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

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
5	Table of Contents		
5		25	
5	40 – 40.6		
5		Exhibit IB	
5			Exhibit III
5	Appendix A		

Red italicized font identifies new material

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2003
IMPLEMENTATION DATE: January 1, 2003

Table of Contents, is revised to add Section 25 and Exhibit 1B. Exhibit III is deleted.

Section 25, Summary of PPO/PFFS Quality Improvement Requirements, provides a summary of quality improvements requirements relating to M+C preferred provider organization and private fee-for-service plans.

Sections 40 – 40.6, are revised to change paragraph formatting and make grammatical corrections. The hypertext link at the end of Section 40.1 has been eliminated and the table included in the text. Section 40.2(B)(3) is revised to state the Sampling and Reporting Unit will be at the contract level for all states. Section 40.4 is revised include the information formerly in Exhibit III.

Exhibits 1–II are moved to the end of Section 40.6 to eliminate the hypertext link. Exhibit 1B, The Health Plan Employer Data and Information Set (HEDIS) Reporting Matrix for M+C Private Fee-For-Service Plans and Preferred Provider Organizations is being added. The HEDIS reporting matrix incorporates changes in typical HEDIS submission requirements to reflect the organizational structures of preferred provider organizations and private fee-for-service plans.

Appendix A, deleted an informational Diabetes Rate Table since it is now outdated.

Medicare Managed Care Manual
Chapter 5 - Quality Assessment

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25 - SUMMARY OF PREFERRED PROVIDER ORGANIZATIONS AND PRIVATE FEE-FOR-SERVICE (PPO/PFFS) QUALITY IMPROVEMENT REQUIREMENTS (Rev. 16, 09-27-02)

The following provides a summary of quality improvement requirements relating to M+C preferred provider organizations and private fee for service plans. These requirements closely follow the provisions of 42 CFR 422.152(e) and 422.154. The requirements for these organizations have been extracted from the overall M+C provisions and are listed separately so that PPO/PFFS plans may quickly identify applicable requirements.

PPO Definition: A PPO plan has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; and provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and is offered by an organization that is not licensed or organized under State law as an HMO. 42CFR 422.4(a)(1)(iv)

PFFS Definition: An M+C PFFS plan is health benefits coverage offered by an organization to Medicare beneficiaries in a defined service area. The plan includes a specific set of benefits offered at a uniform premium and uniform level of cost sharing. The plan pays providers at a pre-determined level on a fee-for-service basis and the payment rate does not vary based on frequency of a rendered service. The plan does not restrict an enrollee's choice of providers who are authorized to provide services if the provider agrees to the plan's payment terms. 42 CFR 422.2 and 422.4(a)(3)

A. *Medicare+Choice PPOs and PFFS plans must have an ongoing quality assessment and performance improvement (QAPI) program per 422.152(a). The program should include the following elements:*

   a. *The policymaking body oversees and is accountable for the QAPI program,*

   b. *A designated senior official is responsible for QAPI program administration,*

   c. *Employed or affiliated providers and consumers actively participate in the QAPI program.*

   d. *There is formal and ongoing communication and collaboration among the policymaking body that oversees the program and the other functional areas of the organization, e.g., health services management and member services.*

Additional requirements of the QAPI program stipulate that it:

1. *Measures and reports performance using standard measures required by CMS including the following areas:*

   1. *clinical areas - effectiveness of care, perception of care, use of services*

2. *non-clinical areas - access and availability to care, appeals and grievances, and organizational characteristics. 422.152(e)(1)*

Currently, CMS has adopted the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS)™ as an acceptable standardized performance reporting system. See Exhibit 1.B for the PPO/PFFS reporting matrix;

2. *Maintains a health information system that collects, integrates, analyzes and reports data that is necessary to implement and support the activities of the QAPI program; 422.152(f)(1)(i)*

3. *Ensures that information and data received from health care providers is reliable and complete. Service data should be collected in standardized formats to the extent feasible and appropriate. The PPO/PFFS plan should routinely review reported data for accuracy, completeness, logic, and consistency; 422.152(f)(1)(ii)*

4. *Makes all collected information available to CMS for review purposes; 422.152(f)(1)(iii)*

5. *Evaluates the continuity and coordination of care to the extent possible. For example, if the plan offers a drug benefit there should be a system to monitor contra-indicated prescriptions; 422.152(e)(2)*

6. *Evaluates the impact and effectiveness of the QAPI program at least annually. This would include an evaluation of the effectiveness of the PPO's or PFFS plan's communications with enrollees. The evaluation should also determine whether the organization has met any performance goals that may be established for that particular organization; 422.152(f)(2) and*

7. *Achieves remedial action for problems that come to the attention of the plan from various sources. This would include correction of systemic problems that come to its attention through internal surveillance, complaints or other mechanisms. Additionally, the organization should routinely monitor the issue resolution process and maintain, aggregate and analyze information on the nature of issues raised by enrollees and on their resolution. This information should be used to develop activities under the QAPI program, both to improve the issue resolution process itself, and to make improvements that address other system issues that have been identified. 422.152(f)(3)*

B. *M+C PPO plans must maintain a written agreement with an independent quality review and improvement organization approved by CMS. These entities are commonly referred to as quality improvement organizations (QIO). If a PFFS plan performs utilization management it must also have an agreement with a QIO; 422.154(a)*

C. *If the M+C organization uses written protocols for utilization review, the protocols must (1) be based on current standards of medical practice and (2) should incorporate mechanisms to evaluate appropriate use of services and to inform enrollees and providers of the evaluation results. The mechanisms should have the capacity to detect both under-utilization and over-utilization of services. 422.152(e)(3)(i) & 422.152(e)(3)(ii)*

D. *The organization oversees and is accountable for any functions or responsibilities that are delegated to other entities, such as claims processing, health services network management, etc. The following requirements apply to all delegated functions: 42 CFR 422.502(i)*

2. *A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance.*

3. *The organization evaluates the entity's ability to perform the delegated activities prior to delegation.*

4. *The performance of the entity is monitored on an ongoing basis and formally reviewed by the organization at least annually.*

If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

40 - Standard Reporting Requirements for Medicare Managed Care Organizations: Health Plan Employer Data and Information Set (HEDIS®) Measures that Include the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Health Plans Study (CAHPS® 2.0H) - (Rev. 16, 09-27-02)

40.1 - Background - (Rev. 16, 09-27-02)

This section provides information regarding the annual Medicare HEDIS submission and provides clarification for Medicare contracting organizations under applicable law, regulations and contract requirements governing Medicare+Choice (M+C) organizations, the §1876 of the Act cost contracting organizations, and demonstration projects. This section also explains reporting requirements for HOS, and CAHPS and addresses specific CMS implementation requirements. Throughout this section of Chapter 5, the general term, Managed Care Organization (MCO), will be used to refer to all contracting organizations, unless otherwise specified. Effective January 1, 1997, CMS began requiring MCOs to report on performance measures from the HEDIS® reporting set relevant to the Medicare managed care population, and to participate both in CAHPS® and the Health Outcomes Survey (HOS). These requirements are consistent with the law and with the requirements of other large purchasers. It is critical to CMS's mission that it collect and disseminate information that will help beneficiaries choose among MCOs and contribute to better health care through identification of quality improvement opportunities. For M+C organizations, HEDIS represents a performance measurement system that is acceptable to CMS since it uses standard measures adopted by CMS and it meets the provision at 42 CFR 422.152(c)(1).

CMS makes summary, plan-level performance measures available to the public through media that are beneficiary-oriented, such as the Medicare Personal Plan Finder and Medicare Health Plan Compare tools on (www.medicare.gov). A subset of HEDIS and CAHPS data is also available in printed form through a toll free line (1-800-MEDICARE). Disenrollment rates are also available in printed form through the same toll free line. HEDIS summary-level data files are available through CMS's Internet Web site as a Public Use File (http://www.hcfa.gov/hedisdwn.htm). This year, CMS hopes to offer a very limited respondent-level dataset as a public use file to facilitate greater customized use of CAHPS data. Extensive steps have been taken to remove any respondent identifying information from the file and ensure that it complies with privacy requirements. Complete HEDIS and CAHPS (including the annual M+C CAHPS survey and the quarterly Disenrollment Reasons Surveys) patient-level files are available at cost to requesters authorized to receive such information. Requesters, for confidentiality reasons, must sign a Data Use Agreement with CMS and must meet CMS's data policies and procedures that include, but are not limited to, submitting a research protocol and study purpose. For information about Data Use Agreements, contact the Division of Data Liaison and Distribution, Enterprise Database Group, within CMS's Office of Information Services. For more information about Medicare data for research purposes, go to www.cms.hhs.gov and then select the area for Researchers.

The following is a chart describing HEDIS, HOS and CAHPS program requirements.

Note: To print this table set your browser print settings to landscape.

Contract Year	Sampling Frame / Period	Dates for Participation Eligibility	Minimum Sample Size	Financial Responsibility	Demon-strations	Mergers and Acquisitions	Cost Contract Report- ing	Due Dates
HEDIS and HEDIS audit	Services delivered in measurement (previous) year (and earlier for some measures)	First Medicare Enrollment on Jan. 1 of prev. year or earlier. Minimum Medicare enrollment of 1,000 as of July 1 in previous year	Measure specific (MCOs must report all CMS-required Medicare measures according to instructions)	MCO pays for external HEDIS Audit	Required in some cases as specified in this manual	Reporting by surviving MCO only	Report Cost Contract Measures Only	MCO must submit Audited Summary and Patient-Level Data by June 28.
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than Jan. 1 of previous year	1000 (If less than 1000 enrollees, all members must be surveyed.)	MCO pays for NCQA certified vendor to administer survey	Yes (See section on demon-strations)	Reporting of surviving MCO's membership only	Yes	MCO must contract with NCQA certified vendor before Feb. 1 of reporting (current) year
Annual CAHPS: Assessment Survey Current Enrollees	Members continuously enrolled 6 mo. prior to July 1 of measurement year	Medicare contract in place no later than July 1 of previous year	600 (If less than 600, all members will be surveyed.)	CMS pays for survey administration	Yes (See section on demon-strations)	Reporting of surviving MCO's membership only	Yes	CMS will conduct survey in the Fall.
Annual CAHPS: Assessment Survey Disenrollees	From May - July of the measurement year members enrolled for 6 months prior to disenrolling	Medicare contract in place no later than July 1 of previous year	Varies, see page for specifics	CMS pays for survey administration	Yes (See section on demon-strations)	Reporting of surviving MCO's membership only	Yes	CMS will conduct survey in the Fall.
Quarterly CAHPS Disenrollment Reasons Survey	Members who have disenrolled during previous quarter	Medicare contract in place no later than Jan. 1 of previous year	Approximately 385, (If less than 385, all disenrolled members will be surveyed)	CMS pays for survey administration	Yes (See section on demonstra-tions)	Reporting of surviving MCO's membership only	Yes	CMS will conduct survey quarterly.

40.2 - Specifics Applicable to CAHPS and HEDIS - (Rev. 16, 09-27-02)

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 2003 data submissions must follow instructions in HEDIS 2003, Volume 2, and the HEDIS 2003, Volume 2 Update (to be released in October 2002). 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. When the HEDIS 2003 Volume 2 Update is released HEDIS specifications are frozen. 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 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."

3. *Sampling and Reporting Unit - Unlike previous years, in 2003 and thereafter, MCOs will have one reporting unit for HEDIS and HOS for each contract. This will align 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. Also, while this collection and reporting at a higher level may mask some performance variation at a lower level, we believe that it is not necessary to collect at a lower level. If necessary, CMS can look at performance in geographic areas within a state by using the HEDIS patient-level detail files to re-construct summary rates for the particular geographic areas.*

4. Medicare CAHPS instituted a local sampling and reporting unit for the traditional CAHPS survey of enrollees and disenrollees (now titled the Medicare+Choice CAHPS Survey that accommodates comparison with Medicare CAHPS fee-for-service (FFS) 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 and Original Medicare are displayed where managed care is available. In fall 2003, CMS plans to include M+C private fee for service plans in this presentation. Please send questions to CAHPS@cms.hhs.gov

5. We recognize that in some cases MCOs have reasons for reporting HEDIS data in other configurations, such as those MCOs that have or are seeking NCQA accreditation for their Medicare product line. On a case-by-case basis, CMS will evaluate the accreditable entities for an MCO to see if we can accommodate an MCO's submission of one HEDIS Data Submission Tool (DST) based on an accreditation unit.

   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. If you have a concern or question regarding the area specified for HEDIS contact: Richard Malsbary, Center for Beneficiary Choices, at (410) 786-1132.

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. 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.

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 HMO	YES	YES	YES	YES	YES
Medicare Choices	YES	YES	YES	YES	YES
Minnesota Senior Health Options	NO	NO	NO	NO	NO
Wisconsin Partnership Program	NO	NO	NO	NO	NO
Evercare	NO	NO	NO	NO	NO
PACE	NO	NO	NO	NO	YES

For demonstration categories not listed in the table, e.g., private fee-for-service plans and preferred provider organizations, contact the CMS project officer in the Division of Demonstration Programs.

D - Implications for Failure to Comply

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's 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 primary audience for the HEDIS, CAHPS, HOS, and Disenrollment summary data is the Medicare beneficiary. These data will provide comparative information on contracts to beneficiaries to assist them in choosing among contracts. In addition, CMS expects MCOs to use the 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, the data 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.

40.3 - HEDIS Submission Requirements - (Rev. 16, 09-27-02)

A - Summary and Patient-Level Data

CMS is committed to assuring the validity of the summary data collected before it is released to the public, and to making the data available in a timely manner for beneficiary information. MCOs must submit summary measures, after completing the NCQA HEDIS Compliance Audit required by Medicare, by the end of June of each reporting year. MCOs, including M+C PPOs and PFFS plans, must submit HEDIS patient-level data at the same time. CMS requires the submission of patient-level data on the same date as summary data to ensure that the patient-level data matches the summary data. Please note that auditors will review patient-level data for the numerator and denominator of audited measures when checking for algorithmic compliance during the HEDIS audit. Both data files are to be submitted directly to NCQA.

1. Summary Data

    a. Required Measures - MCOs that held Medicare contracts in the measurement year and meet the criteria in §30.2, item B.1 of this chapter must report summary data for all required HEDIS measures identified in Exhibit I, except for the Health Outcomes Survey measure which is not a DST item (See discussion at §40.4). M+C organizations that were §1876 cost contractors in the measurement year and continuing open enrollment cost contracts must report summary data for all measures identified in Exhibit IA. The HEDIS measures Flu Shots for Older Adults, Pneumonia Vaccination Status for Older Adults, and Advising Smokers to Quit are collected through the CAHPS survey instrument. MCOs must attempt to produce every Medicare required measure, and report a numerator and denominator even if the numbers are small, i.e., the denominator is less than 30.

    b. Data Submission - NCQA will post Healthcare Organization Questionnaires (HOQ) on the NCQA Web site in late February. MCOs must accurately complete the HOQ in order to have an appropriate HEDIS Data Submission Tool(c) (DST) posted on the NCQA web site in April. MCOs must submit HEDIS results for the measurement year using this tool and should make sure that they have sufficient computing capability to run the DST. The tool is a Microsoftâ Excel-based application. NCQA can provide more information to MCOs regarding the tool and the submission process. MCOs will not be allowed to change data after submission to NCQA.

2. Patient-Level Data - Analysis of data with patient-level identifiers for the numerator and denominator of each measure allows CMS to match HEDIS data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (e.g., ethnic, racial, gender, geographic) are receiving fewer or more services than others. These analyses will not be used for public plan-to-plan comparisons.

    a. Required Measures - MCOs must provide patient-level data identifying the contribution of each beneficiary to the denominator and numerator of every required summary measure on beneficiaries and each beneficiary's months of enrollment. Exhibit II lists the Effectiveness of Care measures (excluding the Health Outcomes Survey measure) and the Use of Services measures for which patient identifiers and member month contributions must be provided. Beneficiaries will be identified by their individual health insurance claim (HIC) number. The HIC number is the number assigned by CMS to the beneficiary when he/she signs up for Medicare. MCOs use this number for enrollment accretions/deletions.

    b. Data Submission - NCQA expects to continue collecting patient-level data as a flat text file and will provide MCOs with the record layout and detailed examples in the spring of each year. Plans must retain data used for reporting for six years. All patient-level data are protected from public dissemination in accordance with the Privacy Act of 1974, as amended, and in accordance with the Health Insurance Portability and Accountability Act. There have been questions and concerns expressed about the provision of patient-level data, particularly with regard to behavioral health measures. Plans are accountable for providing patient-level data, unless prohibited by State law. In such cases, plans must provide CMS with appropriate documentation of the legal prohibition for CMS's consideration.

B - HEDIS Compliance Audit Requirements

Because of the critical importance of ensuring accurate data, CMS continues to require an external audit of the HEDIS measures before public reporting. MCOs are responsible for submitting audited data, according to the "Full Audit" methodology outlined in Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures. CMS requires each MCO to contract with an NCQA Licensed Organization for an NCQA HEDIS Compliance Audit and should do so in a way that will coordinate the audit process for all sources. The licensed audit firms are listed on NCQA's Web site at www.ncqa.org. CMS will require that the Licensed Organizations follow the established standards, policies and procedures in NCQA's HEDIS, Volume 5. The MCO must ensure that the site visit audit team is led by a NCQA Certified HEDIS Compliance Auditor. In addition, the plan's chief executive officer, president, or other authorized person, such as the medical director, will be required to provide written attestation to the validity of the plan-generated data.

C - Final Audit Reports, Use and Release

Following the receipt by the MCO of the Final Audit Report from the NCQA-licensed audit firm, the MCO must make available a copy of the complete final report to the CMS ROs as needed. CMS ROs may request the report upon completion or as part of the pre-site monitoring visit package. In addition, the reports should be available for review onsite during monitoring visits. CMS will use the Final Audit Reports to support contract monitoring and quality improvement activities. CMS may use the assessment of the MCO's administrative and information systems capabilities that are

contained in the audit report and may use the data to conduct post-submission validation. Final Audit Reports are subject to the Freedom of Information Act (FOIA). CMS will follow the FOIA regarding any release of such report and will make a determination about the release of information in each audit report on a case-by-case basis. Information that both the MCO and CMS deem proprietary will not be released, unless otherwise required by applicable law.

40.4 - The Medicare Health Outcomes Survey (HOS) Requirements - (Rev. 16, 09-27-02)

A - Survey Process

The Short Form (SF) 36 supplemented with additional case-mix adjustment variables will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS functional status measure, Medicare Health Outcomes Survey (HOS). This measure is the first "outcomes" measure for the Medicare population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that MCOs are currently using for clinical quality improvement. Each year a baseline cohort will be drawn and 1,000 beneficiaries per reporting unit will be surveyed. The target response rate is at least 70 percent. If the contract-market has fewer than 1,000 eligible members, all will be surveyed.

Additionally, each year a cohort drawn two years previously will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well being of each respondent. Depending on the amount of expected change the respondent will be categorized as having improved, declined, or as having undergone no change in health status over the two-year period. Percentages of respondents whose health status improved, declined, and remained the same by plan will be released publicly in the year following re-measurement. However, since the Health Outcomes Survey measure looks at health status over a two-year period, results from the baseline survey will not be publicly released until the year following the re-measurement.

All M+C organizations and continuing cost contracts that held §1876 risk and cost contracts, as well as Social HMOs (SHMOs), PACE, and Medicare Choices demonstrations, with Medicare contracts in effect on or before January 1st of the measurement year must comply with this survey requirement. To expedite the survey process, MCOs may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means.

MCOs, at their expense, are expected to contract with any of the NCQA certified vendors for administration of the survey to do both the new baseline cohort and the re-measurement cohort (if the MCO participated when an earlier cohort was drawn for baseline measurement). Contracts with vendors are expected to be in place by February 1st to ensure survey implementation by mid-March of the reporting year. Further details will be provided by NCQA, CMS's contractor, regarding organizing the survey.

MCOs must ensure the integrity of the data files they provide to the vendors by checking for, among other things, shifted data fields or out of range values. MCOs will be financially liable for the cost of any re-work (including but not limited to re-administration of the survey) and subsequent delay by the vendor resulting from corrupt data files transmitted to the vendor by the MCO.

B - Data Feedback

Please remember that individual member level data will not be provided to plans after baseline data collection. However, you will receive the following from CMS:

HOS Plan Performance Profile

This profile will be mailed to all plans participating in the last year's baseline cohort. This quality improvement tool, which presents an aggregate overview of the baseline health status of your MCO's Medicare enrollees, was developed and extensively tested to ensure that MCOs would find the data useful and actionable. Your state Peer Review Organization/Quality Improvement Organization will also receive copies of the performance profiles and stands ready to collaborate with you on interpreting the data, identifying opportunities to improve care, assisting you in planning effective, measurable interventions, and evaluating and monitoring the results of your interventions. Using data from the Health Outcomes Survey to plan and conduct a quality improvement project may fulfill one of the Quality Assessment and Performance Improvement (QAPI) program requirements. If you do not receive your performance profile by June 30 of each year, please contact Health Services Advisory Group (HSAG) at 1-(888) 880-0077 or e-mail to azpro.hos@sdps.org. Each MCO receives one performance profile free of charge. Additional and replacement copies are available at cost from HSAG.

Vendor Reports

The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

Please DO NOT ask your vendor for additional analyses or member specific data. They are prohibited from providing this type of information. Requests for interpretation of the data or more detailed analyses of the data should be directed to your State PRO/QIO.

40.5 - Medicare CAHPS Requirements for Enrollees and Disenrollees - (Rev. 16, 09-27-02)

A. Information Regarding the CAHPS Enrollee Survey

In the fall of each year, CMS administers the Medicare Managed Care CAHPS survey, which consists of the core CAHPS questions plus additional questions specific to Medicare. In fall 2003, this survey effort will begin to include private fee-for-service contracts, and CMS will call its CAHPS survey effort, the Medicare+Choice CAHPS Survey. Coordinated care contracts, continuing cost contracts and private fee-for-service contracts in effect on or before July 1st of the previous year are included. Organizations that terminate their contracts on January 1st of the next contract year are included in this administration since they are still participating in the fall before their contract ends.

CMS selects the sample for each local reporting unit within a contract. More information on the local sampling and reporting unit for the M+C CAHPS Survey is described in greater detail under Section 40.2 above.

This survey process includes both enrollees and disenrollees. For the enrollee component of the M+C CAHPS Survey, the sample is a random sample of 600 members who were continuously enrolled in the contract for six months and were not institutionalized. For MCOs with fewer than 600 eligible members, all eligible members are surveyed. For the annual CAHPS Assessment Survey of Disenrollees the sample rate fluctuates. The sample size will be determined by the application of the sampling rate for the CAHPS survey to the population of disenrollees and will not exceed 600. CMS will consider "total enrollment" to be the total enrolled population at the time that CMS pulls the

sample for the CAHPS Enrollee Survey. The survey administration mode includes two mailings with telephone follow-up of non-respondents. To conduct telephone follow-up of non-respondents, CMS requests telephone numbers from MCOs for the CAHPS sample embedded within a larger list of beneficiaries enrolled in the MCO. CMS pays for the administration of the survey.

Selected results from each survey will be released to the public to facilitate plan-to-plan comparisons. Only data gathered through CMS's administration will be publicly released. These data will be disseminated to the public via Medicare Health Plan Compare (www.medicare.gov) and 1-800-MEDICARE. In the summer of each year CMS will provide the MCOs participating in the CMS administration of the CAHPS survey with detailed reports for internal quality improvement efforts, consistent with the Privacy Act (Title 5, USC, §552a).

B. Information Regarding CAHPS Disenrollment Survey

The Medicare CAHPS Disenrollment Reasons Survey asks beneficiaries about their reasons for leaving an M+C organization. CMS combines reasons for disenrolling with the annual disenrollment rates for reporting to beneficiaries through the Medicare Personal Plan Finder and Medicare Health Plan Compare on www.medicare.gov and at 1-800 MEDICARE.

CMS administers the Reasons Survey on a quarterly basis. Beginning in fall 2003, CMS plans to include private fee-for-service plans in its administration of the Reasons Survey, pending sufficient disenrollment in the sampling and reporting units identified for the M+C CAHPS survey. (See above).

The sampling size for the Quarterly Disenrollment Reasons Survey is approximately 385, or if less than 385, all disenrolled members will be surveyed after accommodating the disenrollee stratum of the M+C CAHPS Survey. The survey administration mode includes two mailings with telephone follow-up of non-respondents. To conduct telephone follow-up of non-respondents, CMS requests telephone numbers from MCOs for the CAHPS sample embedded within a larger list of beneficiaries enrolled in the MCO. CMS is paying for the administration of the survey.

Information from the Reasons Survey is provided to the participating contractors in an interim report after the first two quarters of the survey and in a final annual report following survey completion.

40.6 - Minimum Performance Levels and Performance Goals - (Rev. 16, 09-27-02)

While provisions at 42 CFR 422.152(c) permit CMS to establish minimum performance levels which must be met by contracting organizations, CMS has not yet established these levels. To establish minimum performance levels CMS must assure that organizations have had sufficient experience reporting specific measures on which levels would be set. When the accuracy and validity of submissions over time can be determined, CMS will be able to establish not only minimum performance levels but also set benchmarks for MCOs to achieve as specific goals.

CONTACTS:

1 HEDIS Technical Specifications and Reporting and HEDIS Compliance Audit MCOs should address all questions or requests for clarifications about the HEDIS technical specifications and audit to NCQA through its new Policy Clarification Support (PCS) Web page. The PCS page is accessible from the main NCQA Web site (www.ncqa.org). To access PCS, click on Support on the bottom of the gray bar along the left side of the NCQA home page and then click on Policy

Clarification Support. The direct link for the PCS Web page is: Http://www.ncqa.org/programs/faq/PCS.asp. From here, users can view Frequently Asked Questions (FAQ) and Policy Updates or submit a question to PCS staff. You can also reach NCQA through its Customer Support Line at (888) 275-7585. Questions about Medicare HEDIS not resolved through NCQA can be directed to Richard Malsbary at (410) 786-1132 in CMS's Center for Beneficiary Choices. When contacting CMS, MCOs should be prepared to tell CMS both the advice that they received from NCQA and the individual at NCQA with whom they spoke.

2 HOS For technical questions regarding the Medicare Health Outcomes Survey, please contact Chris Haffer in CMS's Center for Beneficiary Choices at (410) 786-8764. Questions relating to the vendors or survey protocol should be addressed to Oanh Vuong at NCQA at (202) 955-1777 or vuong@ncqa.org.

3 CAHPS For technical questions regarding the Medicare+Choice CAHPS Survey, please contact Amy Heller at (410) 786-9234 or Lori Teichman at (410) 786-6684 of CMS's Center for Beneficiary Choices or email CAHPS@cms.hhs.gov. For the Disenrollment Reasons Survey, please contact Chris Smith-Ritter at (410) 786-4636 or email CAHPS@cms.hhs.gov.

4 Demonstrations For questions regarding policy and technical questions on the demonstration projects contact the assigned CMS project officer.

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

Effectiveness of Care
Anti-depressant Medication Management
Cholesterol Management After Acute Cardiovascular Events
Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Comprehensive Diabetes Care
Follow-up After Hospitalization for Mental Illness
Controlling High Blood Pressure
Medicare Health Outcomes Survey

Access to/Availability of Care
Adults' Access to Preventive/Ambulatory Health Services
Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
Years in Business/Total Membership
Practitioner Turnover

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
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
Board Certification/Residency Completion
Total Enrollment by Percentage
Enrollment by Product Line (Member Years/Months)

Reporting Clarifications
The following HEDIS measures will not be required to be submitted:
Health Plan Descriptive Information:
Practitioner Compensation
Arrangements with Public Health, etc.

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

Effectiveness of Care

Anti-depressant Medication Management
Cholesterol Management After Acute Cardiovascular Events
Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Comprehensive Diabetes Care
Follow-up After Hospitalization for Mental Illness
Controlling High Blood Pressure
Medicare Health Outcomes Survey

Access to/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services
Availability of Language Interpretation Services, Parts I & II

Health Plan Stability

Years in Business/Total Membership
Practitioner Turnover

Use of Services

Ambulatory Care
Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information

Board Certification/Residency Completion
Total Enrollment by Percentage
Enrollment by Product Line (Member Years/Months)

Exhibit I.B HEDIS Reporting Matrix for M+C Private Fee For Service Plans and Preferred Provider Organizations

HEDIS 2002 Measure	*Applicable to PFFS/PPO*	*Not Applicable to PFFS/PPO*	*Comments*
Effectiveness of Care			
Breast Cancer Screening	*X*		
Controlling High Blood Pressure		*X*	*Requires medical record review*
Beta Blocker Treatment After a Heart Attack		*X*	*Requires medical record review and prescription information*
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.*
Follow-up After Hospitalization for Mental Illness	*X*		
Antidepressant Medication Management		*X*	*Must be reported, however, by plans with pharmacy and mental health benefit*
Medicare Health Outcomes Survey	*X*		*Requires contract with NCQA certified vendor to administer survey*
Access /Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services	*X*		
Availability of Language Interpretation Services		*X*	

HEDIS 2002 Measure	***Applicable to PFFS/PPO***	***Not Applicable to PFFS/PPO***	***Comments***
Satisfaction with the Experience of Care			
HEDIS/CAHPS ™ 2.0H, 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, however, 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*		

HEDIS 2002 Measure	***Applicable to PFFS/PPO***	***Not Applicable to PFFS/PPO***	***Comments***
Chemical Dependency Utilization--- Percentage of Members Receiving Services	*X*		
Outpatient Drug Utilization	*X*		*Reporting is limited only to plans with a pharmacy benefit*
Health Plan Descriptive Information			
Board Certification/Residency Completion		*X*	
Total Enrollment by Percentage	*X*		
Enrollment by Product Line (Member Years/Member Months)	*X*		

Exhibit II - Submitting Patient-Level Data for HEDIS

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

Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Comprehensive Diabetes Care
Follow-up After Hospitalization for Mental Illness
Anti-depressant Medication Management
Cholesterol Management After Acute Cardiovascular Events
Controlling High Blood Pressure

2 - Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

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
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory 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. 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 www.ncqa.org. MCOs are advised to frequently review the NCQA web site for updates on the data submission process.