What are HEDIS®, CAHPS® and HOS?

Humana strives to support you in providing quality services and improving the health outcomes of your Humana-covered patients. Outlined below are some of the performance measures agencies use to evaluate the care and services provided by physicians, other health care providers and the health plan.

What is HEDIS?

Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used set of performance measures in the managed-care industry. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA). HEDIS has become more than a set of performance measures; it is part of an integrated system to establish accountability in managed care.

HEDIS reporting is mandated by NCQA for compliance and accreditation. Familiarity with HEDIS helps in understanding what health plans are required to report to help improve the quality of care provided to patients.

HEDIS is a multipurpose tool originally designed to address private employers' needs. It has been adopted by public purchasers, regulators and consumers. Quality improvement activities, health management systems and health care provider profiling efforts all have used HEDIS as a core measurement. HEDIS is a part of purchaser requests, an element of NCQA accreditation and the basis of a consumer report card for managed care. HEDIS data are collected through surveys, medical chart reviews and insurance claims/encounter data.

To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by NCQA. Consumers benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's health care system. HEDIS data also are the centerpiece of most health plan "report cards" that appear in national and local publications.

Data collection begins with queries of claims/encounter data. If the encounter data do not contain evidence of a required visit, test or prescription during the specified time frame, the health plan staff must review the patient's medical record to determine if care was provided. For some measures, data are collected only from claims/encounters, and medical record reviewers do not validate the care.

Physicians and other health care providers can improve HEDIS scores significantly by submitting accurately coded claims/encounters data for each service rendered and by keeping accurate, legible and complete patient medical records. Chart documentation must reflect services billed. Claims/encounters data are the most efficient method to report HEDIS measures, and they ensure medical chart reviews and reviewer visits to health care providers are kept to a minimum.

HEDIS 2018 contains 91 measures across six domains of care, which are:

1. **Effectiveness of care:** Immunizations, cancer screenings, diabetes care, weight assessment and appropriate treatment for acute and chronic illnesses
2. **Access/availability of care:** Adult access to preventive/ambulatory services, annual dental visit and children's access to primary care physician
3. **Experience of care:** Measured by patient satisfaction surveys
4. **Utilizations and risk-adjusted utilization:** Frequency of selected procedures, such as well-child visits, inpatient utilization, identification of alcohol and other drug services

5. **Relative resource use:** For people with diabetes, cardiovascular conditions, hypertension, chronic obstructive pulmonary disease and asthma
6. **Health plan descriptive information:** Board certification and membership diversity

Actions physicians and other health care providers can take:

- Submit claims/encounters data that is complete and accurate in a timely manner for each service rendered.
- Submit encounters electronically and rework rejected reports completely.
- Provide lab data as requested.
- Keep accurate, legible and complete medical records for patients.
- Help ensure HEDIS-related preventive screenings, tests and vaccines are performed in a timely and appropriate manner.
- Allow access to or provide records as requested (online capability).

What is CAHPS?

NCQA and the Centers for Medicare & Medicaid Services (CMS) require health plans to conduct a patient satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Results are produced annually and compared with national benchmarks. The surveys are administered in early spring by mail, with follow-up by telephone for nonresponders. Results are available in late summer for commercial and Medicaid health plans and later in the year for Medicare.

CAHPS encompasses a set of core surveys that can be enhanced with supplemental questions selected by the health plan. Individual surveys are tailored according to audience. Current adult commercial and adult Medicaid surveys have 39 and 41 questions, respectively, before supplemental questions are added. Humana's current Medicare Advantage Prescription Drug (MAPD) survey has 68 questions. Each survey is meant to gauge patient satisfaction with services provided by the health plan and patient perceptions of health care provider accessibility, the patient-physician relationship and health care provider communication. Results are reported in composites and overall ratings.

Several questions relate to patient satisfaction with physicians. These might be of interest, as they pertain to the patient-physician relationship, and might highlight opportunities for improvement in everyday practice, such as:

- **Shared decision-making (commercial measure):** Measures patients' experiences with physicians in discussing pros and cons of treatment and asking what was best for the patients
- **Health promotion and education (commercial measure):** Measures patients' experiences with physicians in discussing ways to prevent illnesses
- **Coordination of care (commercial, Medicaid and Medicare measure):** Measures patients' perceptions of the personal physicians' knowledge and if the personal physicians were up-to-date about the care their patients received from physicians and other health care providers
- **How well physicians communicate (commercial, Medicaid and Medicare measure):** Measures patients' experiences with whether the physicians listened, explained, spent time with the patients and respected what the patients had to say
- **Getting care quickly (commercial, Medicaid and Medicare measure):** Measures the experiences patients had in receiving care or advice in a reasonable time, including time spent in waiting rooms
- **Getting needed care (commercial, Medicaid and Medicare measure):** Measures the experiences patients had when attempting to obtain care or services from physicians and specialists, including treatments or tests
- **Getting needed prescription drugs (Medicare measure):** Measures the experiences patients had when attempting to fill a prescription at a local pharmacy or through a mail-order pharmacy
- **Rating of health care (commercial, Medicaid and Medicare measure):** Gives patients an opportunity to rate all the health care they have received in the last six to 12 months
- **Rating of personal physician (commercial, Medicaid and Medicare measure):** Asks patients to rate their primary physicians' performance over the last six to 12 months

- **Rating of specialist (commercial, Medicaid and Medicare measure):** Measures patients' experiences with specialists over the last six to 12 months
- **Rating of health plan (commercial, Medicaid and Medicare measure):** Measures patients' overall experiences with their health plans over the last six to 12 months
- **Rating of the drug plan (Medicare measure):** Measures patients' overall experiences with drug plans over the last six to 12 months

The CAHPS survey also contains effectiveness-of-care measures. Patients are asked whether they received flu/pneumonia shots and direction from their physicians on aspirin usage and if their physicians discussed tobacco cessation.

Actions physicians and other health care providers can take:

- Communicate to patients thoroughly, completely and in a manner they understand.
- Communicate with patients' primary care physicians on status, tests, medications and outcomes, if a specialist.
- Submit referrals and obtain authorizations as appropriate.
- Facilitate appointments, schedule for urgent cases and limit patient wait times.
- Be aware of the time patients wait.
- Listen to patients and make sure they understand orders and communications.
- Encourage preventive measures, such as influenza and pneumococcal vaccines.

What is HOS?

The Health Outcomes Survey (HOS) is a CMS survey that gathers meaningful health status data from Medicare participants. Like HEDIS and CAHPS, HOS is part of an integrated system for use in quality improvement activities and establishing accountability in managed care. All managed care plans with Medicare Advantage (MA) contracts, including Humana's, must participate.

A random sample of Medicare beneficiaries receives a baseline survey in the spring. Two years later, the same respondents are surveyed for follow-up measurement. Survey completion is voluntary. The difference in the scores for the two-year period shows if a patient's physical and mental health status is categorized as better than, the same as or worse than expected. Patient responses are shared with Humana for use in quality-improvement initiatives.

HOS may be of interest to physicians and other health care providers as they could receive questions about the survey from their patients with Medicare Advantage coverage. Survey questions pertain to patient-physician relationships and help identify areas for improving patient health outcomes. Patients are asked about overall physical and mental health status. They also are asked if they had a discussion about or received counseling or intervention from their physicians on the following:

- Management of urinary incontinence
- Physical activity in older adults
- Management of fall risk

Actions physicians can take:

- Understand that HOS is a patient-based, self-reported survey with questions about overall physical and mental health status.
- Discuss and provide counseling and/or interventions as needed for urinary incontinence, physical activity, risk for falls and osteoporosis testing.