DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR DRUG and HEALTH PLAN CHOICE

TO: Medicare Advantage Quality Contacts and Medicare Compliance Officers

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: 2010 HEDIS, HOS and CAHPS Measures for Reporting by Medicare Advantage Organizations

DATE: December 2, 2009

OVERVIEW

This memorandum contains a list of HEDIS® measures required to be reported by all Medicare Advantage Organizations in 2010. 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 plans must submit performance measures as specified by the DHHS Secretary and CMS. These performance measures include HEDIS, HOS, and CAHPS.

HEDIS 2010 Requirements

In 2010, NCQA will collect data for services covered in 2009. Detailed specifications for these measures are in HEDIS 2010, Volume 2, Technical Specifications, published by the National Committee for Quality Assurance (NCQA). All HEDIS 2010 measures must be submitted to NCQA by 11:59 p.m. EDT on **June 30, 2010**. Late submissions will not be accepted. If a plan submits their HEDIS data after June 30, 2010, they will automatically receive a rating of one star on all of their required HEDIS measures for the data that are updated in the Fall 2010, on Medicare Options Compare.

Medicare Advantage Organizations meeting CMS's minimum enrollment requirements for 2009 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 2009 Monthly Enrollment by Contract Report (which can be found 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: 2010 Performance Measure Reporting Requirements

2010 Performance Measure Reporting Requirements				
Organization Type	**CAHPS**	**HEDIS**	**HOS**	**HOS-M**
1876 Cost	✓	✓	✓	×
Chronic Care	×	×	×	×
Demo	✓	✓	×	×
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

○ = Optional reporting

During the data 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 data year, the contract must report if the new organization type is required to report.

In 2010, CMS will also 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 2009 SNP Comprehensive Report (which can be found at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage).

Beginning with HEDIS 2010, PPO plan types have the option to report HEDIS using the Hybrid Method for all measures, with the exception of the *Colorectal Cancer Screening* measure. Because this measure is scored for NCQA accreditation using administrative benchmarks and thresholds, all PPOs must continue to report the *Colorectal Cancer Screening* measure using the Administrative Method.

PFFS and MSA plans may voluntarily collect and submit 2009 calendar year HEDIS data following the HEDIS 2010 specifications. For calendar year 2010, PFFS and MSA plans are required to

collect data on only administrative HEDIS measures following the HEDIS 2011 Technical Specifications and report the audited data to CMS in mid-2011.

For calendar year 2011, PFFS and MSA plans will be required to collect data on all HEDIS measures and report the audited data to CMS during the subsequent year. PFFS and MSA plans will be required to collect data on all HEDIS measures following the HEDIS 2012 Technical Specifications and report the audited data to CMS in mid-2012.

In HEDIS 2011, 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 new to HEDIS must become familiar with the requirements for data submissions to NCQA, and make the necessary arrangements as soon as possible. Information about the HEDIS audit compliance program is available at: http://www.ncqa.org/tabid/204/Default.aspx.

Please note that plans should refer to this memorandum for CMS reporting requirements, and not to the NCQA website. The reporting requirements are summarized in Table 2. For further information on HEDIS, please contact Lori Teichman, Ph.D. at Lori.Teichman@cms.hhs.gov. For information specific to the SNPs, please contact Heidi Arndt, MHA, at Heidi.Arndt@cms.hhs.gov.

Table 2: HEDIS 2010 Measures for Reporting by Organization Types

HEDIS 2010 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA* Contracts	MA §1876 Cost Contracts	SNPs, SNP PPOS, & ESRDs
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	

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

HEDIS 2010 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA* Contracts	MA §1876 Cost Contracts	SNPs, SNP PPOS, & ESRDs
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	X	X	X	
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				
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	
NON	Inpatient Utilization-Non-Acute Care	X	X	X	

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

HEDIS 2010 Measures for Reporting		MA HMO & PPO Contracts	MA PFFS & MSA* Contracts	MA §1876 Cost Contracts	SNPs, SNP PPOS, & ESRDs
MPT	Mental Health Utilization	X	X	X	
IAD	Identification of Alcohol and Other Drug Services	X	X	X	
ORX	Outpatient Drug Utilization	X	X	X	
ABX	Antibiotic Utilization	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	

*PFFS and MSAs may voluntarily collect the HEDIS data for CY 2009.
PPO plans may collect the Colorectal Cancer Screening measure using **only the administrative method.
[1] LDL-C Level is not required due to 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 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.

2010 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, 2009, are **required** to report the Baseline HOS in 2010, 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 11 Baseline Survey in 2008 are required to administer a Cohort 11 Follow-up Survey in 2010.

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 22, 2010**. You will receive further correspondence from NCQA regarding your HOS participation.

New in 2010 – PFFS and MSA Plans Must Report HOS

PFFS and MSA plans, with a minimum enrollment of 500 members, with Medicare contracts in effect on or before January 1, 2009, are now required to report HOS in 2010.

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, 2009, 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 22, 2010**. You will receive further correspondence from NCQA regarding your HOS participation.

For additional information on 2010 HOS or HOS-M reporting requirements, please contact Chris Haffer, Ph.D. at hos@cms.hhs.gov.

CAHPS Survey Requirements

CMS has contracted with Thoroughbred Research Group (TRG) and the Center for the Study of Services (CSS) to conduct the 2010 Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

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, 2009:

- All Coordinated Care contracts, including local and regional preferred provider organizations (PPOs) and contracts with exclusively SNP plan benefit packages, with Medicare contracts in effect on or before January 1, 2009;
- Continuing cost contracts that held §1876 risk and cost contracts, with Medicare contracts in effect on or before January 1, 2009; and,
- Private-Fee-For-Service and MSA Contracts in effect on or before January 1, 2009.

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

As a reminder, Medicare Advantage organizations will be required to contract next year for the 2011 survey administration with an approved MA & PDP CAHPS Survey Vendor. It is anticipated that a list of approved survey vendors will be available by September 2010. Training for survey vendors will take place in early Fall 2010.

For CAHPS, we have been collecting data from PFFS contracts for many years. CMS will be conducting the survey for MSA contracts beginning in 2010. For 2011, like other types of MA organizations, PFFS and MSA contracts will be required to contract with an approved MA and PDP CAHPS Survey Vendor to collect the CAHPS data on their behalf.

CMS will be issuing additional HPMS memorandums about the CAHPS survey for 2010 and 2011.

For additional information on the CAHPS survey, please contact Ted Sekscenski, MPH, at Edward.Sekscenski@cms.hhs.gov.