Supporting Statement Part A
HEDIS Data Collection for Medicare Advantage
CMS-10219, OMB 0938-1028

PURPOSE:

The Centers for Medicare & Medicaid Services (CMS) is requesting a renewal of Office of Management and Budget (OMB) number 0938-1028, that expires February 28, 2017, for the currently approved collection of Healthcare Effectiveness Data and Information Set (HEDIS®) data for managed care contracts which include Medicare Advantage Organizations (MAOs) and §1876 cost contracts. This request for a renewal is supported under the Paperwork Reduction Act and 5 CFR 1320.6. MAOs and §1876 cost contracts are required to submit HEDIS® data to CMS on an annual basis to monitor the care provided to Medicare beneficiaries and to disseminate information to Medicare beneficiaries about the quality of Medicare Advantage plans . Sections 422.152 and 422.516 of Volume 42 of the Code of Federal Regulations (CFR) specify that MAOs must submit quality performance measures as specified by the Secretary of the Department of Health and Human Services and by CMS. These quality performance measures include HEDIS®. HEDIS® data are used in the Medicare Part C Star Ratings, and HEDIS® data are used in the CMS Quality Bonus Payments to Medicare Advantage plans.

The HEDIS® data collection is fundamentally necessary to fulfill the CMS strategic goal of improving the quality of care and health status for Medicare beneficiaries. The HEDIS® measures are used as part of the Medicare Part C Star Ratings. CMS publishes the Medicare Part C Star Ratings each year to: incentivize quality improvement in Medicare Advantage (MA), assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers. The National Committee for Quality Assurance (NCQA) develops HEDIS® measures and NCQA is continually working to revise the HEDIS® measures, to provide new HEDIS® measures, and to retire any HEDIS® measures that become obsolete. NCQA licenses organizations to conduct audits to ensure that HEDIS® data collection is carried out in accordance to NCQA's standards.

HEDIS® data support CMS' efforts to hold MA contracts accountable for delivering care in accordance with widely accepted clinical guidelines and standards of care. This reporting requirement measures the extent to which plans are providing care according to these quality care standards, and allows CMS to obtain the information necessary for the proper oversight of the program. It is critical to CMS' o oversight responsibilities to monitor the quality of care provided by MAOs.

BACKGROUND:

CMS has a responsibility to its Medicare beneficiaries to require that care provided by MAOs and 1876 cost contracts in Part C under contract to CMS is of high quality and

conforms to currently accepted standards of medical care. One way of ensuring high quality care in MAOs is publicly reporting quality data indicators. The reporting of quality data is not only beneficial to the public by supporting transparency, but it also contributes to quality improvement in all MAOs.

CMS is committed to assessing the quality of care provided by Medicare Advantage (MA) contracts. CMS began requiring MAOs, formerly called Medicare managed care organizations (MCOs) to collect and report performance measures from HEDIS® beginning in 1998. HEDIS® is a widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and to assess the quality of care provided by managed care organizations. HEDIS® is designed for private and public health care purchasers to promote accountability and to assess the quality of care provided by managed care organizations. Originally designed for private employers' needs as purchasers of healthcare, HEDIS® has been adapted for use by public purchasers, government compliance monitors, and healthcare consumers. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA) in collaboration with CMS and other representatives of purchaser, managed care industry, provider/practitioner and health services research communities. All participating contracts pay for the auditing of their HEDIS® data.

All Medicare members covered in the following contracts are included in Medicare HEDIS® reporting. CMS communicates directly with all contracted organizations on HEDIS® reporting requirements. Special Needs Plans (SNPs), which are considered MA contracts, are required to report a subset of HEDIS measures, and the SNPs include the dual-eligible, chronic care and institutional benefit packages. The following types of MA contracts (N=515) that are required to report HEDIS® 2017:

- Medicare Advantage-Local CCPs (MA) (N=434)
- Section 1876 cost contracts (N=16)
- Medical Savings Account (MSA) (N=1)
- Private Fee-for-Service (PFFS) (N=7)
- Demonstrations (N=47)
- Regional CCPs (N=10)

HEDIS® 2017 contains 91 measures across 7 domains of care. Additional HEDIS quality measures are additionally collected via the Health Outcomes Survey (HOS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program. The HOS® and CAHPS® surveys have separate OMB PRA packages.

In **Table 1**, we list the required HEDIS® measures in 2017:

Table 1: HEDIS® 2017 Measures for Reporting

HEDIS® 2017 Measures for Reporting: All Organizations Report all Measures except as noted below
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
MMA	Medication Management for People with Asthma
AMR	Asthma Medication Ratio
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 Dependence
MPM	Annual Monitoring for Patients on Persistent Medications
MRP	Medication Reconciliation Post-Discharge[1]
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
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 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
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

[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.

A. JUSTIFICATION

1. Need and Legal Basis

In an effort to promote an active, informed selection among coverage options, the Secretary must provide information to current and potential Medicare beneficiaries about Medicare Advantage organizations, including quality and performance indicators for benefits under the contracts as well as Medicare enrollee satisfaction and information on health outcomes.

2. Information Users

HEDIS® data are used in Medicare Part C Star Ratings. The Medicare Star Ratings are annually published on the website to promote and give incentives for quality

improvement in MA, to assist beneficiaries in choosing the best plan for their needs, and to determine the CMS MA Quality Bonus Payments.

The data are used by CMS staff to monitor MAOs' performances, , and inform beneficiaries' choices through their display in CMS' consumer-oriented public compare tools and websites. MAOs use the data for quality assessment and as part of their quality improvement programs and activities. Quality Improvement Organizations (QIOs), and CMS contractors, use HEDIS® data in conjunction with their statutory authority to improve quality of care. A subset of HEDIS® measures[1] are included in the Part C Star Ratings and MA Quality Bonus Payments. Other HEDIS measures are displayed on a display page on www.cms.hhs.gov for informational purposes. Additionally, CMS makes health plan level HEDIS® data available to researchers and others as Public Use Files (PUFs) on the CMS website www.cms.hhs.gov.

3. Use of Information Technology

The HEDIS® measures are reported through NCQA's Web-Based Interactive Data Submission System (IDSS) that includes many automation and quality control features permitting importing of data, pre-populated fields, and built-in edit checks.

4. Duplication of Efforts

As stated previously above, MAOs have been submitting HEDIS® data to CMS since 1998. NCQA estimates that about 95% of MAOs are also collecting some or all of the HEDIS® data for their commercial and/or Medicaid populations. This estimate is from the most recent year of data collection. For the most part the measures are the same across Medicare, Medicaid and commercial so there systems track the same measures across different reporting programs. The incremental costs of doing HEDIS® for the Medicare population are small relative to the fixed costs that MAOs have invested in to do it for commercial plans.

5. Small Businesses

The burden on small MAOs is reduced by requiring a standardized and commonly accepted measure set in the managed care industry, with which the contracts can meet requirements of Medicare and many private purchasers for reporting performance. There is no way to further reduce the burden and still collect the necessary information.

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[1] The HEDIS measures currently included as part of the Star Ratings program are breast cancer screening, colorectal cancer screening, adult BMI assessment, care for older adults – medication review, care for older adults – functional status assessment, care for older adults, pain assessment, osteoporosis management in women who had a fracture, diabetes care - eye exam, diabetes care – kidney disease monitoring, diabetes care – blood sugar controlled, controlling blood pressure, rheumatoid arthritis management, plan all-cause readmissions, and medication reconciliation post discharge.

6. Less Frequent Collection

CMS collects the HEDIS® data annually. To collect data less frequently would actually increase burden because we would lose the efficiencies gained by using a standardized, industry accepted and commonly used measurement set which makes it possible for MAOs to meet the data reporting requirements of Medicare and other private purchasers using the same instrument and submission process.
CMS publishes the Medicare Part C Star Ratings each year to: incentivize quality improvement in Medicare Advantage (MA), assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers. In addition, contracts between CMS and MAOs are renewable on an annual basis, so we need this performance data for program management and contracting decisions. It is also used to help Medicare beneficiaries and their caregivers make decisions about which health plan to choose, each year during open enrollment season.

7. Special Circumstances

The publicly reported data that CMS makes available will not identify beneficiaries in any way. The HEDIS® patient level file is available only to requesters who for confidentiality reasons must sign a Data Use Agreement with CMS and must meet CMS' 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' Office of Information Services.

8. Federal Register Notice/Outside Consultation

The 60-day notice published in the Federal Register on December 9, 2016 (81 FR 89104). One comment was received.

We received a comment that, "These metrics are critical to setting a foundation for comparison across care settings. Yes, they're a pain in the neck to collect for providers. Yes, they could use a little tweaking. But it's a great first step if we can't measure it, we can't hold our healthcare industry accountable. Please continue to roll these out and invest in refining them."

The 30-day notice published in the Federal Register on February 17, 2017 (82 FR 11037). No comments were received.

9. Payment/Gifts to Respondents

This is Not Applicable.

10. Confidentiality

This is not applicable. The SORN number is 09-70-500. Sensitive Questions

The HEDIS® measurement set does not contain any sensitive questions because it is collected from health plan administrative data and medical record review. These data are primarily administrative record data and clinical record data.

11. Burden Estimate (Hours and Wages)

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

In consultation with NCQA we had previously determined that the most appropriate labor categories included both a Medical Records Review Technologist and a Database Administrator. In this iteration we are moving away from those categories and adopting BLS labor information. Please note that the level of effort by these professionals is unchanged from what is set out in the currently approved collection.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Database Administrators	15-1141	41.89	41.89	83.78
Medical Records and Health Information Technicians	29-2071	19.93	19.93	39.86

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden Estimates

Outside of the labor occupation titles, codes and wages, the following burden estimates are based on NCQA's experience working with health plans.

The Medical Records and Health Information Technician will pull and examine the data, by reviewing the administrative data and the medical records data of the contract members. The Technician will pull administrative data from electronic files and will conduct the medical record review. This work will entail approximately 240 hours annually.

The Database Administrator will pull the administrative records, while the Medical Records and Health Information Technician pulls both administrative records and the medical records any measures that permit hybrid methodology.

In aggregate, the total hours for the Medical Records and Health Information Technician in all contracts is estimated at 123,600 hours (240 hr x 515 contracts) at a cost of $4,902,780 (123,000 hr x $39.86/hr) or $9,519.96 per contract.

The Database Administrator will need 80 hours to accomplish the work. In aggregate, the total hours for the Database Administrator in all contracts is estimated at 41,200 hours (80 hr x 515 contracts) at a cost of $3,451,736 (41,200 hr x $83.78/hr) or $6,702.40 per contract.

The total annual burden to the 515 contracts is 164,200 hours at a cost of $8,354,516.

Table 2: Summary of Annual Burden Estimates

	Medical Records Technician	Database Administrator	Total
Hours	123,600	41,200	164,800 hours
Costs	$4,902,780	$3,451,736	$8,354,516

12. Capital Costs

There are no capital costs.

13. Cost to Federal Government

The Federal contract cost for HEDIS® data collection to the federal contractor(s) is about $400,000 annually. In addition to the federal contractor costs, CMS funds one GS-14 to be the COR for the HEDIS® data collection, and the CMS COR's work associated with the HEDIS® contract is approximately 20% of her 40-hour weekly work schedule.

Note: $ 130,692/yr @ GS-14 step 5 for the Washington-Baltimore-Arlington locality (effective January 2017). See https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2017/DCB.pdf.

$400,000 (contractor costs)
+ $26,138 (fed labor at 20% of $26,138)

$426,138

14. Changes to Burden

We are correcting and adjusting our burden estimates as follows:

The currently approved information collection request inadvertently set out 573 contracts in the ROCIS burden table while the Supporting Statement set out 576 contracts. In this regard, the ROCIS burden was off by 3 respondents. The number of ROCIS hours was correct.

We are adjusting our hour estimate by -19,520 based on a decrease in the number of contracts (from 573 contracts to 515 contracts). The time per response (320 hr) is unchanged. Consequently, we are adjusting our burden from 184,320 hr (573 contracts x 320 hr) to 164,800 hr (515 contracts x 320 hr).

In consultation with NCQA we had previously determined that the most appropriate labor categories included both a Medical Records Review Technologist and a Database Administrator. In this iteration we are moving away from those categories and adopting BLS labor information (see section 12 of this Supporting Statement) including BLS occupation titles, occupation codes, and wages. While missing in previous iteration, we are now accounting for fringe benefits and overhead in our cost calculations.

15. Publication /Tabulation Dates

HEDIS® data have been published in beneficiary information products since 1998 and have consistently been contained in more CMS information products about quality assurance over time. CMS makes HEDIS® data available to Medicare beneficiaries on its consumer website (www.medicare.gov) and in print materials available through the toll-free consumer phone line, upon request. This information is available through the beneficiary website in an enhanced comparison tool called Medicare Plan Finder. CMS makes health plan-level HEDIS® data freely available to researchers and others in Public Use Files on the CMS website (www.cms.hhs.gov).

16. Expiration Date

The expiration date is displayed.

17. Certification Statement

There are no exceptions to this certification statement.