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CENTER FOR MEDICARE

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TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

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SUBJECT: Reporting Requirements for 2016 HEDIS®, HOS and CAHPS® Measures

Overview

This memorandum contains the Healthcare Effectiveness Data and Information Set (HEDIS) measures required for reporting in 2016 by all Medicare Advantage Organizations (MAOs) and other health plan organization types (**Table 1**). 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 contracts must submit performance measures as specified by the U.S. Department of Health & Human Services (DHHS) Secretary and the Centers for Medicare & Medicaid Services (CMS).

HEDIS 2016 Requirements

In 2016 (the reporting year), the National Committee for Quality Assurance (NCQA) will collect data for services covered in 2015 (the measurement year). NCQA publishes detailed specifications for HEDIS measures in *HEDIS 2016, Volume 2: Technical Specifications for Health Plans*.

All HEDIS 2016 audited summary-level data must be submitted to NCQA by 11:59 p.m. Eastern Time on June 15, 2016. This is a mandatory requirement. Please note that late submissions will **not** be accepted. If an organization (contract/plan) does not submit audited summary-level data by June 15, 2016, it will automatically receive a Star Rating of one star for each HEDIS measure used to populate the Star Ratings in Medicare Plan Finder (in the fall of 2016). MA Star Ratings affect MA Quality Bonus Payments. For Medicare-Medicaid Plans (MMPs), failure to submit audited data by the deadline may affect quality withhold payments.

Health plans 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.

For the 2016 reporting year, MAOs and other health plan organization types listed in **Table 1** must submit audited summary-level data to NCQA. **Table 1** also indicates which organization types must report CAHPS and HOS data.

Table 1: 2016 Performance Measure Reporting Requirements

2016 Performance Measure Reporting Requirements				
Organization Type	**CAHPS**	**HEDIS**	**HOS**	**HOS-M**
Section 1876 Cost contracts	✓	✓	✓	×
Chronic Care	×	×	×	×
Demonstration (Plan Type: Medicare-Medicaid Plans or MMPs)	✓	✓	✓	×
Employer/Union Only Direct Contract Local CCP	✓	✓	✓	×
Employer/Union Only Direct Contract PFFS	✓	✓	✓	×
HCPP-1833 Cost	×	×	×	×
Local Coordinated Care Plans (CCP)	✓	✓	✓	×
MSA	✓	✓	✓	×
National PACE	×	×	×	✓
PFFS	✓	✓	✓	×
Regional CCP	✓	✓	✓	×
RFB Local CCP	✓	✓	✓	×
RFB PFFS	✓	✓	✓	×

× = Not required to report ✓ = Required to report

HEDIS 2016 Summary-Level Data

CMS requires all contracts with an effective date of January 1, 2015 or earlier, that have an organization type marked in **Table 1,** to collect and submit to NCQA the audited summary-level data for the HEDIS measures listed in **Table 2**.

We reiterate the language in last year's memorandum that there is no minimum enrollment requirement for submitting audited summary-level data.

Please note this memorandum supersedes the reporting requirements information found in the CMS Medicare Managed Care Manual (any volume) or other sources.

If your Health Plan Management System (HPMS) contract status is listed as a consolidation, a merger or a novation during the measurement year, then the surviving contract must report audited summary-level data for all members of all contracts involved. If a contract status is listed as a conversion in the measurement year, then the contract must report if their new organization type is required to report. If your HPMS contract status is listed as, "Withdrawn Contract" or "Terminated" with a termination date on or before the June 15, 2016 submission date, then your contract is not required to report for HEDIS 2016. MMPs that terminate effective January 1, 2016 or after, however, are required to report for HEDIS 2016 if they were in operation for the full 2015 contract year.

All 1876 Cost contracts are required to report the HEDIS measures listed in **Table 2**, regardless of their enrollment closure status.

HEDIS 2016 Patient-Level Detail (PLD)

All contracts are also required to submit audited HEDIS Patient-Level Data (PLD) files to the designated CMS contractor. All HEDIS PLD data must be submitted by 11:59 p.m. Eastern Time on June 15, 2016. No late submissions are permitted. CMS expects these PLD files to contain the member level details for the data reported in the contracts' summary data submissions.

If HEDIS PLD data are missing for any of the star measures, the contract will automatically receive a Star Rating of one star for each HEDIS measure used to populate the Star Ratings in Medicare Plan Finder (in the fall of 2016).

More details about the HEDIS 2016 PLD file submission requirements will be forthcoming in a separate memorandum in HPMS.

Table 2: HEDIS 2016 Measures for Reporting

HEDIS 2016 Measures for Reporting: All Organizations Report all Measures	
Effectiveness of Care	
ABA	Adult BMI Assessment
BCS	Breast Cancer Screening
COL	Colorectal Cancer Screening
PSA	Non-Recommended PSA-Based Screening in Older Men
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
PCE	Pharmacotherapy Management of COPD Exacerbation
CBP	Controlling High Blood Pressure
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack[1]
CDC	Comprehensive Diabetes Care[2]
ART	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW	Osteoporosis Management in Women Who Had a Fracture
AMM	Antidepressant Medication Management
FUH	Follow-Up After Hospitalization for Mental Illness
MPM	Annual Monitoring for Patients on Persistent Medications
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly
DAE	Use of High-Risk Medications in the Elderly
HOS	Medicare Health Outcomes Survey
FRM	Falls Risk Management (collected in HOS)
MUI	Management of Urinary Incontinence in Older Adults (collected in HOS)
OTO	Osteoporosis Testing in Older Women (collected in HOS)

PAO	Physical Activity in Older Adults (collected in HOS)
FVO	Flu Vaccinations for Adults Ages 65 and Older (collected in CAHPS)
MSC	Medical Assistance With Smoking and Tobacco Use Cessation (collected in CAHPS)
PNU	Pneumococcal Vaccination Status for Older Adults (collected in CAHPS)
SPC	Statin Therapy for Patients with Cardiovascular Disease[1]
SPD	Statin Therapy for Patients With Diabetes[1]
MRP	Medication Reconciliation Post-Discharge[1]
Access/Availability of Care	
AAP	Adults' Access to Preventive/Ambulatory Health Services
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Utilization and Risk Adjusted Utilization	
FSP	Frequency of Selected Procedures[1]
AMB	Ambulatory Care
IPU	Inpatient Utilization - General Hospital/Acute Care[1]
IAD	Identification of Alcohol and Other Drug Services[1]
MPT	Mental Health Utilization[1]
ABX	Antibiotic Utilization
PCR	Plan All-Cause Readmissions[3]
IHU	Inpatient Hospital Utilization[1]
EDU	Emergency Department Utilization[1]
HPC	Hospitalization for Potentially Preventable Complications[1]
Health Plan Descriptive Information	
BCR	Board Certification
ENP	Enrollment by Product Line
EBS	Enrollment by State
LDM	Language Diversity of Membership
RDM	Race/Ethnicity Diversity of Membership
TLM	Total Membership

[1] If they do not have inpatient claims, Section 1876 Cost contracts do not have to report the following inpatient measures: PBH, SPC, MRP, SPD, FSP, IPU, IAD, MPT, IHU, EDU and HPC.

[2] HbA1c control <7% for a selected population is not reported for Medicare contracts.

[3] Section 1876 Cost contracts are not required to report the PCR measure, but may do so voluntarily. If an 1876 Cost contract voluntarily submits audited summary-level PCR data, then the 1876 Cost contract must also have corresponding audited HEDIS PLD data for the PCR measure.

PBP-Level HEDIS Reporting for CCPs with SNPs and Demonstrations (MMPs)

In 2016, CMS will continue collecting audited summary-level data from each Plan Benefit Package (PBP) designated as a Special Needs Plan (SNP) offered by any coordinated care plan (CCP) organization. CMS will also collect audited summary-level data for each Demonstration (Medicare-Medicaid Plan) PBP.

A SNP PBP must have had 30 or more members enrolled as listed in the February 2015 SNP Comprehensive Report (this report can be found at this link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html). SNP PBPs that meet the enrollment criteria must also exist in both the measurement year and reporting years. PBPs that terminated as of December 31, 2015 are not required to report, but may still do so voluntarily.

A Demonstration (Medicare-Medicaid Plan) must have had 30 or more members enrolled as listed in the February 2015 Monthly Enrollment by Plan report (this report can be found at this link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan.html). Any Demonstration (Medicare-Medicaid Plan) that meets the enrollment criteria must also exist in both the measurement year and reporting years. MMP PBPs that terminated as of December 31, 2015 are required to report, if they were in operation for the full 2015 calendar year.

All SNP and Demonstration (Medicare-Medicaid Plan) PBPs must report the HEDIS measures in **Table 3**. If a contract has multiple qualifying PBPs, then each qualifying PBP in the contract must report the measures in **Table 3** in a separate submission. Demonstrations (Medicare-Medicaid Plan) and contracts with SNP PBPs do not have to report any additional PLD files. The HEDIS PLD submission at the contract level data will already include the detail data about the MMPs and SNP PBPs. **Table 3** lists the 2016 HEDIS measures for reporting by all SNP and demonstration PBPs.

Table 3: HEDIS 2016 Measures for Reporting by SNP and Demonstration MMPs

HEDIS 2016 Measures for Reporting: All SNP & Demo (MMP) PBPs Report All Measures	
Effectiveness of Care	
COL	Colorectal Cancer Screening
COA	Care for Older Adults (SNP-only measure)
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
PCE	Pharmacotherapy Management of COPD Exacerbation
CBP	Controlling High Blood Pressure
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
OMW	Osteoporosis Management in Women Who Had a Fracture
AMM	Antidepressant Medication Management
FUH	Follow-Up After Hospitalization for Mental Illness
MPM	Annual Monitoring for Patients on Persistent Medications
MRP	Medication Reconciliation Post-Discharge

DDE	Potentially Harmful Drug-Disease Interactions in the Elderly
DAE	Use of High-Risk Medications in the Elderly
	Utilization and Risk Adjusted Utilization
PCR	Plan All-Cause Readmissions
	Health Plan Descriptive Information
BCR	Board Certification

HEDIS Contacts

Please send all questions about HEDIS measure specifications to NCQA's Policy Clarification Support system at my.ncqa.org. Questions about HEDIS reporting or data submission requirements for 2016 or prior years should be sent to the CMS mailbox at: HEDISquestions@cms.hhs.gov.

2016 HOS and HOS-M Reporting Requirements

Who Must Report HOS

The following types of MAOs and other health plan organization types with Medicare contracts in effect on or before January 1, 2015 are **required** to report the Baseline HOS in 2016, provided that they have a minimum enrollment of 500 members as of February 1, 2016:

- All MAOs, including all coordinated care plans, PFFS contracts, and MSA contracts
- Section 1876 Cost contracts even if they are closed for enrollment
- Employer/union only contracts
- Medicare Medicaid Plans (MMPs)

In addition, all organizations that reported a Cohort 17 Baseline Survey in 2014 are required to administer a Cohort 17 Follow-up Survey in 2016.

If your Health Plan Management System (HPMS) contract status is listed as a consolidation, a merger or a novation during the measurement year, then the surviving contract must report Follow-Up HOS 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.

To report HOS, all organizations must contract with a CMS-approved HOS survey vendor and notify NCQA of their survey vendor choice no later than **January 15, 2016**. Approved HOS survey vendors are listed on www.hosonline.org. 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 Star Rating of one star for the HOS data that are part of the Star Ratings 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. Voluntary reporting will be in addition to standard HOS requirements for quality reporting at the contract level. Information specific to optional reporting for FIDE SNPs in 2016 will be forthcoming in a separate memo.

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 Programs of All-Inclusive Care for the Elderly (PACE) to generate information for payment adjustment.

All PACE Medicare contracts in effect on or before January 1, 2015 are required by CMS to administer the HOS-M survey in 2016, provided that they have a minimum enrollment of 30 members.

To report HOS-M, eligible plans must contract with the CMS-approved HOS-M survey vendor no later than **January 15, 2016**. You will receive further correspondence from NCQA regarding your HOS-M participation.

For additional information on 2016 HOS or HOS-M reporting requirements, please email hos@cms.hhs.gov.

2016 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, 2015:

- All MAOs, including all coordinated care plans, PFFS contracts, and MSA contracts
- Section 1876 Cost contracts even if they are closed for enrollment
- Employer/union only contracts
- Medicare-Medicaid Plans

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

Organizations are required to contract with an approved MA & PDP CAHPS vendor for the 2016 survey administration. Approved CAHPS survey vendors are listed on www.MAPDPCAHPS.org. CMS will issue additional HPMS memorandums about the CAHPS survey for 2016.

If an approved CAHPS vendor does not submit a contract's CAHPS data by the June data submission deadline, the contract will automatically receive a Star Rating of one star for the required CAHPS measures for the data that are updated on Medicare Plan Finder (in the fall of 2016), which also impacts the MA Quality Bonus Payments.

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