
FEHB Program Carrier Letter

All Fee-for-Service Carriers

U.S. Office of Personnel Management
Insurance Services Programs

Letter No. 2006-21

Date: July 17, 2006

Fee-for-service [7]

SUBJECT: Guidance on HEDIS® Measures for Fee-for-Service Plans

This letter provides additional guidance on our healthcare quality transparency initiative for fee-for-service (FFS) plans. HEDIS has the longest track record in the industry for healthcare quality measurement. For years, OPM has required Health Maintenance Organizations (HMOs) to submit HEDIS measures as evidence of high quality performance. Since 2002, HEDIS scores overall have improved nearly six percent, which means there are measurable increases in the numbers of health plan members receiving appropriate care.

In 2005, the Centers for Medicare and Medicaid Services (CMS) tested the feasibility of a few hybrid HEDIS measures through administrative data systems and determined it was feasible to report results from administrative data sources. As referenced in Carrier Letter 2006-11, we are requiring fee-for-service plans to collect five specific measures in 2007, using administrative data only. The data will be based on 2006 claims experience. Depending on the results of this initial data collection, four or more measures may be added the following year.

Please keep in mind these HEDIS measures are not to be collected in lieu of any other healthcare quality measurements and reports.

SPECIFICATIONS

Members included in HEDIS surveys are referred to as an “Eligible Population”. An eligible population includes all members who meet specified criteria. The following five criteria define the eligible population for survey measures:

- **Product lines** specifies the product lines (Commercial, Medicare, Medicaid) for which the measure should be reported.
- **Age** specifies the age group requirement.
- **Continuous enrollment** specifies the continuous enrollment criteria (minimum amount of time a member must be enrolled in the health plan before becoming eligible for the measure) for the measure.
- **Allowable gap** specifies any allowable gaps during the continuous enrollment period.
- **Current enrollment** specifies the current enrollment criteria (member must be enrolled in the health plan at the time the survey is completed) for the measure.

All survey measures have specific codes (ICD, CPT, and/or DRG) to identify the measure and/or subsets of that particular measure. Those codes are listed in table format with the measures in the HEDIS technical specification book. In addition, each survey measure has its own definition of an eligible population. Below are descriptions of the five measures and the eligible populations.

❖ **Breast Cancer Screening** –

1. The percentage of women 50-69 years of age who had a mammogram during the measurement year or the year prior to the measurement year.

Eligible Population for this measure:

- Product line – Commercial
- Ages – Women 52-69 years as of December 31 of the measurement year
- Continuous enrollment – The measurement year and the year prior to the measurement year
- Allowable gap – No more than one gap in enrollment of up to 45 days during each year of continuous enrollment
- Current enrollment – Enrolled as of December 31 of the measurement year

❖ **Cholesterol Management for Patients with Cardiovascular Conditions** –

The percentage of members 18-75 years of age who, from January 1 through November 1 of the year prior to the measurement year, were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), and had the following performed during the measurement year:

2. LDL-C screening performed

Eligible Population for this measure:

- Product line – Commercial
- Ages – 18-75 years as of December 31 of the measurement year
- Continuous enrollment – The measurement year and the year prior to the measurement year
- Allowable gap – No more than one gap in enrollment of up to 45 days during each year of continuous enrollment
- Current enrollment – Enrolled as of December 31 of the measurement year

❖ **Comprehensive Diabetes Care** – The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

3. Hemoglobin A1c (HbA1c) testing

4. Eye Exam (retinal) performed
5. LDL-C screening performed

Eligible Population for this measure:

- Product line – Commercial
- Ages – 18-75 years as of December 31 of the measurement year
- Continuous enrollment – The measurement year
- Allowable gap – No more than one gap in enrollment of up to 45 days during the measurement year
- Current enrollment – Enrolled as of December 31 of the measurement year

To better understand the HEDIS process and responsibilities of the plans, NCQA is offering a one-day training session. The session will be held in early January, 2007. The estimated cost will be \$495.00 per person. We will need a headcount for the number of participants attending the session no later than October 31, 2006. All plans participating in the training session will be expected to pay NCQA directly. They will provide you with their address and payment information at a later date. We recommend all fee-for-service plans participate in the training session.

Some health plans are currently reporting HEDIS data to NCQA for their other lines of business and are familiar with the process of collecting and reporting. However, if your plan is not familiar with the process we strongly recommend contracting with a certified HEDIS vendor that will collect and submit your data for reporting (to be discussed in the training course).

In Carrier Letter 2006-11, we also described the NCQA's procedures for HEDIS reporting including the Compliance Audit. It is NCQA's policy that all publicly reported data must be audited by a NCQA certified auditor. We are planning to collect the HEDIS data beginning in 2007, but it will not be publicly reported next year. Therefore, we are not requiring a Compliance Audit for 2007.

Finally, below are key HEDIS PPO reporting activities that you should be aware of:

In order for you to fully understand the HEDIS measures and the posted public comment document, you will need the current HEDIS technical specifications. If you are not in possession of the current *HEDIS 2006 Volume 2 – Technical Specifications* (approximately \$285.00), you can order it or pre-order the *HEDIS 2007 Volume 2* (approximately \$285.00 or \$850.00 for the entire set).

October 2006

NCQA will spend the rest of the summer reviewing public comments and revising the HEDIS PPO specifications as needed. In October, NCQA will release the final HEDIS PPO technical specifications that plans will use for reporting in 2007.

January 2007

NCQA issues HEDIS Data Submission kick-off letters to Primary HEDIS Reporting Contacts at health plans.

February 2007

NCQA distributes its annual Healthcare Organization Questionnaire (HOQ) for health plans to complete. Information NCQA collects and confirms in the HOQ is used for the HEDIS data collection process.

April 2007

NCQA distributes HEDIS Data Submission Tools[®] (DSTs) to health plans.

June 2007

Health plans are required to send their HEDIS submission to NCQA by June 15, 2007.

All plans are subject to the timeline noted above.

Fee-for-service plans should review their current administrative cost limitations to determine whether they will likely cover the costs of implementing HEDIS measures within this limit. Any plans that believe they will request a non-recurring cost exception for 2007 should contact their contracting officer.

We will continue to work closely with you and your health plans. If you have any questions please contact Tanya Woodyard at Tanya.Woodyard@opm.gov or by telephone at 202-606-2397.

Sincerely,

Robert F. Danbeck
Associate Director
Human Resources Products and Services