DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: August 3, 2012

TO: Medicare Advantage and 1876 Cost Contracts Quality Contacts and Medicare Compliance Officers

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group
Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

SUBJECT: Updated Requirements for Reporting of 2013 HEDIS®, HOS and CAHPS® Measures

Overview

This memorandum contains the Healthcare Effectiveness Data Information Set (HEDIS) measures required to be reported by all Medicare Advantage Organizations (MA organizations or MAOs) and other organization types in 2013. It also includes information about which contracts are required to participate in the Medicare Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. Sections 422.152 and 422.516 of Volume 42 of the Code of Federal Regulations (CFR) state that Medicare Advantage (MA) contracts must submit performance measures as specified by the Department of Health & Human Services (DHHS) Secretary and the Centers for Medicare & Medicaid Services (CMS). HOS requirements are updated in this version and can be found in the HOS section in italics.

HEDIS 2013 Requirements

In 2013 (the reporting year), the National Committee for Quality Assurance (NCQA) will collect data for services covered in 2012 (the measurement year). NCQA publishes detailed specifications for HEDIS measures in *HEDIS® 2013, Volume 2, Technical Specifications for Health Plans*.

All HEDIS 2013 measures must be submitted to NCQA by 11:59 p.m. Eastern Time on **June 17, 2013**. Please note that late submissions will **not** be accepted. If an organization (contract/plan) does not submit HEDIS data by June 17, 2013, they will automatically receive a rating of one star for each HEDIS measure used to populate the Plan Ratings in Medicare Plan Finder (in the fall of 2013). MA ratings affect MA Quality Bonus Payments.

For the reporting year of 2013, MAOs and other organization types listed in Table 1 must submit audited, summary-level HEDIS data to NCQA. Table 1 also indicates which organization types need to report CAHPS and HOS data.

Table 1: 2013 Performance Measure Reporting Requirements

2013 Performance Measure Reporting Requirements				
Organization Type	**CAHPS**	**HEDIS**	**HOS**	**HOS-M**
1876 Cost	✓	✓	✓	×
Chronic Care (not Demonstration)	×	×	×	×
Employer/Union Only Direct Contract PFFS	✓	✓	✓	×
HCPP-1833 Cost	×	×	×	×
Local Coordinated Care Plans (CCP)	✓	✓	✓	×
MSA	✓	✓	✓	×
National PACE	×	×	×	✓
PFFS	✓	✓	✓	×
Regional CCP	✓	✓	✓	×
RFB PFFS	✓	✓	✓	×
RFB Local CCP	✓	✓	✓	×

× = Not required to report

✓ = Required to report

All contracts marked as required to report in Table 1, and whose contract effective date is January 1, 2012 or earlier are required to collect and submit HEDIS summary data to CMS. The minimum enrollment requirement from previous HEDIS data collections has been eliminated so quality data are available for all contracts.

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

All 1876 Cost contracts are required to report HEDIS regardless of their enrollment closure status.

All contracts are also required to submit Patient-Level Detail (PLD) files to the designated CMS contractor. CMS expects these files to contain the details of the data used for the contracts' summary data submission. More details about the patient-level data submission will be forthcoming in a separate memorandum.

In 2013, CMS will continue collecting audited data from each Plan Benefit Package (PBP) designated as a Special Needs Plan (SNP). The SNP must have had 30 or more members enrolled as listed in the February 2012 SNP Comprehensive Report (the report can be found at this link: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage). SNP PBPs which meet the enrollment criteria must also exist in both the measurement year and reporting years. PBPs which end as of December 31, 2012 are not required to report, but may still do so voluntarily.

Contracts with SNP PBPs do not have to report any additional PLD files. The PLD for the contract level data includes the data about the SNP PBPs.

MAOs that are new to HEDIS must become familiar with the requirements for data submission 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.
Please note that MAOs should refer to this memorandum for CMS Medicare HEDIS reporting requirements, rather than to the NCQA website or any other third-party source. The measures to be reported in HEDIS 2013 are summarized in Table 2.

Please address all questions on the measures, reporting or submission requirements to the CMS mailbox at: HEDISquestions@cms.hhs.gov.

Table 2: HEDIS 2013 Measures for Reporting by Organization Types

HEDIS 2013 Measures for Reporting		MA HMO, MSA, PFFS, E-PFFS & PPO Contracts	§1876 Cost Contracts	SNP* PBPs
Effectiveness of Care				
ABA	Adult BMI Assessment	X	X	-
BCS	Breast Cancer Screening	X	X	-
COL	Colorectal Cancer Screening	X	X	X
GSO	Glaucoma Screening in Older Adults	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
PCE	Pharmacotherapy Management of COPD Exacerbation	X	X	X
CMC	Cholesterol Management for Patients With Cardiovascular Conditions	X	X	-
CBP	Controlling High Blood Pressure	X	X	X
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	X	X	X
CDC	Comprehensive Diabetes Care[1]	X	X	-
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	X	X	-
OMW	Osteoporosis Management in Women Who Had a Fracture	X	X	X
AMM	Antidepressant Medication Management	X	X	X
FUH	Follow-up After Hospitalization for Mental Illness	X	X	X

Table 2: HEDIS 2013 Measures for Reporting by Organization Types

HEDIS 2013 Measures for Reporting		MA HMO, MSA, PFFS, E-PFFS & PPO Contracts	§1876 Cost Contracts	SNP* PBPs
MPM	Annual Monitoring for Patients on Persistent Medications	X	X	X
MRP	Medication Reconciliation Post-Discharge (SNP-only measure)	-	-	X
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly	X	X	X
DAE	Use of High-Risk Medications in the Elderly	X	X	X
HOS	Medicare Health Outcomes Survey	X	X	X*
FRM	Falls Risk Management (collected in Medicare Health Outcomes Survey)	X	X	X*
MUI	Management of Urinary Incontinence in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X*
OTO	Osteoporosis Testing in Older Women (collected in Medicare Health Outcomes Survey)	X	X	X*
PAO	Physical Activity in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X*
FSO	Flu Shots for Older Adults (collected in CAHPS)	X	X	
MSC	Medical Assistance With Smoking Cessation (collected in CAHPS)	X	X	
PNU	Pneumonia Vaccination Status for Older Adults (collected in CAHPS)	X	X	
Access /Availability of Care				
AAP	Adults' Access to Preventive/Ambulatory Health Services	X	X	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	X	
CAT	Call Answer Timeliness	X	X	

	Utilization and Relative Resource Use			
FSP	Frequency of Selected Procedures	X	X	
AMB	Ambulatory Care	X	X	
IPU	Inpatient Utilization - General Hospital/Acute Care	X	X	
IAD	Identification of Alcohol and Other Drug Services	X	X	
MPT	Mental Health Utilization	X	X	
ABX	Antibiotic Utilization	X	X	
PCR	Plan All-Cause Readmissions	X		X
	Health Plan Descriptive Information			
BCR	Board Certification	X	X	X
ENP	Enrollment by Product Line	X	X	
EBS	Enrollment by State	X	X	
LDM	Language Diversity of Membership	X	X	
RDM	Race/Ethnicity Diversity of Membership	X	X	
TLM	Total Membership	X	X	

[1] HbA1c control <7% for a selected population is not required for Medicare contracts.
* Contracts with exclusively SNP plan benefit packages – see also specific HOS requirements in this memorandum.
** 1876 Cost Contracts do not have to report the inpatient measures since they do not have inpatient claims.

2013 HOS and HOS-M Reporting Requirements

Who Must Report HOS

The following types of MAOs and other organization types with Medicare contracts in effect on or before January 1, 2012 are **required** to report the Baseline HOS in 2013, provided that they have a minimum enrollment of 500 members:

- All Coordinated Care contracts, including health maintenance organizations (HMOs), local and regional PPOs and contracts with exclusively SNP plan benefit packages
- Continuing cost contracts that held §1876 cost contracts with open enrollment
- PFFS contracts
- MSA contracts
- Employer/Union Only Direct Contract PFFS contracts

In addition, all MAOs that reported a Cohort 14 Baseline Survey in 2011 are required to administer a Cohort 14 Follow-up Survey in 2013.

To report HOS, all organizations must contract with an NCQA-certified HOS survey vendor and notify NCQA of their survey vendor choice no later than **January 18, 2013**. You will receive further correspondence from NCQA regarding your HOS participation.

If the above organizations do not submit HOS data they will automatically receive a rating of one star for the HOS data that are updated on Medicare Plan Finder, which also impacts the MA Quality Bonus Payments.

Optional HOS Reporting for FIDE SNPs

MAOs sponsoring fully integrated dual eligible (FIDE) SNPs may elect to report HOS at the FIDE SNP level to determine eligibility for a frailty adjustment payment under the Affordable Care Act, similar to those payments provided to PACE programs. Voluntary reporting will be in addition to standard HOS requirements for quality reporting at the contract level.

Who Must Report HOS-M

The HOS-M is an abbreviated version of the Medicare HOS. The HOS-M assesses the physical and mental health functioning of the beneficiaries enrolled in PACE Programs to generate information for payment adjustment.

All PACE Programs with Medicare contracts in effect on or before January 1, 2012 are required by CMS to administer the HOS-M survey in 2013, provided that they have a minimum enrollment of 30 members.

To report HOS-M, eligible plans must contract with the CMS-certified HOS-M survey vendor, no later than **January 18, 2013**. You will receive further correspondence from NCQA regarding your HOS-M participation.

For additional information on 2013 HOS or HOS-M reporting requirements, please email hos@cms.hhs.gov.

CAHPS Survey Requirements

The following types of organizations are included in the CAHPS survey administration provided that they have a minimum enrollment of 600 eligible members as of July 1, 2012:

- All MAOs, including all coordinated care contracts, PPOs, PFFS contracts and MSA contracts
- Section 1876 (§1876) cost contracts even if they are closed for enrollment
- Employer/union only contracts

PACE and HCPP 1833 cost contracts are excluded from the CAHPS administration.

MAOs are required to contract with an approved MA & PDP CAHPS vendor for the 2013 survey administration. Approved CAHPS survey vendors are listed on www.MA-PDPCAHPS.org. CMS will issue additional HPMS memorandums about the CAHPS survey for 2013.

If an approved CAHPS vendor does not submit a contract's CAHPS data by the data submission deadline of June 13, 2013, 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 2013), which also impacts the MA Quality Bonus Payments.

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