 days of age, and who received up to six well-child visits with a primary care provider during their first year of life. A child should be included in only one numerator (i.e. a child receiving six well-child visits will not be included in the rate for five, four, or fewer well-child visits).

Well-visits provide an opportunity for health professionals to identify physical, developmental, behavioral and emotional problems. They also provide an opportunity to conduct anticipatory guidance and counseling for families and children.

A. Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

This measure estimates the percentage of Medicaid-enrolled children who are four, five and six years old, who received a well child visit with a primary care provider during those ages.

Well-child visits for preschool children provide the opportunity for early identification and treatment of physical health, developmental, behavioral and emotional problems. Well-child visits enable the detection of vision, speech and language problems early so that a child may improve communication skills and avoid or reduce later language and academic problems. They also provide an opportunity to conduct anticipatory guidance and counseling for families and

children.

B. Adolescent Well-Care visits.

This measure takes into account the percentage Medicaid enrolled adolescents aged 12-21 during the reporting year who had one or more comprehensive well-care visits with a primary care provider during that year

Well-child visits for adolescents (11-21 years of age) enables the opportunity to address both physical and psychosocial aspects of health, and promote a healthy lifestyle and disease prevention.

C. Inpatient Utilization: Non-Acute Care

These measures report for each of the specific Medicaid age groups and eligibility categories, the number of discharges, discharges per 1000 members months, days per 1000 member months and average length of stay. These data exclude mental health and chemical dependency.

D. Inpatient Utilization: General Hospital/Acute Care

This measure estimates the number of discharges and rates per 1,000 members months, number of days of inpatient care and rates per 1000 members months and the average length of stay.

E. Emergency Room Utilization

This measure counts the units of emergency room visits (each unit equals one ER visit).

This category measures emergency room use. While patient behavior is a factor in the decision to use an ER rather than a clinic or physician's office, the decision may be a result of insufficient access to primary care. West Virginia's ER utilization ranks above national average. West Virginia is at a 34% greater ER utilization rate than the national average.

F. Health Plan Stability

A. Provider Turnover

This measure estimates the percentage of providers by type (primary care physicians, non-physician primary care providers, chemical dependency, mental health, OB/GYN and other prenatal care providers and dentists) who left the plan during the reporting period.

Lower physician turnover rates indicate that a member will more likely maintain the relationship with their primary care provider and physician satisfaction with the health plan. Because of mental health benefits provided under PEIA, mental health provider turnover is important to members and purchases. Lower mental health provider turnover rates increase the opportunity to develop a therapeutic relationship.

B. Indicators of Financial Stability: Medical Loss Ratio and Administrative Cost

These financial measures are the most basic indicators of the plan's ability to effectively manage care. Together, they represent the plan's overall level of profitability or loss. Benchmarks will be established using the most up-to-date information available from the West Virginia Department of Insurance, as well as national data available from the American Association of Health Plans.

B. Satisfaction with Care

A. Member Satisfaction Survey

Measures from a standardized survey will be selected to estimate member satisfaction with care and services received from contracted managed care organizations. The satisfaction survey and the performance targets for the selected measures will be based on the survey developed and conducted by PEIA in the summer of 1997, and by any equivalent survey data for Medicaid.

Attachment 6: West Virginia Regions

A.	<u>Ohio Region</u>	<u>Wood Region</u>	<u>Monongalia Region</u>
	Brooke	Calhoun	Barbour
	Hancock	Pleasants	Doddridge
	Marshall	Ritchie	Gilmer
	Ohio	Wirt	Harrison
	Tyler	Wood	Lewis
	Wetzel		Marion
			Monongalia
			Preston
			Randolph
			Taylor
			Tucker
			Upshur
A.	<u>Berkeley Region</u>	<u>Raleigh Region</u>	<u>Kanawha Region</u>
	Berkeley	Fayette	Boone
	Grant	Greenbrier	Braxton
	Hampshire	McDowell	Cabell
	Hardy	Mercer	Clay
	Jefferson	Monroe	Jackson
	Mineral	Raleigh	Kanawha
	Morgan	Summers	Lincoln
	Pendleton	Wyoming	Logan
	Pocahontas		Mason
			Mingo
			Nicholas
			Putnam
			Roane
			Wayne
			Webster

Attachment 7: Key Attributes and Processes

Development of the facility-specific “report card.” The data (listed below) would be reported for each provider, as well as summarized by region and for the state as a whole.

Inpatient Data:

- Average Length of Stay (ALOS)
- Charges/Discharge
- Cost/Discharge
- Charges/Day
- Costs/Day
 - Labor Expense/Day
- Number of inpatient surgical procedures
- Inpatient Revenue

Outpatient Data

- Outpatient Visits:
 - Emergency room
- Surgical procedures
- Other
 - Outpatient Revenue
 - Charges/Visit
- Costs/Visit

Combined Inpatient/Outpatient Operations

- Deductions from Revenue
 - Contractual allowances
- Charity/Uncompensated care
 - Net Revenue
- Expenses
- FTEs/Adjusted Occupied Bed¹
- Net Property, Plant and Equipment/Bed
- Net Assets/Bed
- Net Liabilities/Bed

Intensity of service indicators by payer

- Emergency Room visits
- Average Length of Stay (ALOS):
- Charges/Discharge
- Cost/Discharge
- Charges/Day
- Costs/Day
- ICU (include all adult monitored units such as CCU) Days
- NICU Days

Annual Statewide/Regional Aggregated Statistics for Facility Providers

- Beds/1,000 population (total, acute, rehabilitation, psychiatric, behavioral health and hospice)
- Admissions/1,000 population
- Patient Days/1,000 population
- Surgical Procedures/1,000 population
- Outpatient Visits/1,000 population - Emergency
- Outpatient Visits/1,000 population - Other

Home Health Agencies

- Gross revenues
- Deductions from revenues
 - Contractual allowances
 - Charity/Uncompensated care
- Net revenues
- Expenses
- Rate of return
- Summary of gross revenues by payer
- Visits and clients by payer
- Visits and clients by County

Physician

- Total number of physicians in active practice
- Number of primary care physicians in active practice
- Number of OB/GYN physicians in active practice
- Number of all other specialists in active practice
- PCP/1,000 population
- Physician report card for Medicaid and PEIA comparing utilization activity for an individual physician with an average for like specialty including:
 - Office visits
 - Physician referrals
 - ER visits
 - Hospital visits
 - Hospital admissions (OB and non-OB)
 - Prescriptions
 - Independent lab services
 - Radiology services
 - EPSDT (Children's Preventive Services)
 - Family planning
 - Other services
 - Average total expenditures per member per month
- Average monthly enrollment

Primary Care Clinics/Other Organized Provider Locations¹

- Total number of visits
- Number of physicians

Year Two Operational Reporting:

The Authority would build upon the report cards developed in Year One, adding the following data elements:

Inpatient Data

DRG reports for one disease (i.e., 250 - Diabetes Mellitus)

- Average Length of Stay (ALOS)
- Charges/Discharge
- Cost/Discharge
- Charges/Day
- Costs/Day
 - Labor Expense/Day
- Number of inpatient surgical procedures
- Re-admissions
- Re-admissions/Discharge
- Discharge status (where discharged)
- Acuity
- Morbidity/Mortality data

Outpatient Data

- Outpatient Visits:
 - Emergency room
- Surgical procedures
- Other
 - Outpatient Revenue
 - Deductions from Revenue
- Contractual allowances
- Charity/Uncompensated care
 - Net Revenue
 - Expenses
- Charges/Visit
- Costs/Visit

Home Health Agencies

- Visits by DRG
- Admissions by DRG (not presently an unduplicated count)

¹ Includes Primary Care Centers, Free Clinics, School-Based Health Centers and other locations.

Physician

- PCP Physician visits/1,000 Medicaid/PEIA/Medicare beneficiaries
- OB/GYN Physician visits/1,000 Medicaid/PEIA/Medicare beneficiaries
- Specialty visits/1,000 Medicaid/PEIA/Medicare beneficiaries
- PEIA/Medicaid physician visits for DRG
- PEIA/Medicaid physician visits for DRG/1,000 beneficiaries [break out FFS vs. MC]
- PEIA/Medicaid hospital admissions for DRG/1,000 beneficiaries [break out FFS vs. MC]
- PEIA/Medicaid re-admission rates for DRG/1,000 patients

Primary Care Clinics/Other Organized Provider Locations²

- Physician visits for DRG
- Physician visits for DRG/patient
- Hospital admissions for DRG/1,000 patients
- Hospital re-admission rates for DRG/1,000 patients
- Utilization patterns tracked in Year One for the physician report card would be extended to all patients with the DRG selected for tracking:
 - Physician referrals
 - ER visits
 - Outpatient visits
 - Prescriptions
 - Independent lab services
- Radiology services
- Other services
- Average total expenditures per member per month
- Average monthly enrollment

Year Three Operational Reporting:

Report cards developed in Years One and Two, adding three new DRGs to track.

² Includes Primary Care Centers, Free Clinics, School-Based Health Centers and other locations.

Attachment 8: Standard Definitions for Data Elements

Inpatient Data: Information submitted for persons admitted to the facility as an inpatient

Outpatient Data: Information submitted for persons receiving services at the facility who were not admitted as inpatients

Average Length of Stay (ALOS): Total number of inpatient days of service provided within the facility during a defined period of time (reporting period) divided by the total number of discrete discharges during the same time period. In the case of diagnosis specific reporting - report the average length of stay in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Charges/Discharge: The average amount charged per inpatient discharge for all discharges occurring during the reporting period. In the case of diagnosis specific reporting, report charges per discharge in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Cost/Discharge: Average total cost incurred per inpatient discharge for all discharges occurring during the reporting period. Cost is to be calculated by multiplying the Charge/Discharge by the facility's overall inpatient cost-to-charge ratio as reported in its Medicare Cost Report for the same time period. In the case of diagnosis specific reporting - report the cost per discharge in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Charges/Day: The average amount charged per inpatient day for all inpatient days in the reporting period. In the case of diagnosis specific reporting, report the charges per day in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Cost/Day: Average total cost incurred per inpatient day for all inpatient days in the reporting period. Cost is to be calculated by multiplying the Charges/Day by the facility's overall inpatient cost-to-charge ratio as reported in its Medicare Cost Report for the same time period. In the case of diagnosis specific reporting - report the cost per day in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Labor Expense/Day: Total personnel cost (including all benefit costs) for the reporting period divided by the total inpatient days in the reporting period.

Inpatient Surgical Procedures: All surgical procedures performed on inpatients in the facility's operating room. In the case of diagnosis specific reporting - report the inpatient surgical procedures in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Emergency Room Visits: All visits provided in the facility's emergency room for which a claim (or bill) is submitted with a 450 or 459 revenue code. In the case of diagnosis specific reporting - report the emergency room visits in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Outpatient Surgical Procedures: All surgical procedures performed on outpatients in the

facility's operating room (Place of Service code 22 - outpatient hospital or code 24 - ambulatory surgical center on the HCFA 1500; or Type of Bill code 13X, hospital outpatient, 43X - Christian Science hospital outpatient, or 83X - specialty facility outpatient on the UB92) during the reporting period. In the case of diagnosis specific reporting - report the outpatient surgical procedures in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Charges per Outpatient Visit: The average amount charged per outpatient visit for which a claim (or bill) is submitted. In the case of diagnosis specific reporting - report the charges per outpatient visit in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Cost per Outpatient Visit: Average total cost incurred per outpatient visit for all such visits in the reporting period. Cost is to be calculated by multiplying the charge per visit by the facility's overall outpatient cost-to-charge ratio as reported in its Medicare Cost Report for the same time period. In the case of diagnosis specific reporting - report the cost per outpatient visit in the same manner but only for persons with the specified diagnosis as their primary or secondary discharge diagnosis.

Primary Care Physicians: Includes family and general practitioners, general internists, and general pediatricians (Medical Doctors and Doctors of Osteopathy).

Specialist Physicians: Includes all other medical and surgical specialties.

Physician Referral: Occurs when a physician, either verbally or in writing, directs a patient to see another physician, practitioner, or therapist for consultation and/or treatment. Such referrals should be documented in the patient's medical record.

Independent Laboratory Services: Any services prescribed by a physician or other licensed practitioner operating within their legal scope of practice that are provided by an independent laboratory (not a laboratory operated by the provider).

Child/Adolescent Preventive Services: Any "well-child" visit provided in accordance with the periodicity schedule recommended by the American Academy of Pediatrics.

Family Planning: Any visit primarily related to family planning, including counseling and contraceptive services.

Re-admissions: Any inpatient admission that occurs within seven days of an inpatient discharge for the same or a related condition.

Discharge Status: The location to which an inpatient is discharged (e.g., home, nursing facility, hospice)

Note: All revenue and expense information shall be reported in a manner consistent with the current definitions applicable to facilities reporting data to the Health Care Authority. Similarly information on assets and liabilities, and property, plant and equipment (per occupied bed or staffed bed) should be reported consistent with current HCA definitions.

¹..... An algorithm equates outpatient to inpatient activity.