



## SUMMARY OF CHANGES TO THE HEDIS 3.0 DRAFT

On September 25 and 26, 1996, NCQA's Committee on Performance Measurement met to consider thousands of comments received following the July 1996 public release of the draft version of HEDIS 3.0, and to make final changes to the measurement set. The following pages list the highlights of those discussions, and the rationale for the changes. Part I contains changes and clarifications to data collection and reporting guidelines, and Part II contains changes to the measures themselves, which are organized by domain.

One fundamental clarification involves the time-frame over which the transition to HEDIS 3.0 from earlier versions of HEDIS reporting will be expected. In short, for the Effectiveness of Care, Health Plan Stability, Cost of Care, Informed Health Care Choices and Health Plan Descriptive Information domains, all HEDIS 3.0 measures are required for all populations to which they are applicable in **Reporting Year 1996** (data to be reported in 1997).

For the Use of Services and Access/Availability of Care domains, measures that originated in HEDIS 2.5 will be upgraded to 3.0 specifications and applicable to the appropriate populations in **Reporting Year 1996**, and measures that originated in Medicaid HEDIS will be upgraded to HEDIS 3.0 specifications, but applicable only to the Medicaid populations until **Reporting Year 1997** (data reported in 1998). Health plans should be prepared to report their HEDIS information to external requesters by June 1, 1997.

This transition timeline both allows health plans to make the necessary adjustments for collecting data, and provides the significant advantages of the improved measures in HEDIS 3.0

### PART I: CHANGES TO GENERAL GUIDELINES FOR DATA COLLECTION AND REPORTING

- **Change:** A separate HEDIS report should be produced for each state in which the health plan has a Medicaid contract. (The draft instructed plans to prepare a single report for all of its Medicaid enrollees.)
- **Rationale:** State Medicaid agencies reported that HEDIS information would not be useful unless it was prepared for each state.
- **Change:** Medicare HMO members under age 65 should be included in a plan's Medicare HEDIS report. (The draft excluded these members.)
- **Rationale:** Only about 4 percent of Medicare managed care enrollees are under 65, but this change makes HEDIS a more inclusive document.
- **Change:** Members who are eligible for both Medicaid and Medicare should be included in **both** HEDIS reports. (The draft instructed that plans include these members in one or the other.)

- **Rationale:** This change ensures that all Medicaid enrollees are accounted for, whether or not they are dually eligible.
- **Change:** The following passage from the draft has been deleted: “If data is not 95% complete, plans should be prepared to submit again six months after the close of the reporting year if requested.”
- **Rationale:** Plans and purchasers will negotiate time-frame arrangements that work best for them.
- **Change:** Information obtained from medical records must come from an “author-identified” note. (The draft required that a provider sign or initial such notes.)
- **Rationale:** This change makes HEDIS consistent with NCQA Accreditation standards. Over the next 12 months, the CPM will develop guidelines and audit standards that will allow health plans to use letters of attestation from providers in place of medical record review, thereby easing administrative burden on plans and providers.

## **PART II: CHANGES TO THE MEASURES**

### **EFFECTIVENESS OF CARE MEASURES**

- **Change:** Movement of the Flu Shots for High-Risk Adults measure to the Testing Set.
- **Rationale:** The CPM decided to move this measure to the Testing Set to evaluate various operational issues, including how to consistently identify the high-risk population.
- **Change:** Change in the methodology for the Flu Shots for Older Adults measure.
- **Rationale:** The CPM decided that health plans should collect the information for this measure using patient survey data, rather than administrative or medical records. Flu shots are often provided outside of the health plan, and relying on plan records may lead to underreporting.
- **Change:** Extend the time frame associated with the Beta Blocker Treatment After A Heart Attack measure to seven days after discharge (the draft specified two days), and 30 days before hospitalization..
- **Rationale:** A sample of beta blockers may be rendered in the hospital prior to discharge, or patients may already be taking beta blockers prior to the heart attack. Allowing five extra days to fill the prescription will give health plans an additional opportunity to use administrative data (i.e., pharmacy data) to collect this measure.
- **Change:** Change in the specifications for the Treating Children’s Ear Infections measure.

- **Rationale:** This measure, which reports how many children receive appropriate antibiotic treatment for ear infections, was modified so that rates will resemble those of other Effectiveness of Care measures. Specifically, the numerator was modified to capture members who receive an antibiotic other than a preferred antibiotic, in order to recognize cases in which children were appropriately not prescribed any antibiotic.
- **Change:** Movement of the Use of Appropriate Medications for People With Asthma measure to the Testing Set.
- **Rationale:** Public comment revealed methodological limitations and questions about the clinical value and appropriateness of this measure for assessing the quality of care delivered to asthmatics. For example, some commenters stated that there was no evidence that inhaled corticosteroids or cromolyn – the medications reported in the measure -- are effective forms of treatment for *all* asthmatics. Given the high prevalence of the disease, however, the CPM intends to include, next year, one or more asthma related measures currently being tested under a joint project between NCQA and the Robert Wood Johnson Foundation.
- **Change:** Maintenance of the annual screening interval for Diabetic Eye Exams
- **Rationale:** Appropriate retinal screening intervals for people with diabetes are currently the subject of some debate. While the draft of HEDIS 3.0 proposed moving from a one-year to a two-year screening interval, evolving evidence suggests that a two-year screening interval may be inappropriate for a significant number of diabetics. The CPM decided that it was preferable to remain with the measure as it has been reported over the past three years, to allow the further evolution of evidence in support of a change. The CPM anticipates substantial improvement in this measure over time.
- **Change:** Standardization of Medical Advice to Quit Smoking
- **Rationale:** The CPM decided to require that questions regarding advice to stop smoking be added to the Annual Member Health Care Survey, in order to achieve standardized reporting.
- **Change:** Revision in sampling for the Health of Seniors measure.
- **Rationale:** There was concern that over time the replenishment strategy employed in the draft would lead to a biased cohort -- a sample that no longer provides meaningful information on plan performance. An alternate approach was accepted by the CPM, whereby plans will establish a new cohort of 1,000 members to survey every year.

#### ACCESS/AVAILABILITY OF CARE MEASURES

- **Change:** Deletion of Appointment Access and Telephone Access measures.
- **Rationale:** The CPM concluded that the lack of standard methodologies for determining actual waiting times imposes limitations on inter-plan comparisons, and

the questions in the Annual Member Health Care Survey that address patient satisfaction with appointment and telephone access provide better information. The CPM also decided to give the development of additional measures in these areas high priority.

- **Change:** Deferral (for one year) of the Low Birth Weight Deliveries at Facilities for High Risk Deliveries and Neonates of High Risk measure.
- **Rationale:** The inclusion of this measure in the set required for the 1996 reporting year was an oversight in the draft. The measure uses the same methodology for identifying low birth weight babies as the Low Birth Weight Babies measure in the Effectiveness of Care domain. Both are deferred until the 1997-reporting year, in anticipation of the development of improved methodology.

### HEALTH PLAN STABILITY MEASURES

- **Change:** Disenrollment information applicable to commercial and Medicare risk populations only.
- **Rationale:** Since most Medicaid beneficiaries leave health plans because they lose eligibility (e.g., in many states, pregnant women lose Medicaid eligibility 60 days after delivery), aggregate disenrollment rates provide no useful information for Medicaid agencies.

### USE OF SERVICES MEASURES

- **Change:** Age stratification for persons 65 and older modified.
- **Rationale:** Age stratification in most use of services tables will be : 65-74; 75-84; and 85+, to account for the needs of the users of the information. (The draft specified age strata of 65-79, and 80+.)
- **Change:** Frequency of Selected Procedures for Medicare populations.
- **Rationale:** Based on updated information from the U.S. Health Care Financing Administration, the following procedures will be measured for Medicare enrollees: Coronary Artery Bypass Graft (CABG); Angioplasty; Prostatectomy; Cholecystectomy; Reduction of Fracture of Femur; Total Knee Replacement; Partial Excision of Large Intestine; Carotid Endarterectomy; Total Hip Replacement; and Hysterectomy. (The draft specified CABG, Angioplasty, Cardiac Catheterization; Cholecystectomy; and Prostatectomy.)
- **Change:** Births and Average Length of Stay, Newborn
- **Rationale:** The table in this measure was modified to facilitate adding newborn utilization rates to utilization rates reported in the table on Inpatient Utilization -Acute Care.

- **Change:** Continuous enrollment criterion in the tables "Mental Health Utilization. Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Service," and Chemical Dependency Utilization. Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Service."
- **Rationale:** The continuous enrollment criterion specified for these tables in the draft was dropped because of concerns about excluding a significant number of Medicaid enrollees. HEDIS 2.5 specifications for these tables will be retained for 1996 reporting.

# NCQA

Subsequent to the release of the Advance Copy of *HEDIS<sup>®</sup> 3.0, Volume II: Technical Specifications* in October 1996, NCQA learned from those implementing the new measurement specifications of several errors, inconsistencies and/or areas needing clarification. In order to share this information, already provided to individual organizations, with everyone who uses HEDIS 3.0, we made the necessary modifications to the final HEDIS 3.0 technical specifications. The following pages list each change from the Advance Copy to the final *HEDIS 3.0, Volume 2*. *All changes documented in the attached pages are reflected in HEDIS 3.0, Volume 2.*

The changes are listed in order by domain, and within each domain by measure. Each change is listed along with the page number and location reference in the Advance Copy and corresponding page number and location reference in the final *HEDIS 3.0, Volume 2*. When appropriate, we also included the reason for the change in brackets [ ]. *The changes do not significantly alter the specifications and should require minor, or no, programming changes; the majority of changes are clarifications to the specifications.*

**Note:** In November 1996, NCQA released the replacement technical specifications for the Member Satisfaction Survey measure. The revised specifications for this measure, contained in the Satisfaction with the Experience of Care domain, are not included in the following pages. The final *HEDIS 3.0, Volume 2* contains the updated specifications for this measure.

**Note:** For organizations that ordered the complete set of HEDIS 3.0 (i.e., Volumes 1-4), Volume 4, *A Road Map for Information Systems*, will be released this spring.

For assistance with interpreting the HEDIS 3.0 Reporting Set measurement specifications, please call NCQA, HEDIS Technical Support Line at 202-955-1737.

**CHANGES FROM THE ADVANCE COPY HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS - OCTOBER 1996  
TO THE FINAL HEDIS 3.0, VOLUME 2 - JANUARY 1997**

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
<b>GUIDELINES FOR DATA COLLECTION AND REPORTING</b>					
	1	Summary of Changes...	Information obtained from the medical record must come from an author-identified note.  Members who switch from a plan's HMO product to its POS product or vice versa during a particular measure's continuous enrollment period may now be considered continuously enrolled for the reporting of that measure.	1	Information obtained from the medical record must come from an author-identified note, which allows for handwritten, stamped or electronic identification.  Members who switch from a plan's HMO product to its POS product or vice versa during a particular measure's continuous enrollment period should now be considered continuously enrolled for the reporting of that measure.
	2	How many HEDIS Reports...	"Commercial members" are those...For the commercial population, report data for different product types separately.	2	"Commercial members" are those...For the commercial population, report data for different product types separately (i.e., draw a separate sample for each product type).
	6	Specific Guidelines...	A health plan is ultimately responsible...An author-identified note in the medical record indicating the date the procedure was performed, the place of the service, and the result (when applicable), or a consultation, lab or imaging report supports inclusion in the numerator.	6	A health plan is ultimately responsible...When reviewing the medical record, an author-identified note (i.e., includes handwritten, stamped, or electronic initials/signature) in the medical record indicating the date the procedure was performed, the place of the service, and the result (when applicable), or a consultation, lab or imaging report supports inclusion in the numerator
	9-10	Specific Guidelines... Obtaining Data from the Medical Record	For information obtained from patient history, HEDIS will allow the health plan to count the procedure if the medical record contains the following information: an author-identified note indicating the date the service was rendered, the place of the service, and the result (when applicable) or a consultation, lab or imaging report. Entries made in the medical record at the time the service was provided must include author identification, the date, and the result (when applicable). All medical record entries must be made and all service(s) must be rendered by the deadline for delivery ...	9	For information obtained from patient history,...Medical records transferred from the member's previous provider must include a note from the provider to whom they were transferred indicating that he or she reviewed them. Entries made in the medical record at the time the service was provided must include author identification, the date, and the result (when applicable) or a consultation, lab or imaging report. All medical record entries must be made, all transferred records must be reviewed, and all service(s) must be rendered by the deadline for delivery...

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<i>GUIDELINES FOR DATA COLLECTION AND REPORTING</i>					
		Important Information on HEDIS 3.0 Implementation for Reporting Years 1996-1997		15-18	Pages 15-18 have been incorporated into the document; they were previously released with the Advance Copy HEDIS 3.0 as an insert.
<i>DOMAIN: EFFECTIVENESS OF CARE</i>					
Childhood Immunization Status	16	Description	The percentage...(including members who have had no more than one break in enrollment of up to 45 days during the reporting year)...	19	The percentage...(including members who have had no more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday)...
	16	Description	<ul style="list-style-type: none"> <li>Four DTP or DTaP vaccinations (or an initial DTP followed by at least three DTP and/or DT) by the second birthday...</li> </ul>	19	<ul style="list-style-type: none"> <li>Four DTP or DTaP vaccinations (or an initial DTP or DTaP followed by at least three DTP, DTaP and/or DT) by the second birthday.</li> </ul> <p>[To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]</p>
	17	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two populations, are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for the 12 months immediately preceding their second birthday. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure	19-20	Two separate denominators, one for each of the two populations, are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for the 12 months immediately preceding their second birthday and who were not contraindicated for any of the specified antigens. Members who have no more than one break in enrollment of up to 45 days during the 12 months preceding their second birthday should be included in this measure.

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<i>DOMAIN: EFFECTIVENESS OF CARE</i>					
Childhood Immunization Status (cont'd)	17	Administrative Data Spec - Numerator	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP followed by at least three DTP and/or DT (CPT-4 code 90702)	20	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP or DTaP followed by at least three DTP, DTaP and/or DT (CPT-4 code 90702)  [To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]
	18	Hybrid Method Spec - Denominator	Two separate denominators,...Eligible members include all children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday, and who were continuously enrolled for the 12 months immediately preceding their second birthday. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	20	Two separate denominators,...Eligible members include all children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday, and who were continuously enrolled for the 12 months immediately preceding their second birthday and who were not contraindicated for any of the specified antigens. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their second birthday should be included in this measure.
	18	Hybrid Method Spec - Numerator	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP followed by at least three DTP and/or DT (CPT-4 code 90702).	21	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP or DTaP followed by at least three DTP, DTaP and/or DT (CPT-4 code 90702).  [To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]

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<i>DOMAIN: EFFECTIVENESS OF CARE</i>					
Childhood Immunization Status (cont'd)	18-19	Hybrid Method Spec - Numerator	Note: For immunization information...Add records transferred from a previous health care provider or agency without a note that the responsible authorized health care provider or agency reviewed them.	21	For immunization information...Add records transferred from a previous health care provider or agency without a note that the authorized health care provider, to whom the records were transferred, has reviewed them.
Adolescent Immunization Status	22	Hybrid Method Spec - Denominator	Two separate denominators,...Eligible members include, respectively, Medicaid enrolled adolescents and commercially enrolled adolescents who turned 13 years old during the reporting year, who were members of the plan as of their 13th birthday, and who were continuously enrolled for 12 months immediately preceding their 13th birthday.	24	Two separate denominators,...Eligible members include, respectively, Medicaid enrolled adolescents and commercially enrolled adolescents who turned 13 years old during the reporting year, who were members of the plan as of their 13th birthday, who were continuously enrolled for 12 months immediately preceding their 13th birthday and who were not contraindicated for MMR.
	22-23	Hybrid Method Spec - Numerator	Note: For immunization information...Records transferred from a previous health care provider or agency without a note that the responsible authorized health care provider or agency reviewed them.	24	Note: For immunization information...Records transferred from a previous health care provider or agency without a note that the authorized health care provider, to whom the records were transferred, has reviewed them.
Advising Smokers to Quit	25	Description	Among Medicaid, commercial and Medicare risk enrolled adults age 21 and older as of the December 31 of the reporting year...	26	Among Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year...  [To be consistent with the Member Satisfaction Survey measure]
	25	Specifications - Calculation	This specification uses membership data to identify adults age 21 and older and survey data to identify individuals who had one (or more) visits with a plan provider...	26	This specification uses membership data to identify adults age 18 years and older and survey data to identify individuals who had one (or more) visits with a plan provider...

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<i>DOMAIN: EFFECTIVENESS OF CARE</i>					
Advising Smokers to Quit (con't)	25	Specifications - Denominator	The denominator for this...First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults aged 21 and older as of December 31 of the reporting year....	26	The denominator for this...First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year...
Flu Shots For Older Adults	30	Notes	6) Plans may identify...Individuals residing in hospice care (UB-92 "type of Bill" code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650 or 659).	29	Plans may identify...Individuals residing in hospice care (UB-92 "type of Bill" code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650, 651, 652, 655, 656, 657 or 659).  [Added other relevant codes]
Breast Cancer Screening	31	Administrative Data Spec - Denominator	Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years old as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year.	30	Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years old as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy.
	32	Hybrid Method Spec - Denominator	Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year.	31	Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy.

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Breast Cancer Screening (con't)	33	Table 1C - Exclusionary Codes	19240-50 19200-50 19220-50	31	19240-50 or 19240 and 09950 19200-50 or 19200 and 09950 19220-50 or 19220 and 09950  [Added other relevant codes]
Cervical Cancer Screening	34	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year.	32	Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix.
	35	Hybrid Method Spec - Denominator	Two separate denominators...Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plans as of December 31 of the reporting year, and who were continuously enrolled during the reporting year.	33	Two separate denominators...Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix.
Prenatal Care in the First Trimester	37	Description	The percentage of Medicaid and commercially enrolled women with a live birth during the reporting period, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	34	The percentage of Medicaid and commercially enrolled women who delivered live birth during the reporting year, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

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Prenatal Care in the First Trimester (cont'd)	37	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two required calculations, are derived using all members who had (a) live birth(s) during the reporting period and who were enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	34	Two separate denominators, one for each of the two required calculations, are derived using all women who delivered (a) live birth(s) during the reporting year and who were <b>continuously</b> enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.
	39	Hybrid Method Spec - Denominator	Eligible members include all women who had (a) live birth(s) during the reporting period, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	35	Eligible members include all women who delivered (a) live birth(s) during the reporting year, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.
	43	Table 1E - Decision Rule 2	<p>CPT-4 = 99201-99205, 99211-99215; or Revenue code 514</p> <p style="text-align: center;">with either</p> <p>ICD-9 -CM = (640.0x-648.9x or 651.0x - 659.9x) where x (5th digit)=3</p> <p style="text-align: center;">OR</p> <p>ICD-9-CM = V22.0-V23.9 or V28.x</p> <p style="text-align: center;">or</p> <p>CPT-4 = 80055 alone or 90090 alone or 86762 with 86900 or 86901;</p> <p style="text-align: center;">OR</p> <p>CPT-4 = 76805, 76815, or 76816</p>	39	<p>CPT-4 = 99201-99205, 99211-99215; or Revenue code 514</p> <p style="text-align: center;"><i>with either</i></p> <p>CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901;</p> <p style="text-align: center;"><i>or</i></p> <p>CPT-4 = 76805, 76815, or 76816</p> <p style="text-align: center;"><i>OR</i></p> <p>ICD-9 -CM = (640.0x-648.9x or 651.0x - 659.9x) where x (5th digit)=3</p> <p style="text-align: center;"><i>or</i></p> <p>ICD-9-CM = V22.0-V23.9 or V28.x</p> <p>[No codes were deleted or added. Order of codes was reversed to align with the Marker Event Description]</p>

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<b>DOMAIN: EFFECTIVENESS OF CARE</b>					
Low Birth-Weight Babies	49	Table 1F	1st row (count as one newborn)	43	New code added--first line of the table - V35.xx
Treating Children's Ear Infections	55	Description	Health plans should only count the first episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure.	48	Health plans should only count the first uncomplicated episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure.
	59	Table 1G	Other bacterial infection - 040.x, 041.xx	51	Other Bacterial infection - 040.xx, 041.xx  [Code correction]
Beta Blocker Treatment After a Heart Attack	64	Notes	3. Any patient with ICD-9-CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.	55	Any episode with ICD-9 CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.
Eye Exams for People with Diabetes	69	Notes		60	Note: Plans may exclude members who, through medical record review, are identified as not being diabetic.  [New note added]
Follow-up After Hospitalization for Mental Illness	75	Administrative Data Spec - Denominator	If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. However, if a discharge is followed by a readmission for any selected mental health-disorder within the 30-day follow-up period, only the readmission discharge should be counted.	65	If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.

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Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
<i>DOMAIN: EFFECTIVENESS OF CARE</i>					
Follow-up After Hospitalization for Mental Illness (con't)	77	Hybrid Method Spec - Denominator	If a member has more than one discharge during the 30-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge is followed by a readmission for any mental health disorder within the 30-day follow-up period, only the readmission discharge should be counted.	67	If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. <b>Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.</b>
	78	Notes	2. If a Medicaid, commercial or Medicare risk member identified in the denominator of this measure is rehospitalized for any mental health or chemical dependency diagnosis within 30 days of discharge for one of the selected mental health disorder hospitalizations, only the rehospitalization should be counted in this measure. <b>Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.</b>	67	<b>This note was removed; it was added to the denominator specifications.</b>
	78	Notes	3. Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to another inpatient setting (e.g., nursing facility, residential treatment facility).	67	Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to a non-acute setting (e.g., nursing facility, residential treatment facility).

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Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
<i>DOMAIN: ACCESS/AVAILABILITY OF CARE</i>					
Availability of Mental Health/Chemical Dependency Providers	91	Specifications - Definition	An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has master's degree in social work or is licensed to practice as a social worker, if required by the state of practice.	77	An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has master's degree in social work and is licensed to practice as a social worker, if required by the state of practice.
<i>DOMAIN: USE OF SERVICES</i>					
Frequency of Ongoing Prenatal Care	144	Description	The percentage of pregnant Medicaid-enrolled women who received <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted for gestational age and the month prenatal care begin.	125	The percentage of pregnant Medicaid-enrolled women who received <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted gestational age and the month prenatal care begin.
	144	Administrative Data Spec - Calculation	For each woman who had ...4) report an unduplicated count of the number of women who had <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.	125	For each woman who had...4) report an unduplicated count of the number of women who had <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.
	146	Administrative Data Spec - Numerator	The number of women in the denominator who had an unduplicated count of <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.	126	The number of women in the denominator who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.

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Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
<b>DOMAIN: USE OF SERVICES</b>					
Frequency of Ongoing Prenatal Care (con't)	146-147	Administrative Data Spec - Numerator	For each woman included in the denominator...8) Report each woman in the appropriate category: <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits.	127	For each woman included in the denominator.. Report each woman in the appropriate category: <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits.
	148	Hybrid Method Spec - Numerator	The number of enrolled women in the sample who had an unduplicated count of <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age.	128	The number of enrolled women in the sample who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age.
Frequency of Selected Procedures	169	Table 5B: Codes	These classification codes are used to identify the procedures reported in Tables 5C-1a-d, 5C-2a-b, 5C-3	146	Removed the "-d" to state 5C-1a. Measure should be reported for "Total Medicaid Only.
Ambulatory Care	191	Observation Room Stays	UB-92 Revenue code (Form Locator 42): 76.2 (Observation Room)	166	UB-92 Revenue code (Form Locator 42): 762 (Observation Room)
	189	Ambulatory Surgery/ Procedures	Instructions:....CPT-4 code: all Codes included in HCFA Ambulatory Surgical Center (ASC) payment listing,....  Note: The HCFA ASC payment listing is available on diskette for \$75 through the Bureau of Data Management and Strategy at (410) 786-3689. The listing is also available in hard copy for \$20	165	Instructions...CPT-4 code: All codes included in the HCFA Ambulatory Surgical Center (ASC) Base Eligibility File...  Note: The HCFA ASC Base Eligibility File is available through the Bureau of Data Management and Strategy at (410) 786-3691.  [The listing is no longer available in hard copy.]
	191	Observation Room Stays - Notes	2. UB 82/92 revenue codes 76.0 and 76.9.	167	UB-92 revenue codes 760 and 769.

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<i>DOMAIN: COST OF CARE</i>					
Rate Trends	244	Table 6B - Rate Trend Assumptions	Please provided the percent change in prospective rate trend assumptions used to calculate the PMPM premium rates for the plan's commercial book of business for each year indicated.	212	Please provide the percent change in prospective rate trend assumptions used to calculate PMPM premium rates for the plan's Medicaid, commercial, or Medicare risk book of business for each year indicated.
<i>DOMAIN: HEALTH PLAN DESCRIPTIVE INFORMATION</i>					
Provider Compensation	260	Definition of mental health providers	Mental health providers include psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists and providers with a Specialty Certification in Mental Health Counseling from the National Board Certified Counselors (NBCC).	227	Mental health providers include psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists and professional counselors.
<i>HEDIS 3.0 MEASURES GRID</i>					
	330	Effectiveness of Care	Flu Shots for Older Adults indicated reporting for all populations (Medicaid, commercial, Medicare risk).		It is only applicable to Medicare population.
	331	Health Plan Stability	Disenrollment indicated reporting for all populations (Medicaid, commercial, Medicare risk)		It is only applicable to Medicare and commercial populations.
	331	Health Plan Stability	Physician Turnover	298	Measure called Provider Turnover
	331	Health Plan Stability	Performance Indicators	298	Measure called Indicators of Financial Stability
	332	Use of Services	Discharge and Average Length of Stay for Females in Maternity Care	299	Measure called Discharge and Average Length of Stay - Maternity Care
<i>GUIDELINES FOR SAMPLING AND CALCULATIONS</i>					
	308	Sample Size - New Measures or New Populations	In general, for new measures... A plan collecting HEDIS data for the first time must use Table I. Since all measure specifications have changed from HEDIS 2.5 to HEDIS 3.0, Table I must be used ...	271	In general, for new measures... A plan collecting HEDIS data for the first time must use Table I. (Language was removed)

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Measure	Page	Location	Old Language	Page	New Language
<i>GUIDELINES FOR SAMPLING AND CALCULATIONS</i>					
	308	Sample Size - Existing Measures	In general, if a plan has calculated...As a plan's rate improves, the sample size will decrease. Table II cannot be used in 1997 because of the changes in specifications from HEDIS 2.5 to HEDIS 3.0.	271	In general, if a plan has calculated...Because of the changes in specifications from HEDIS 2.5 to HEDIS 3.0, the previous year's rate cannot be used in 1997 for measures brought forward from HEDIS to HEDIS 3.0.
	309	Table I	Advising smokers to quit--Samples sizes for all populations to be provided	272	Advising smokers to quit - sample size provided for all populations.

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The attached 'Correction Sheet for HEDIS<sup>®</sup> 3.0' documents errors contained in the final *HEDIS 3.0, Volume 2* and the corrected language. The domain, measure name, page number and description of the correction is documented on the following three pages. These corrections should be implemented for the HEDIS 3.0 1996 data collection period.

**Note:** The changes listed in the attached document are NOT reflected in the final *HEDIS 3.0, Volume 2*.

**Correction Sheet for HEDIS 3.0  
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Domain	Measure	Page Number, final <i>HEDIS</i> <sup>®</sup> 3.0, Volume 2	Location	Correction (in Bold)
Effectiveness of Care	Breast Cancer Screening	30	Administrative Data Spec - Numerator	ICD-9-CM code 174.xx should be <b>174.x</b> ; there are no 5th digits within the 174 series
Effectiveness of Care	Check-ups After Delivery		Administrative Data Spec - Numerator	The number of women in the denominator for each of the two populations...A woman is considered to have had a postpartum visit if a submitted claim/encounter includes any of the following codes and has a date of service between the <b>date of delivery</b> and the 42nd day after the delivery.
Effectiveness of Care	Treating Children's Ear Infections	51	Table 1G--Rickettsioses & arthropod disease	ICD-9-CM code range 081.x1-083.x should be <b>081.x-083.x</b>
Effectiveness of Care	Treating Children's Ear Infections	52	Table 1G--Cholecystitis	ICD-9-CM code 574.6x does not exist; code range should be <b>574.5x-574.8x</b>
Effectiveness of Care	Treating Children's Ear Infections	52	Table 1G--Cholecystitis	ICD-9-CM code 575.1x should be <b>575.1</b> ; there are no 5th digits for the 575 series
Effectiveness of Care	Eye Exams for People with Diabetes	56	First Bullet	ICD-9-CM code <b>648.0x</b> should be listed as a diagnosis of diabetes; it was erroneously left out of the final.
Satisfaction with the Experience of Care	Member Satisfaction Survey	102	Sample Frame	The sample should include only current health plan members who were age 18 years and older as of <b>December 31</b> of the reporting year, who have been continuously enrolled for the twelve months of the HEDIS reporting year. Continuous enrollment allows for one break of up to 45 days.

**Correction Sheet for HEDIS 3.0  
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Domain	Measure	Page Number, final HEDIS <sup>®</sup> 3.0, Volume 2	Location	Correction (in Bold)
Use of Services	Well-Child Visits in the First 15 Months of Life	131	Administrative Data Spec - Denominator	The following language should be added: For each population...Members who have had no more than one break in enrollment of up to 45 days <b>during the continuous enrollment period</b> should be included in this measure.
Use of Services	Well-Child Visits in the First 15 Months of Life	133	Hybrid Method Spec - Denominator	The following language should be added: For each population...Members who have had no more than one break in enrollment of up to 45 days <b>during the continuous enrollment period</b> should be included in this measure.
Use of Services	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	134	Administrative Data Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year and <b>who were members of the plan as of December 31 of the reporting year.</b>
Use of Services	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	135	Hybrid Method Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year and <b>who were members of the plan as of December 31 of the reporting year.</b>
Use of Services	Adolescent Well-Care Visits	137	Administrative Data Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year and <b>who were members of the plan as of December 31 of the reporting year.</b>

**Correction Sheet for HEDIS 3.0  
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Domain	Measure	Page Number, final <i>HEDIS</i> <sup>®</sup> 3.0, Volume 2	Location	Correction (in Bold)
Use of Services	Adolescent Well-Care Visits	138	Hybrid Method Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year and who were members of the plan as of December 31 of the reporting year.
Use of Services	Frequency of Selected Procedures	149	Notes	The following note should be added: <b>Angioplasties or cardiac catheterizations performed in conjunction with (i.e., on the same date of service as) a coronary artery bypass graft should not be counted in the angioplasty or the cardiac catheterization rate; count only the coronary artery bypass graft.</b>
Use of Services	Frequency of Selected Procedures	152	Table 5C-3	The table asks for Total member months for males and females age < 65, 65-74, 75-84 and 85+. Total member months are <u>not</u> used in this table; each procedure is reported separately by sex.
Use of Services	Mental Health Utilization - % of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	192	Algorithm for identifying inpatient, day/night and ambulatory services - Instructions.	Separate the CPT-4 codes...Revenue code (Form Locator 42): <b>912</b> (Psychiatric/psychological services-partial hospitalization) or <b>913</b> (Psychiatric/psychological services-night care)

**Correction Sheet for HEDIS 3.0  
January 1997**

Domain	Measure	Page Number, final <i>HEDIS</i> <sup>®</sup> 3.0, Volume 2	Location	Correction (in Bold)
Use of Services	Chemical Dependency Utilization - % of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	205	Algorithm for identifying inpatient, day/night and ambulatory services - Instructions.	Separate the CPT-4 codes...Revenue code (Form Locator 42): <b>912</b> (Psychiatric/psychological services-partial hospitalization) or <b>913</b> (Psychiatric/psychological services-night care)
Health Plan Descriptive Information	Preventive Care and Health Promotion	237	Specifications - step 1.	For each population...identify the health promotion/education programs provided by your health plan and the number of members who participated in each program during the reporting year.