CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 65

Date: March 18, 2005

SUBJECT: Surveys, Contracting Strategy, and Appeals

I. SUMMARY OF CHANGES: This revision updates the references to the Health Plan Employer Data and Information Set (HEDIS). Where appropriate the phrase "relevant updates" replaces references to specific annual revisions.

Also, Exhibits I, IA, IB, and II are updated with revised HEDIS reporting requirements

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 5, Section 40.2 - Specifics Applicable to CAHPS and HEDIS Section 40.2.B.1.a -- Replaced references to HEDIS 2003 to HEDIS 2005, replaced other HEDIS year references with "relevant updates, and deleted references to HEDIS 2003 update.
R	Chapter 5, Exhibit I - Required HEDIS Measures for Reporting Medicare Summary Data -- adds new measures for 2005. Reporting of a new measure in the first year is optional., but strongly encouraged.
R	Chapter 5, Exhibit IA - Continuing Cost Contracts: Required HEDIS Measures for Reporting Medicare Summary Data -- adds new measures for 2005. Reporting of a new measure in the first year is optional, but strongly encouraged.
R	Chapter 5, Exhibit IB -- HEDIS Reporting Matrix for M+C Private Fee for Service Plans and Preferred Provider Organizations -- adds new measures for 2005. Reporting of a new measure in the first year is optional, but strongly encouraged.
R	Chapter 5, Exhibit II - Submitting Patient Level Data -- adds new measures for 2005. Reporting of a new measure in the first year is optional, but strongly encouraged.

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

40.2 - Specifics Applicable to CAHPS and HEDIS

(Rev. 65, Issued 03-18-05 Effective Date: 01/01/05)

A - Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the Medicare+Choice program, which replaced the §1876 program of risk and cost contracting starting with contracts effective January 1, 2000. The reporting requirements contained in this section of Chapter 5 apply to organizations that hold an M+C contract, a §1876 cost contract, or a demonstration contract, in accordance with applicable law, regulations, and contract requirements. HEDIS submission requirements also apply to deemed M+C organizations. Please see section C below for exceptions to this requirement, such as organizations that have terminated their M+C contract or §1876 contract with CMS.

B - Requirements for MCOs

1. Reporting Requirements

    a. HEDIS - A MCO must report HEDIS measures for its Medicare managed care contract(s), as detailed in the "HEDIS Volume 2: Technical Specifications" if all of the following criteria are met:

        - The contract was in effect on 1/1 of the measurement (previous) year or earlier;
        - The contract had initial enrollment on 1/1 of the measurement year or earlier;
        - Contract had an enrollment of 1,000 or more on 7/1 of the measurement year;
        - The contract was not terminated on or before 1/1 of the reporting (current) year.

The HEDIS technical specifications are updated annually. For example, MCOs preparing HEDIS *2005* data submissions must follow instructions in HEDIS *2005*, Volume 2 and relevant updates. Please note that where there are differences between this manual chapter and HEDIS Volume 2, this chapter takes precedence for reporting data. The final HEDIS Volume 2: Technical Specifications is available from NCQA. Please call NCQA Customer Support at 1-888-275-7585 to obtain a copy. MCOs are required to take into account the update. You may wish to check periodically the HEDIS Data Submission section of NCQA's Web site to review Frequently Asked Questions (FAQs).

The Medicare relevant HEDIS measures that M+COs must report are listed in Exhibit I, and the Medicare relevant measures that continuing cost contractors must report are listed in Exhibit IA. M+C PPO and PFFS plan reporting requirements are shown in Exhibit IB. Note that two measures in the Health Plan Descriptive Information Domain (that are listed in NCQA's Technical Specifications as appropriate for Medicare) are not required to be submitted to CMS - Practitioner Compensation and Arrangements with Public Health, Educational and Social Service Organizations.

b. Health Outcomes Survey (HOS) - All MCOs, including the Program of All Inclusive Care for the Elderly (PACE) plans, that had a Medicare contract in effect on or before January 1st, of the previous year must comply with the HOS requirements for current year reporting. See the chart in section C below for specific requirements for demonstration projects.

c. Medicare+Choice CAHPS Survey - All Organizations that had a Medicare contract in effect on or before July 1, of the previous year, must comply with the M+C CAHPS survey of current enrollees and disenrollees.

d. Medicare CAHPS Disenrollment Reasons Survey - All organizations that had a Medicare contract in effect on or before January 1 of the previous year must comply with the Medicare CAHPS disenrollment Reasons Survey (hereinafter "The Reasons" Survey. The Reasons Survey does not apply to organizations that began a contract effective after January 1 of the previous year. However, such MCOs may be required to undertake an enrollee satisfaction survey to comply with the CMS regulations on physician incentive plans (Volume 61, "Federal Register," 13430, March 27, 1996). The Medicare CAHPs can be used for this purpose.

2. Minimum Size Requirements - There is a minimum size requirement for MCOs to report HEDIS measures; MCO enrollment must be 1,000 or more on July 1st of the measurement year. In reviewing previous HEDIS submissions, CMS noted that this is the enrollment level at which most MCOs could submit valid data on the Effectiveness of Care measures. There is no minimum size requirement to participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size requirements (see table above for specific program requirements) or the HOS sample size of 1,000, at the time the sample is drawn, the entire membership must be surveyed. An MCO must report all the CMS-required Medicare HEDIS measures, even if the MCO has small numbers for the denominator of a measure. For specific instructions on how to handle small numbers, review the Specific Guidelines in the "HEDIS Volume 2, Technical Specifications." For information regarding the audit designation for these measures review "HEDIS Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures."

Sampling and Reporting Unit - MCOs will have one reporting unit for HEDIS, HOS, and Disenrollment Reasons and Rates, for each contract. This aligns HEDIS and HOS reporting with the level at which MCO performance is monitored and quality assessment and performance improvement projects are performed, i.e. at the contract level. Note that HEDIS reporting will be based on the membership in the service area in place during the measurement (previous) year while the reporting entity will reflect the contract or entity structure under the reporting (current) year configuration.

Medicare CAHPS instituted a local sampling and reporting unit for the traditional CAHPS survey of enrollees and disenrollees that accommodates comparison with Medicare CAHPS fee-for-service (FFS) and Private Fee-For-Service (PFFS) plans and retains the collection of beneficiary satisfaction and experience data at a local level. The sampling unit is a collection of counties combined into a Health Service Area (HSA), which is a standard unit of measure of health services utilization as determined by the Department of Health and Human Services. Currently, the CAHPS data on Medicare managed care plans is compared to CAHPS data on Original Medicare at the State level in the Medicare Personal Plan Finder and Medicare Health Plan Compare on www.medicare.gov and in the annual CAHPS health plan reports. The comparisons between managed care, private fee-for-service, and Original Medicare are displayed. Please send questions to CAHPS@cms.hhs.gov.

C - MCOs With Special Circumstances

1. MCOs with Multiple Contract Types - A MCO cannot combine small contracts of different types, e.g., risk and cost, into a larger reporting unit.

2. MCOs Carrying Cost or former HCPP Members - HEDIS performance measures will be calculated using only the Medicare enrollment in the M+C contract or the §1876 of the Act contract in effect at the end of the measurement year. Therefore, any residual cost based enrollees within an M+C contract should not be included in HEDIS calculations.

3. For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

4. MCOs with New Members “Aging-in” from their Commercial Product Line - These MCOs must consider “aging in” members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members who switch from a MCO’s commercial product line to the MCO’s Medicare product line are considered continuously enrolled. Please read the General Guidelines of HEDIS Volume 2: Technical Specifications for a discussion of “age-ins” (see Members who switch product lines) and continuous enrollment requirements.

5. MCOs with Changes in Service Areas - MCOs that received approval for a service area expansion during the previous year and those that will be reducing their service area effective January 1st of the next contract and reporting year must include information regarding those beneficiaries in the expanded or reduced areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

6. HMOs with Home and Host Plans - The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with CMS. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled in the plan.

7. New Contractors and Contractors Below the Minimum Enrollment Threshold - MCOs that did not have enrollment on January 1st of the measurement year or later will not report HEDIS performance measures for the corresponding reporting year. In addition, MCOs with enrollment below 1,000 on July 1st of the measurement year will not be required to submit a HEDIS report and they will not need to request a DST from NCQA. However, these plans must have systems in place to collect performance measurement information so that they can provide reliable and valid HEDIS data in the next reporting year.

8. Non-renewing/Terminating MCOs - Entities that meet the HEDIS reporting requirements stated above but which have terminated contracts effective January 1st of the reporting year will not be required to submit a HEDIS report or participate in the HOS survey. These contracts are required to participate in the CAHPS surveys in the fall prior to their contract termination date.

9. MCOs with Continuing §1876 Cost Contracts - For cost contracts, CMS has modified the list of HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Exhibit I.A. CMS does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from the MCO. Thus, CMS and the public would not know to what degree the data for these measures are complete.

10. Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Exhibit I.A.)

11. M+C preferred provider organizations and private fee for service plans due to the structure of their organizations are not able to report all measures of M+C

coordinated care plans. Consequently, a separate reporting matrix for these organizations is included as Exhibit I.B.

12. Mergers and Acquisitions - The entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the enrollment of the surviving company. The CMS recognizes that a separate set of beneficiaries and affiliated providers may be associated with the surviving entity’s contract. However, HEDIS measures based on the combined membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract. The surviving contract(s) must comply with all aspects of this section for all members it had in the measurement year.

    NOTE: An entity that acquires and novates an existing Medicare contract must file a HEDIS report since the membership, benefits and medical delivery system are essentially unchanged. Therefore, during negotiations for the acquisition it is essential that parties agree on a method of data exchange that will permit the acquiring organization to file a HEDIS report covering the measurement year in which the transaction occurred.

13. Demonstration Projects - CMS also requires demonstration projects to meet the HEDIS, CAHPS, and HOS reporting requirements, in accordance with applicable law, regulations, and contract requirements for similar type plans. However, specific waivers contained in the demonstration contracts that have been or will be negotiated with CMS take precedence over any requirements specified in this manual section. The chart below summarizes reporting requirements by type of demonstration. For further information on the requirements for specific demonstrations, contact the CMS project officer in the Division of Demonstration Programs.

Demonstration	HEDIS	HEDIS Audit	M+C CAHPS	Disenrollee Reasons Survey	HOS
Social HMOs	YES	YES	YES	YES	YES
Minnesota Senior Health Options	NO	NO	NO	NO	YES
Massachusetts Health Senior Care Options	NO	NO	NO	NO	YES
Wisconsin Partnership Program	NO	NO	NO	NO	YES
Evercare	NO	NO	NO	NO	NO
Medicare Alternative Payment Demo I	*	*	YES	YES	*
PPO	*	*	YES	NO	*

***Contact the CMS project officer in the Division of Demonstration Programs with additional questions and for advice on whether a report should be filed.**

D - Implications for Failure to Comply

The CMS expects full compliance with the requirements of this section. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate and audited. In addition, many of the HEDIS requirements described herein will be reviewed as part of CMS' contractor performance oversight process using the M+C Monitoring Review Guide, Version I.

E - Use of Data

Data reported to CMS under this requirement will be used in a variety of ways. The HEDIS, CAHPS, and Disenrollment summary data is available to assist the Medicare beneficiary to make informed choices. This data will provide comparative information on contracts to beneficiaries to assist them in choosing among MMC plans and FFS. In addition, CMS expects MCOs to use the data, including HOS data, for internal quality improvement. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted and may be used as the baseline data for Quality

Assessment and Performance Improvement (QAPI) projects. Additionally, all four data sets may be used for research purposes by public or private entities. Further, the data will provide CMS with information useful for monitoring the quality of, and access to, care provided by MCOs. CMS may target areas that warrant further review based on the data. For example, CMS has developed a Performance Assessment System that will array information from the HEDIS, HOS, CAHPS, and disenrollment data sets in a manner that will permit performance evaluation by CMS. The MCOs can also view their own PAS information online via secured access to the Health Plan Management System. For organizations that are subject to frailty adjusted payment, the data will also be used to determine an organization-level frailty adjuster.

Exhibit I - Required HEDIS Measures for Medicare Reporting for Summary Data

(Rev. 65, Issued 03-18-05 Effective Date: 01/01/05)

Effectiveness of Care

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women Who Had a Fracture

Controlling High Blood Pressure

Beta Blocker Treatment After A Heart Attack

**Persistence of Beta-Blocker Treatment After a Heart Attack*

Cholesterol Management After Acute Cardiovascular Events

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication Management

**Glaucoma Screening in Older Adults*

Medicare Health Outcomes Survey

Management of Urinary Incontinence in Older Adults (collected through HOS)

**Physical Activity in Older Adults (collected through HOS)*

Access to/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

**Claims Timeliness*

**Call Answer Timeliness*

**Call Abandonment*

Health Plan Stability

Practitioner Turnover

Years in Business/Total Membership

Use of Services

Frequency of Selected Procedures

Inpatient Utilization - General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization - Non-Acute Care

Mental Health Utilization - Inpatient Discharges and Average Length of Stay

Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay

Identification of Alcohol and Other Drug Services

Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information

Board Certification

Total Enrollment by Percentage

Enrollment by Product Line (Member Years/Months)

* New measure for HEDIS® *2005*. Reporting of a new measure in the first year is optional, *but strongly encouraged.*

Exhibit IA - Continuing Cost Contracts: Required HEDIS Measures for Medicare Reporting for Summary Data

(Rev. 65, Issued 03-18-05 Effective Date: 01/01/05)

Effectiveness of Care

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women Who Had a Fracture

Controlling High Blood Pressure

Beta Blocker Treatment After A Heart Attack

**Persistence of Beta-Blocker Treatment After a Heart Attack*

Cholesterol Management After Acute Cardiovascular Events

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication Management

**Glaucoma Screening in Older Adults*

Medicare Health Outcomes Survey

Management of Urinary Incontinence in Older Adults (collected through HOS)

**Physical Activity in Older Adults (collected through HOS)*

Access to/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

**Claims Timeliness*

**Call Answer Timeliness*

**Call Abandonment*

Health Plan Stability

Practitioner Turnover

Years in Business/Total Membership

Use of Services

Ambulatory Care

Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information

Board Certification

Total Enrollment by Percentage

Enrollment by Product Line (Member Years/Months)

* New measure for HEDIS®*2005*. Reporting of a new measure in the first year is optional, *but strongly encouraged.*

Exhibit IB - HEDIS Reporting Matrix for M+C Private Fee For Service Plans and Preferred Provider Organizations

(Rev. 65, Issued 03-18-05 Effective Date: 01/01/05)

HEDIS 2005 Measure	Applicable to PFFS/PPO	Not Applicable to PFFS/PPO	Comments
Effectiveness of Care			
Colorectal Cancer Screening		**X**	*Requires medical record review*
Breast Cancer Screening	X		
Osteoporosis Management in Women Who Had a Fracture	X		Must be reported only by plans with a pharmacy benefit
Controlling High Blood Pressure		X	Requires medical record review
Beta Blocker Treatment After a Heart Attack		**X**	Requires medical record review and prescription information
**Persistence of Beta-Blocker Treatment After a Heart Attack*			
Cholesterol Management After Acute Cardiovascular Events	X		LDL-C Screening rate is required. LDL-C Level is not required due to need for medical record review.
Comprehensive Diabetes Care	X		Rates are required for HbA1c Testing, Eye Exams and LDL-C Screening but not for HbA1c control, LDL-C control or Monitoring for Diabetic Nephropathy which requires medical record review.

HEDIS 2005 Measure	Applicable to PFFS/PPO	Not Applicable to PFFS/PPO	Comments
Follow-up After Hospitalization for Mental Illness	X		
Antidepressant Medication Management	*X*		Must be reported *only* by plans with pharmacy and mental health benefit
**Glaucoma Screening in Older Adults*			
Medicare Health Outcomes Survey	X		Requires contract with NCQA certified vendor to administer survey
Management of Urinary incontinence in Older Adults	X		Measure will be collected through Health Outcomes Survey
**Physical Activity in Older Adults*			*Measure will be collected through Health Outcomes Survey*
Access /Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services	X		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X		
**Claims Timeliness*	*X*		
**Call Answer Timeliness*	*X*		
**Call Abandonment*	*X*		

HEDIS 2005 Measure	Applicable to PFFS/PPO	Not Applicable to PFFS/PPO	Comments
Satisfaction with the Experience of Care			
HEDIS/CAHPS ™ 3.0H , Adult (enrollee and disenrollee components)	X		Must provide information that CMS needs to administer survey
Health Plan Stability			
Practitioner Turnover	*X*		Measure must be reported *only* by PPOs with a contracted physician network.
Years in Business/Total Membership	*X*		
Use of Services			
Frequency of Selected Procedures	X		
Inpatient Utilization --- General Hospital/Acute Care	X		
Ambulatory Care	X		
Inpatient Utilization- Non-Acute Care	X		
Mental Health Utilization --- Inpatient Discharges and Average Length of Stay	X		
Mental Health Utilization-Percentage of Members Receiving Services	X		
Chemical Dependency Utilization-- Inpatient Discharges and Average Length of Stay	X		

HEDIS 2005 Measure	Applicable to PFFS/PPO	Not Applicable to PFFS/PPO	Comments
Identification of Alcohol and Other Drug Services	X		
Outpatient Drug Utilization	X		Reporting is limited only to plans with a pharmacy benefit
Health Plan Descriptive Information			
Board Certification	X		Measure must be reported only by PPOs with a contracted physician network
Total Enrollment by Percentage	X		
Enrollment by Product Line (Member Years/Member Months)	X		

* New measure for HEDIS *2005*. Reporting of a new measure in the first year is optional, *but strongly encouraged.*

Exhibit II - Submitting Patient-Level Data

(Rev. 65, Issued 03-18-05 Effective Date: 01/01/05)

Required Measures

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by reporting unit. The HIC number is assigned by CMS to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

NOTE: Section 1876 cost contracts (whether or not they convert to become an M+C MCO in the reporting year) should only report patient-level data for the summary measures that are listed in Attachment I.A for the following three domains.

1 - Effectiveness of Care

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women Who Had a Fracture

Controlling High Blood Pressure

Beta Blocker Treatment After A Heart Attack

Persistence of Beta-Blocker Treatment After a Heart Attack

Cholesterol Management After Acute Cardiovascular Events

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication Management

Glaucoma Screening in Older Adults

2 - Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

3 - Use of Services

Frequency of Selected Procedures

Inpatient Utilization - General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization - Nonacute Care

Mental Health Utilization- Inpatient Discharges and Average Length of Stay

Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay

Identification of Alcohol and Other Drug Services

To be useful, patient-level data must match the summary data for the measures discussed here, i.e., the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO should make a copy, or "freeze" its database when the summary measures are calculated. If the measure was calculated using the hybrid methodology, the patient-level data should be reported on the minimum required sample size (411) or the total denominator population if less than 411. National Committee for Quality Assurance (NCQA) will provide MCOs with exact file specifications and explicit instructions by the spring of the reporting year, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement. These instructions and file specifications will be posted on NCQA's Web site at http://www.ncqa.org. MCOs are advised to frequently review the NCQA Web site for updates on the data submission process.