HEDIS 2014
Compliance Audit Kickoff

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Call us at (407) 444-2770
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LET'S GET STARTED

HEDIS 2014 Kick-off Meeting Agenda

- Introductions
- Audit Process Details and Changes
- Baseline Schedule
- Appendix - Technical Specification Changes

Your Plan

- Organizational changes?
- System changes?
- Personnel changes?
- Auditor feedback/suggestions?

Audit Process Details and Changes

CAHPS

- Commercial and Medicaid Plans
  - Health Plans can produce either entire sample frame or reduced sample frame (30,000 members randomly selected from the entire eligible population for each CAHPS submission)
  - MCO request a CAHPS submission in NCQA's HOQ (opens approx. 1/10/14)
  - MCO ensures auditor on the list of authorized users. Add auditor e-mail if required

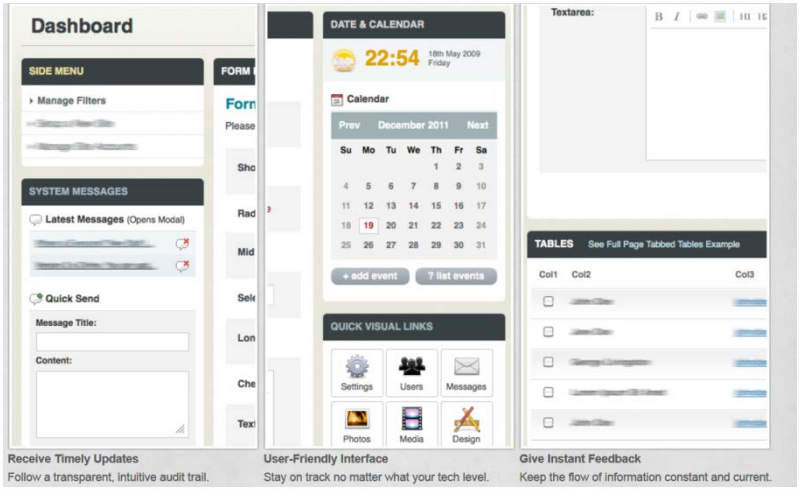
- Medicare Plans
  - Health plans select and pay for a survey vendor
    - All organizations must contract with an NCQA-certified HOS survey vendor and notify NCQA of their survey vendor choice no later than **January 18, 2014**.
  - CMS sends the survey sample frame/membership file to the survey vendor via RAND
  - Health plan coordinates information with the survey vendor
  - DTS Group does **not** audit the Medicare CAHPS submission

CAHPS - Commercial and Medicaid

- MCO posts the following to the DTS website:
  - A completed CAHPS survey form from DTS. This CAHPS background info to help the auditor assess your survey sample frame. Here is the website address to a survey sample form: < web address here>
  - The entire sample frame or the reduced sample frame (include method for reducing sample frame)
  - Program code used to generate sample frame (if you program source code internally)
- Auditor validates CAHPS program code and sample frame
- Auditor provides plan with CAHPS approval letter indicating the survey sample frame supports reporting
- Auditor indicates approval of the sample frame in the Healthcare Organization Questionnaire (by end of January. HOQ typically closes 2/28/14)
- Plan submits CAHPS approval letter and approved sample frame to survey vendor to begin survey administration

Roadmap

- Almost identical to last year. Link to blank Roadmap is
  <web address here>
- Auditor will read Roadmap and create Issue Log of questions and clarifications.
- Post responses to issues in folder #02 – All Issues and Follow-Up Information
- Put the Issue # in the Title of the Document - see example below



- The submission date for the completed Roadmap is January 15-31st, 2014.
- All Issues to be closed by June 1, 2014
- (new) Plan will complete Roadmap attestation after all issues are closed

Program Code Review

- Plans using certified software - Auditor reviews CAT and BCR only
- Plans programming measures internally
  - Core set minimum number equal to 15 measures plus the survey sample frames, focusing on new measures, changed measures, and challenging measures.
  - Provide list of programmers by measure will significantly speed up core set selections
  - Post code as soon as available. All code due no later than March 31st for first review
  - Always post Data Control Sheet so we have the right contact info. Here is the website address to the form <web address here>
  - Send e-mail notification to your auditor and ashley.griffin@dtsg.com when code is posted

On-Site Review

- DTS is finalizing the entire schedule
- DTS will send agenda requirements and advance queries to help the plan prepare for the onsite
- Follow-up interviews may be conducted for special circumstances, e.g., with medical record review staff or outside vendors
- All issues from the onsite will be documented on the Issue Log
- Please post follow-up items in the <location>on the website.

Supplemental Data

- Supplemental data is information used for HEDIS reporting that is not part of a transactional, adjudicated claims or encounter.
- Type #1 – Standard
  - Electronic files from service providers
  - Examples - Lab, immunization data, BH encounter data, or EHR vendor systems
- Type #2 – Non-Standard
  - Irregular files, may change over time, custom developed.
  - Examples - EHR modules (eMeasures), Provider portals (electronic systems providers use to enter information about services rendered),Health Information Exchange registries or Provider abstraction forms
- Type #3 – Member reported
  - Information reported by the member to a provider
  - Example - Member tells physician about prior services while taking history and physical (ex. paps, mammograms, colorectal cancer screenings)
  - Example - Member tells physician about an exclusion (ex. total hysterectomy, double mastectomy, or total colectomy)

Supplemental Data Requirements

- Flag data by source
  - Plans must be able to identify the source of data
  - Use vendor naming convention or develop internally
    - A = Administrative claim/encounter data
    - H = Hybrid, medical record data
    - S = Supplemental data
  - Example
    - SA-Labcorp = Standard supplemental data from Labcorp
    - SN-DDD = Non-standard supplemental mastectomy, hysterectomy, colectomy exclusions
    - SM - Screening = Member reported supplemental data for screenings

Proof-of-Service (POS) Requirements

- Standard
  - No - Do not require proof-of-service
- Non-standard
  - Yes - Must be substantiated by proof-of-service documentation from the legal health record
- Member-Reported
  - Yes - Requires POS unless
    - Info is collected during the measurement year by the PCP* during a face-to-face visit while taking a patient history
    - Info is recorded, date and maintained in the member's legal health record. Plans must get copies of the member's record from the PCP who recorded the information

*NCQA FAQ says specialist or non-PCP provider is OK

Proof-of-Service (POS)

- Proof-of-service must include all data elements required by the measure
  - Member identification
  - Date of service
  - Prescription
  - Test results
  - Practitioner type
- Hybrid specifications must be followed for data collected for hybrid measures

Non-Standard Data

- Allowed POS
  - Copy of chart from the rendering provider or PCP **(must be recorded, signed and dated by provider)**
  - Copy of lab report, super-bill, radiology report (i.e. form from the rendering provider)
  - Screenshot of online EHR record
  - Screenshot of immunization record from state or county
  - Member survey for LDM, RDM measure only
  - Health Assessment for the COA measure performed by a clinician
- Disallowed POS
  - Member surveys
  - Member-administered biometrics (BPs, HbA1c, LDL-C, BMI, height and weight)
  - Recorded or unrecorded phone calls

Primary Source Verification (PSV)

- Where PSV is required, auditor will select sample from each supplemental database
  - Nonstandard example file events =500, sample size = 25
  - Member reported example:

    File events = 104

    sample size = 37

    104-30= 74

    10% of 74 = 7

    30 + 7 = 37

Nonstandard Supplemental Data	
Number of Events in File	**Minimum Sample Size**
0-400	16
401-999	5%
1000+	50

Member-Reported Supplemental Data	
Number of Events in File	**Minimum Sample Size**
0-30	100%
31-199	30 + 10% of remaining events
200+	50

PSV Process

- Health plan completes and stops all nonstandard member report supplemental data collection and entry
- Plan provides database/spreadsheet to auditor
- Auditor selects records for PSV
- Plan provides POS for selected records
  - Missing POS is counted as an error
  - No substitutions are allowed
- Auditor reviews POS and concurs or non-concurs with each sample
- If a critical error is found in 2 or more events. The auditor either:
  - For isolated errors - requests another sample. If no errors are found in the second sample, the samples pass
  - For pervasive errors – permits the health plan to remove or correct the errors, requests another sample. If no errors are found in the second sample, the samples pass.
  - If any additional errors are found in the second sample, the supplemental data source fails.

Audit requirements – Timeline

- Roadmap – Due Jan. 15-31, 2014
  - Include all Section 5 attachments for each Supplemental Data source
- Member Reported
  - Data collection stops by March 3. Charts selected and approved by auditor by March 14
- Nonstandard
  - Data collection stops by March 3. Charts selected and approved by auditor by March 28
- Standard
  - Auditor reviews/approves files by Mar. 28

Medical Record Review Validation – Convenience Sample

- The plan will be exempt from the convenience sample if:
  - The plan received a “Pass” from DTS Group on the MRR validation for the prior year HEDIS audit
  - The current MRRV process has not changed significantly
  - The plan does not report hybrid measures the auditor determines to be at risk of inaccurate reporting

- If a convenience sample is required:
  - DTS Group will request a small number of medical records (around 10) once abstraction fieldwork begins
  - The plan will select the records to be sent to DTS Group
  - DTS Group will communicate any errors to the plan so systematic problems can be corrected before proceeding with additional reviews

Medical Record Review Validation – Measure Groups

A - Biometrics

- Adult BMI Assessment (ABA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI
- Comprehensive Diabetes Care (CDC)— BP <140/80
- Controlling High BP (CBP)
- Prenatal and Postpartum Care (PPC)—Prenatal
- PPC—Postpartum
- Freq of Ongoing Prenatal Care (FPC)

B - Anticipatory Guidance and Counseling

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- WCC—Nutrition
- WCC—Physical Activity

C - Laboratory

- CDC—HbA1c Rates
- CDC—LDL <100
- CDC—Nephropathy
- Cervical Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions (CMC)—LDL-C <100
- Lead Screening in Children

D – Immunizations and Other Screenings

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Colorectal Cancer Screening
- CDC—Eye Exam

E - SNP

- Care for Older Adults (COA)—Advance Care Planning
- COA—Functional Status Assessment
- COA—Medication Review
- COA—Pain screening
- Medication Reconciliation Post-Discharge (MRP)

F - Exclusions

- All MRR exclusions

MRRV – Step 1

- DTS Group selects one measure each from Group A-E
- All MRR exclusions (Group F) are subject to review
- DTS Group notifies the plan of these measures

Notes

- We can't tell you the measures early (defeats the purpose)
- If an entire group doesn't apply, no measure is selected (ex. If you don't have a SNP, ignore Group E)

MRRV – Step 2

May 15

- Plan completes MRR for all measures and sends final list of MRR numerators for selected measures and exclusions to DTS
- Plan also sends total numerator count for all other hybrids

Notes

- Yes, all MRR must be done by this date
- Yes, you need to finish field abstractions prior to May 15th so you can compile your final list for DTS Group
- We will get 2 lists from you
  - **For measures selected for MRRV -** we need the list of each member ID or MRR ID# with a hybrid hit so we can select 16 from each group
  - **For all other hybrid measures -** we need a final numerator count that will be randomly checked against the IDSS. Plans cannot add hybrid hits after May 15th
- Yes, this applies to every plan in the country

MRRV – Step 3

- DTS Group selects 16 records from each group and informs the plan of the selections

Notes

- Yes, we will try to turn-around our list of selections as soon as possible. We know you want it!
- If there are fewer than 16 records for the measure, we will review them all

MRRV – Step 4

- Plan sends Data Collection Tool and relevant chart documentation to DTS Group for review

Notes

- You can scan and upload to our website or send via traceable mail to DTS Group in Orlando
- If a record is unavailable, it is considered an error
- DTS will review charts and look for critical errors (ones that change the member's numerator compliance)
- Non-critical errors are allowed at auditor discretion. For example, the wrong date is recorded for a colonoscopy but the record is still compliant for the measure

MRRV – Step 5

- DTS Group begins communicating MRRV results including corrective actions

Notes

- Results depend on the number of errors found
  - 0 errors – measure passes
  - 1 error – try again (see next page)
  - 2+ errors – measure fails
- If a measure fails, DTS Group will work the plan to:
  - investigate source and extent of error
  - correct the error if possible
  - validate correction as required,
- If error cannot be corrected in time, plan may report admin rate for reporting
- Errors in the exclusion group will be reviewed to affected measures

Data Submission

- Data submitted via web-based interactive data submission system (IDSS)
- Plan loads data onto IDSS and runs through NCQA's Tier I and Tier II validations
- Plan applies Plan Lock to data submission and notifies DTS it is ready for review by:
  - May 25th – June 1st (including patient-level detail file)
- All Attestations are electronic only
  - Cannot be submitted until plan lock is applied
  - Must be re-submitted if plan lock is removed for changes
- DTS runs benchmark and year-over-year analysis and provides Benchmark Report to plan
- Plan responds to Benchmark Report
- Iterations continue until issues are resolved and results are satisfactory. DTS applies Auditor Lock to dataset
- Plan "Marks Final" and submission cannot be changed by:
  - June 16th for Commercial, Medicaid and Medicare data

Data Submission

- Preliminary rate review as part of DTS queries and onsite review. Either
  - Provide a .csv file of preliminary rates or
  - Provide an .xml file of preliminary rate or
  - Provide admin rates in an easy-to-read format for review
- IDSS has 2 submission files
  - 1 for RRUs
  - 1 for all other measures
- Medicare has 2 Patient Level Detail Files
  - 1 for PCR measure that accommodates multiple admits per member
  - 1 for all other measures

Report

- Final Report documents plan's conformance to specifications
- IS Standards Compliance Tool
  - Provides more detail
  - Filed in workpapers only
- DTS will provide draft of Report and IS Tool to plan
- Plan has opportunity to review/make corrections
- DTS provides final copy with signatures to plan and NCQA

Baseline Schedule

Baseline Schedule

#	Task	Suggested Completion Date	Actual Completion Date
1	**Kickoff**		
	Kickoff Conference Call or plan internally reviews Kickoff Presentation	12/31/13	
2	**CAHPS**		
	Plan submits CAHPS Survey Form to DTS Group	1/10/14	
	Plan submits CAHPS sample frame and code (as necessary) to DTS Group	1/10/14	
	DTS Group Review sample frame and output file for compliance	1/17/14	
	DTS Group sends plan CAHPS approval letter	1/31/14	
	Plan submit approved survey sample frame and letter to survey vendor	1/31/14	
3	**Roadmap**		
	Plan completes Roadmap and submit to DTS Group	1/15/14 - 1/31/14	
	DTS Group completes Roadmap Issue Log	2/10/14	
4	**Program Code Review**		
	DTS Group selects core measures (if measures programmed internally)	2/14/14	
	Plan submits any required program code	3/3/14	
	DTS Group reviews measures for compliance	4/15/14	
	Iterations and re-work	5/1/14	
5	**Onsite Visit**		
	DTS develop agenda requirements	1/6/14	
	Plan creates agenda	1/14/14	
	DTS Group and plan conduct pre-onsite conf. call to confirm details	1 wk. before onsite	
	Onsite visit	Jan - Apr 2014	
	DTS Group completes follow-up letter with open items	10 days after onsite	
	Plan resolves all open items	5/31/14	

Baseline Schedule - cont.

#	Task	Suggested Completion Date	Actual Completion Date
6	**Supplemental Data Review**		
	Plan provides documentation in Roadmap on all intended supplemental databases	1/15/14 - 1/31/14	
	For non-standard supplemental database		
	- Plan sends database/file to DTS	3/3/14	
	- DTS selects samples and notifies plan	3/5/14	
	- Plan sends documentation for selected samples to DTS	3/7/14	
	- DTS reviews and approves samples and use of supplemental databases	3/14/14	
	For member-reported supplemental database		
	- Plan sends database/file to DTS	3/3/14	
	- DTS selects samples and notifies plan	3/5/14	
	- Plan sends documentation for selected samples to DTS	3/12/14	
	- DTS reviews and approves samples and use of supplemental databases	3/28/14	
	DTS sends approval letters for plan's inclusion of all supplemental databases	3/28/14	
7	**Medical Record Review Validation**		
	DTS Group selects measures for MRRV	5/1/14	
	Plan sends list of positive hits for selected measures to DTS Group	5/15/14	
	Plan sends count of total hybrid numerator hits for non-selected measures to DTS Group	5/15/14	
	DTS Group select samples	5/17/14	
	Plan sends requested medical record samples to DTS Group	5/24/14	
	DTS Group performs re-abstraction and completes MRRV	5/29/14	

Baseline Schedule - cont.

#	Task	Suggested Completion Date	Actual Completion Date
8	**Data Submissions**		
	Plan creates dataset to NCQA and apply initial validation checks	5/24/14 - 5/31/14	
	Plan creates Patient Level Detail Files for Medicare submissions	5/24/14 - 5/31/14	
	Plan applies plan lock to datasets and notifies DTS Group	5/24/14 - 5/31/14	
	DTS Group performs benchmark and year over year comparison	6/4/14	
	Plan provides feedback to plan on validity of results	6/4/14	
	DTS Group responds to feedback	6/10/14	
	Iterations / rework	6/10/14	
	DTS Group completes audit designation table/applies auditor lock	6/16/14	
	Plan marks final and send e-attestations to NCQA	6/16/14	
9	**Final Audit Reports**		
	DTS Group submits draft report and IS standards compliance tool to plan	7/2/14	
	Plan provides feedback on draft report	7/8/14	
	DTS Group submits final audit report to NCQA	7/15/14	
	DTS Group provides final report and IS standards compliance tool to plan	7/15/14	

Appendix - Technical Specification Changes

New Measure - NCS

Non-Recommended Cervical Cancer Screening in Adolescent Females

- The percentage of adolescent female members 16–20 years of age who were screened unnecessarily for cervical cancer.

Eligible Population

- Commercial and Medicaid product lines
- Adolescent females 16–20 years as of December 31 of the measurement year
- Continuous enrollment period for the measurement year

Numerator

- The number of members who had Cervical cytology (Cervical Cytology Value Set) or an HPV test (HPV Tests Value Set) performed during the measurement year

Specific Measure Changes

WCC

- A distinct BMI value or percentile, if applicable, is required for numerator compliance.
- Educational materials must be received during a face-to-face visit
- Weight or obesity counseling count as numerator compliant for both nutrition and physical activity counseling
- Services specific to an acute or chronic condition do not meet numerator criteria (e.g. child presents with stomachache and physician discusses food intake)
- A physical exam finding or observation alone is not compliant for Counseling for physical activity.

BCS

- Revised continuous enrollment time frame
- Revised the age criterion to women 50-74 years of age
- Expanded the numerator time frame from 24 to 27 months

Specific Measure Changes (cont.)

COA - Pain Assessment

- Replaced “pain screening” with “pain assessment”
- Remove the wording requiring the pain assessment be comprehensive
- Revised the hybrid requirements - any documentation of a pain assessment (including positive or negative findings) is acceptable
- Removed statement that pain assessment limited to acute or single condition, event of body system does not meet criteria
- Documentation of pain management plan or pain treatment plan alone does not qualify
- Documentation of “chest pain” alone is not sufficient

COA - Functional Status Assessment

- Clarified the hybrid specification – notation of sensory ability (hearing, vision, speech) must include hearing AND vision AND speech
- Clarified that ADLs assessed must include, at a minimum, bathing, dressing, eating, transferring, using toilet, walking
- Clarified IADLs assessed must include, at a minimum shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.

Specific Measure Changes (cont.)

AMM

- Removed the IESD (earliest encounter during intake period with a dx of depression and 90-day negative med. history)
- Revised the negative medication history, continuous enrollment, and anchor date criteria
- Event/diagnosis steps begin with the IPSD
- Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.
- Then exclude members who did not have a dx of major depression in the appropriate setting and timeframe

Specific Measure Changes (cont.)

DDE

- Updated to align with the AGS updated Beers criteria
- Added chronic kidney disease stage IV to the codes identifying chronic kidney disease
- Added drug classes be avoided for members with dementia
- Added drug classes to be avoided by members with a history of falls
- Removed upper respiratory combinations – added exclusion for psychosis
- Added exclusions for seizure disorders – removed dementia codes from psychosis exclusions

Specific Measure Changes (cont.)

DAE

- Revised criteria for numerator 2 for medications with days supply criteria and medications with average daily dose criteria
- Days supply: if the total days supply for all medications in a medication class >90 days count as one high risk medication
- Average daily dose: if a member has two Rx for the same medication that meet the average daily dose criteria, count as one high-risk medication. If a member has two Rx for different meds that meet criteria, count as two high-risk medications

RRU

- Members with evidence of ESRD and kidney transplants are no longer required exclusions for RDI and RCA
- Expanded RCA quality composite to include all asthma measures (ASM, MMA, and AMR)
- Lowered the minimum eligible pops for all RRU measures from 400 to 200

Specific Measure Changes (cont.)

PPC

- Consolidated decision rules from 4 to 3 for identifying numerator events

CMC

- Denominator and LDL requirements changed (a documented range or threshold that indicated the most recent result is less than 100)

IPU

- Changed the order of how inpatient stays are captured/counted

PCR

- Clarified that the average adjusted probability and variance calculations should be rounded to four decimal places, using the .5 rule

ABA

- Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance

Rotation

General Guideline 14 - Updated the measures eligible for rotation

- CBP - Controlling High Blood Pressure
- FPC - Frequency of Ongoing Prenatal Care
- PPC - Prenatal and Postpartum Care
- WOP - Weeks of Pregnancy at Time of Enrollment

Other Criteria for Rotation

- MCO had an audited, reportable, hybrid rate from HEDIS 2013
- MCO reporting entity has remained constant from HEDIS 2013
- Small denominator (NA in HEDIS 2013 is ok if NA in HEDIS 2014)

Other Changes – Health Plan Rankings Changed to Ratings

- NCQA's existing ranking scale gives undue weight to minor differences between plans

- 2013 and earlier
  - Plans ranked based on 0 – 100 score
  - Reported to four decimal places

- 2014
  - Plans earn overall rating of 0 – 5 in half-point increments
  - All plans in the same group treated equally
  - Overall score is the weighted average of all measures used

Thank You