DEPARTMENT OF HEALTH & HUMAN SERVICES
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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 2018 HEDIS®, HOS, and CAHPS® Measures

Overview

This memorandum contains the Healthcare Effectiveness Data and Information Set (HEDIS) measures required for reporting in 2018 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 quality performance measures as specified by the U.S. Department of Health & Human Services (DHHS) Secretary and the Centers for Medicare & Medicaid Services (CMS).

This memorandum supersedes the reporting requirements for HEDIS, HOS, and CAHPS in the CMS Medicare Managed Care Manual (any volume) or other sources.

HEDIS 2018 Requirements

In 2018 (the reporting year), the National Committee for Quality Assurance (NCQA) will collect data for services covered in 2017 (the measurement year). NCQA publishes detailed specifications for HEDIS measures in *HEDIS 2018, Volume 2: Technical Specifications for Health Plans*.

All HEDIS 2018 audited summary-level data must be submitted to NCQA by 11:59 p.m. Eastern Time on June 15, 2018. This is a mandatory requirement. CMS will **NOT** accept late submissions for any reason. If an organization (contract/plan) does not submit audited summary-level data by June 15, 2018, it will automatically receive a rating of one star for each HEDIS measure used to populate the Star Ratings on Medicare Plan Finder (in the fall of 2018). 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.

All health plan organizations 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 2018 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: 2018 Performance Measure Reporting Requirements

2018 Performance Measure Reporting Requirements				
Organization Type	**CAHPS**	**HEDIS**	**HOS**	**HOS-M**
Section 1876 Cost contracts	✓	✓	✓	×
Chronic Care	×	×	×	×
Demonstration: Medicare-Medicaid Plans (MMPs)	✓	✓	✓	×
Employer/Union Only Direct Contract Local CCP	✓	✓	✓	×
Employer/Union Only Direct Contract PFFS	✓	✓	✓	×
HCPP-1833 Cost	×	×	×	×
Local Coordinated Care Plans (LCCP)	✓	✓	✓	×
Medical Savings Account (MSA)	✓	✓	✓	×
National PACE	×	×	×	✓
Private Fee-for-Service (PFFS)	✓	✓	✓	×
Regional Coordinated Care Plans (RCCP)	✓	✓	✓	×
Religious Fraternal Benefit Local Coordinated Care Plans (RFB CCP)	✓	✓	✓	×
Religious Fraternal Benefit Private Fee-for-Service	✓	✓	✓	×

× = Not required to report ✓ = Required to report

HEDIS 2018 Summary Contract-Level Data

CMS requires all contracts with an effective date of January 1, 2017 or earlier, that have an organization type marked in **Table 1,** to collect and submit to NCQA the audited summary contract-level data for the HEDIS measures listed in **Table 2**. There is no minimum enrollment requirement for submitting audited summary-level data.

Contract Closures: If your Health Plan Management System (HPMS) contract status becomes "Withdrawn Contract" or "Terminated" with a termination date on or before the June 15, 2018 submission date, then your contract is not required to report for HEDIS 2018. MMPs that terminate as of December 31, 2017 or after, however, are required to report for HEDIS 2018 if they were in operation for the full 2017 contract year. All 1876 Cost contracts are required to report the HEDIS measures listed in **Table 2**, regardless of enrollment closure status.

Contract Consolidations: If your organization consolidates one or more contracts during the change over from measurement to reporting year, then only the surviving contract is required to report audited summary contract-level data on all members from all contracts involved.

Contract Merger or Novation: Organizations that merge or novate at any time throughout the measurement year up until the time of reporting must report audited summary contract-level HEDIS data for each contract in the organization.

Table 2: HEDIS 2018 MA Contract Level Measures for Reporting

HEDIS 2018 MA Contract Level Measures for Reporting: All organizations report all measures except as noted in the footnotes	
Effectiveness of Care	
ABA	Adult BMI Assessment
BCS	Breast Cancer Screening
COL	Colorectal Cancer Screening
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]
SPC	Statin Therapy for Patients with Cardiovascular Disease[1]
CDC	Comprehensive Diabetes Care[2]
SPD	Statin Therapy for Patients With Diabetes[1]
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
FUM	Follow-Up After Emergency Department Visit for Mental Illness
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
MPM	Annual Monitoring for Patients on Persistent Medications
MRP	Medication Reconciliation Post-Discharge[1]
TRC	Transitions of Care[1]
FMC	Follow-up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions
PSA	Non-Recommended PSA-Based Screening in Older Men
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly
DAE	Use of High-Risk Medications in the Elderly
UOD	Use of Opioids at High Dosage
UOP	Use of Opioids from Multiple Providers
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)

Access/Availability of Care	
AAP	Adults' Access to Preventive/Ambulatory Health Services
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or 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
HAI	Standardized Healthcare-Associated Infection Ratio[1, 3]
PCR	Plan All-Cause Readmissions[1]
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
Measures Collected Using Electronic Clinical Data Systems [4]	
DSF	Depression Screening and Follow-Up for Adolescents and Adults
DMS	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
DRR	Depression Remission or Response for Adolescents and Adults
ASF	Unhealthy Alcohol Use Screening and Follow-Up
PVC	Pneumococcal Vaccination Coverage for Older Adults

1 Section 1876 Cost contracts do not report the following measures: PBH, SPC, SPD, MRP, TRC, FSP, IPU, IAD, MPT, HAI, PCR, IHU, EDU and HPC.

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

3 The Standardized Healthcare-Associated Infection Ratio measure (HAI) will NOT be included in the Patient-Level Data in HEDIS 2018

4 The measures in the Electronic Clinical Data Systems (ECDS) domain are considered first-year measures, do not require an audit (although they can be audited), and reporting is completely voluntary. CMS is collecting the data for review only. The ECDS measures will NOT be included in the Patient-Level Data in HEDIS 2018. Data collected for these measures will NOT be included in any publicly reported data.

HEDIS 2018 Patient-Level Data (PLD)

All organizations that submit HEDIS summary contract-level data are also required to submit audited HEDIS Patient-Level Data (PLD) files to the designated CMS contractor. **All HEDIS PLD files must be submitted by 11:59 p.m. Eastern Time on June 15, 2018.** Late submissions are not permissible. CMS expects these PLD files to contain the member level details for all of 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 2018).

All details about the HEDIS 2018 PLD file submission requirements will be forthcoming in a separate memorandum in HPMS.

2018 Summary PBP-Level Reporting for CCPs with SNPs and MMPs

In 2018, CMS will continue collecting audited summary plan benefit package (PBP) level data from each PBP designated as a SNP offered by any CCP organization. CMS will also collect audited summary PBP level data for each MMP PBP.

A SNP PBP must have had 30 or more members enrolled as listed in the February 2017 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, 2017 are not required to report, but may still do so voluntarily.

An MMP PBP must have had 30 or more members enrolled as listed in the February 2017 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). MMP PBPs that terminated as of December 31, 2017 or after are required to report, if they were in operation for the full 2017 calendar year.

All SNP and MMP 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. MMP and contracts with SNP PBPs do not have to report any additional PLD files. The required HEDIS PLD file submission at the contract level data will already include the detail data about the members in the SNP and MMPs PBPs. **Table 3** lists the 2018 HEDIS measures for reporting by all SNP and MMP PBPs.

Table 3: HEDIS 2018 Measures for Reporting by SNPs and MMP PBPs

HEDIS 2018 Plan Benefit Package (PBP) Level Measures for Reporting: All SNP & MMP PBPs Report All Measures	
Effectiveness of Care	
COL	Colorectal Cancer Screening
COA	Care for Older Adults (SNP- and MMP-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. For other information about HEDIS, please email HEDISquestions@cms.hhs.gov.

2018 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, 2017 are **required** to report the Baseline HOS in 2018, provided that they have a minimum enrollment of 500 members as of February 1, 2018:

- 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 19 Baseline Survey in 2016 are required to administer a Cohort 19 Follow-up Survey in 2018. In the event of a contract consolidation, merger or novation, the surviving contract must report Follow-Up HOS for all members of all contracts involved. All eligible members of consolidated, merged, or novated contracts will be resurveyed and the results will be supported as one under the surviving contract. In the event of a contract conversion, 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 12, 2018**. Approved 2018 HOS survey vendors will be listed on www.HOSonline.org. You will receive further correspondence from NCQA regarding your HOS participation.

If an approved HOS survey vendor does not submit a contract's HOS data by the data submission deadline, they will automatically receive a rating of one star for the HOS measures 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 at the plan level will be in addition to standard HOS requirements for quality reporting at the contract level. Information specific to optional reporting for FIDE SNPs in 2018 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, 2017 are required by CMS to administer the HOS-M survey in 2018 if 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 12, 2018**. You will receive further correspondence from NCQA regarding your HOS-M participation.

For additional information on 2018 HOS or HOS-M reporting requirements, please email hos@cms.hhs.gov.

2018 CAHPS Survey Requirements

The following types of organizations are included in the CAHPS survey administration if they have a minimum enrollment of 600 eligible members as of July 1, 2017:

- 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 2018 CAHPS survey administration. All approved CAHPS survey vendors for the 2018 survey administration will be listed on www.MA-PDPCAHPS.org. CMS will issue additional HPMS memorandums about the CAHPS survey for 2018.

If an approved CAHPS vendor does not submit a contract's CAHPS data by the data submission deadline, 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 2018), which also impacts the MA Quality Bonus Payments.

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