DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

TO: Medicare Advantage Quality Contacts and Medicare Compliance Officers

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SUBJECT: 2011 HEDIS, HOS and CAHPS Measures for Reporting by Medicare Advantage Organizations

DATE: November 4, 2010

OVERVIEW

This memorandum contains a list of HEDIS® measures required to be reported by all Medicare Advantage Organizations in 2011. It also includes information about which plans are required to participate in HOS and CAHPS®. Sections 422.152 and 422.516 of Volume 42 of the Code of Federal Regulations (CFR) specify that Medicare Advantage contracts must submit performance measures as specified by the DHHS Secretary and CMS.

HEDIS 2011 Requirements

In 2011 (the reporting year), NCQA will collect data for services covered in 2010 (the measurement year). Detailed specifications for these measures are in *HEDIS 2011, Volume 2, Technical Specifications*, published by the National Committee for Quality Assurance (NCQA). All HEDIS 2011 measures must be submitted to NCQA by 11:59 p.m. EDT on **June 30, 2011**. Please note that late submissions will **not** be accepted. If an organization (contract/plan) submits HEDIS data after June 30, 2011, they will automatically receive a rating of one star for the required HEDIS measures for the data that are updated on Medicare Plan Finder (in the fall of 2011). Beginning with the 2010 reporting year, MA ratings affect MA quality bonus payments.

Medicare Advantage Organizations meeting CMS's minimum enrollment requirements for 2010 must submit audited, summary-level HEDIS data to NCQA. Table 1 includes information about which organizational types need to report HEDIS, CAHPS and HOS data. Contracts with 1,000 or more members enrolled as reported in the July 2010 Monthly Enrollment by Contract Report (at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MEC/list.asp#TopOfPage) must collect and submit HEDIS data to CMS. Closed cost contracts are required to report HEDIS regardless of enrollment closure status. Patient-level data must be reported to HCD International. More information on the patient-level data submission will be forthcoming in a separate memorandum.

Table 1: 2011 Performance Measure Reporting Requirements

2011 Performance Measure Reporting Requirements				
Organization Type	**CAHPS**	**HEDIS**	**HOS**	**HOS-M**
1876 Cost	✓	✓	✓	×
Chronic Care	×	×	×	×
Demonstration	✓	✓	×	×
Employer/Union Only Direct Contract PDP	×	×	×	×
Employer/Union Only Direct Contract PFFS	×	×	×	×
HCPP-1833 Cost	×	×	×	×
Local CCP	✓	✓	✓	×
MSA	✓	✓	✓	×
National PACE	×	×	×	✓
PDP	✓	×	×	×
PFFS	✓	✓	✓	×
POS Contractor	×	×	×	×
Regional CCP	✓	✓	✓	×
RFB PFFS	✓	✓	✓	×

× = Not required to report

✓ = Required to report

During the measurement year, if your HPMS contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS data for all members of the contracts involved. If a contract status is listed as a conversion in the measurement year, the contract must report if the new organization type is required to report.

In 2011, CMS will continue collecting audited data from all benefit packages designated as Special Needs Plans (SNPs) and ESRD Demonstration Plans that had 30 or more members enrolled as reported in the February 2010 SNP Comprehensive Report (at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage).

In 2011, PPO plan types must report the HEDIS measures listed in Table 2. If a required measure allows the hybrid method to be used for data collection, PPO plans may choose that method, except for Colorectal Cancer Screening. In 2012, the hybrid method will be allowed for this measure for PPOs. If a required measure offers only the hybrid method for data collection, PPO plans must use that method (e.g., controlling blood pressure).

In 2011, PFFS and MSA plans are **required** to report data for only the HEDIS measures on Table 2, using only the administrative method. Other measures can be reported voluntarily using the hybrid method. In 2012, PFFS and MSA plans will be required to collect data on **all** HEDIS measures, using the administrative or hybrid method where applicable, and report the audited data to CMS.

In HEDIS 2012, the submission of Use of Service measures is subject to change as CMS moves to submission of audited data for CMS Part C and D reporting requirements.

Medicare Advantage Organizations that are new to HEDIS must become familiar with the requirements for data submissions to NCQA, and make the necessary arrangements as soon as possible. All information about the HEDIS audit compliance program is available at http://www.ncqa.org/tabid/204/Default.aspx.

If a Contract has multiple SNP plan benefit packages (PBPs), the Contract is required to submit the SNP-specific information for each PBP. SNP-only Contracts are also required to meet the Medicare Advantage HMO requirements.

Please note that MA organizations should refer to this memorandum for CMS reporting requirements, rather than to the NCQA website or any other third-party source. The reporting requirements are summarized in Table 2. For further information on HEDIS, please email HEDISquestions@cms.hhs.gov. For information specific to the SNPs, please contact Marsha Davenport, MD, MPH, at Marsha.Davenport@cms.hhs.gov.

Table 2: HEDIS 2011 Measures for Reporting by Organization Types

HEDIS 2011 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA Contracts	§1876 Cost Contracts	SNP PBPs and ESRD Contracts
Effectiveness of Care					
ABA	Adult BMI Assessment	X		X	
BCS	Breast Cancer Screening	X	X	X	
COL	Colorectal Cancer Screening	X*		X	X*
GSO	Glaucoma Screening in Older Adults	X	X	X	X
COA	Care for Older Adults (SNP-only measure)				X
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	X	X	X	X
PCE	Pharmacotherapy Management of COPD Exacerbation	X	X	X	X
CMC	Cholesterol Management for Patients with Cardiovascular Conditions	X	X[1]	X	
CBP	Controlling High Blood Pressure	X		X	X
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	X	X	X	X
CDC	Comprehensive Diabetes Care[2]	X	X[3]	X	
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	X	X	X	

(Refer to the Footnotes at the end of Table 2, page 5)

Table 2: HEDIS 2011 Measures for Reporting by Organization Types

HEDIS 2011 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA Contracts	§1876 Cost Contracts	SNP PBPs and ESRD Contracts
OMW	Osteoporosis Management in Women Who Had a Fracture	X	X	X	X
AMM	Antidepressant Medication Management	X	X	X	X
FUH	Follow-up After Hospitalization for Mental Illness	X	X	X	X
MPM	Annual Monitoring for Patients on Persistent Medications	X	X	X	X
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly	X	X	X	X
DAE	Use of High-Risk Medications in the Elderly	X	X	X	X
MRP	Medication Reconciliation Post-Discharge (SNP-only measure)				X
HOS	Medicare Health Outcomes Survey	X	X	X	X[4]
FRM	Falls Risk Management (collected in Medicare Health Outcomes Survey)	X	X	X	X[4]
MUI	Management of Urinary incontinence in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X	X[4]
OTO	Osteoporosis Testing in Older Women (collected in Medicare Health Outcomes Survey)	X	X	X	X[4]
PAO	Physical Activity in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X	X[4]
FSO	Flu Shots for Older Adults (collected in CAHPS)	X	X	X	
MSC	Medical Assistance With Smoking Cessation (collected in CAHPS)	X	X	X	
PNU	Pneumonia Vaccination Status for Older Adults (collected in CAHPS)	X	X	X	
Access /Availability of Care					
AAP	Adults' Access to Preventive/Ambulatory Health Services	X	X	X	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	X	X	
CAB	Call Abandonment	X	X	X	
CAT	Call Answer Timeliness	X	X	X	
Health Plan Stability					

Table 2: HEDIS 2011 Measures for Reporting by Organization Types

HEDIS 2011 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA Contracts	§1876 Cost Contracts	SNP PBPs and ESRD Contracts
TLM	Total Membership	X	X	X	
***Use of Services*[5]**					
FSP	Frequency of Selected Procedures	X	X	X	
IPU	Inpatient Utilization --- General Hospital/Acute Care	X	X	X	
AMB	Ambulatory Care	X	X	X	
MPT	Mental Health Utilization	X	X	X	
IAD	Identification of Alcohol and Other Drug Services	X	X	X	
ABX	Antibiotic Utilization	X	X	X	
PCR	Plan All-Cause Readmissions	X	X		X
Health Plan Descriptive Information					
BCR	Board Certification	X	X	X	X
ENP	Enrollment by Product Line	X	X	X	
EBS	Enrollment by State	X	X	X	
RDM	Race/Ethnicity Diversity of Membership	X	X	X	
LDM	Language Diversity of Membership	X	X	X	

*PPO plans may collect the Colorectal Cancer Screening measure using **only** the administrative method.

[1] LDL-C Level is not required due to the need for medical record review.

[2] HbA1c Control <7% For a Selected Population is not required for Medicare contracts.

[3] HbA1c control, LDL-C control or Monitoring for Diabetic Neuropathy and blood pressure control are not required due to need for medical record review.

[4] Contracts with exclusively SNP plan benefit packages – see also specific HOS requirements in this memorandum.

[5] 1876 Cost Contracts do not have to report the inpatient measures if they do not have inpatient claims.

2011 HOS and HOS-M REPORTING REQUIREMENTS

Plans that Must Report HOS

The following types of Medicare Advantage Organizations with Medicare contracts in effect on or before January 1, 2010, are **required** to report the Baseline HOS in 2011, provided that they have a minimum enrollment of 500 members:

- All Coordinated Care Plans, including health maintenance organizations (HMOs), local and regional preferred provider organizations (PPOs) and contracts with exclusively SNP plan benefit packages;
- Continuing cost contracts that held §1876 risk and cost contracts;
- Private Fee-for-Service (PFFS) plans; and,
- Medical Savings Account (MSA) plans.

In addition, all Medicare Advantage Organizations that reported a Cohort 12 Baseline Survey in 2009 are required to administer a Cohort 12 Follow-up Survey in 2011.

To report HOS, all plans must contract with a certified HOS survey vendor and notify NCQA of their survey vendor choice no later than **January 21, 2011**. You will receive further correspondence from NCQA regarding your HOS participation.

Plans that Must Report HOS-M

The HOS-M is an abbreviated version of the Medicare Health Outcomes Survey (HOS). The HOS-M assesses the physical and mental health functioning of the beneficiaries enrolled in PACE Programs and certain Medicare Advantage Organizations to generate information for payment adjustment.

All Programs of All Inclusive Care for the Elderly (PACE) Programs with Medicare contracts in effect on or before January 1, 2010, are required by CMS to administer the HOS–M survey in 2010.

To report HOS-M, eligible plans must contract with Datastat, Inc., the certified HOS-M survey vendor, no later than **January 21, 2011**. You will receive further correspondence from NCQA regarding your HOS participation.

For additional information on 2011 HOS or HOS-M reporting requirements, please contact Chris Haffer, Ph.D. at hos@cms.hhs.gov.

CAHPS Survey Requirements

The following types of Medicare Advantage Organizations are included in the CAHPS survey administration provided that they have a minimum enrollment of 600 eligible members as of July 1, 2010:

- Continuing cost contracts that held §1876 risk and cost contracts, with Medicare contracts in effect on or before January 1, 2010; and,
- Private-Fee-For-Service and MSA Contracts in effect on or before January 1, 2010.

The Programs of All Inclusive Care for the Elderly (PACE), HCPP – 1833 cost and employer/union only contracts are excluded from the CAHPS administration.

Medicare Advantage organizations are required to contract with an approved MA & PDP CAHPS vendor for the 2011 survey administration. A list of approved survey vendors is available on www.MA-PDPCAHPS.org. Training for survey vendors will take place in November 2010.

CMS will be issuing additional HPMS memorandums about the CAHPS survey for 2011.

If an approved CAHPS vendor does not submit a contract's CAHPS data by the data submission deadline of June 15, 2011, the contract will automatically receive a rating of one star for the required CAHPS measures for the data that are updated on Medicare Plan Finder (in the fall of 2011) which also impacts the MA quality bonus payments.

For additional information on the CAHPS survey, please email mp-cahps@cms.hhs.gov.