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 on November 30, 2020, for the currently approved collection of Healthcare Effectiveness Data and Information Set (HEDIS®) data for Medicare Advantage Organizations (MAOs).

This request is a renewal with very minor changes. Table 2 lists all of the 2017 and 2020 measures for comparisons. These relatively small changes from 2017 to 2020 do not translate into a change in hours and costs.

This renewal is supported under the Paperwork Reduction Act and 5 CFR 1320.6. CMS requires MAOs, §1876 cost contracts, and Medicare Medicaid Plans (MMPs or demonstrations) to submit HEDIS® data on an annual basis to (1) assess care that is provided to Medicare beneficiaries and (2) to provide information to Medicare beneficiaries to make more informed decisions when choosing a health plan.
The HEDIS® data collection supports the CMS strategic goal of improving the quality of care and health status for Medicare beneficiaries. The HEDIS® measures are part of the Medicare Part C Star Ratings as described at §§ 422.160, 422.162, 422.164, and 422.166. CMS publishes the Medicare Part C Star Ratings each year to: (1) incentivize quality improvement in Medicare Advantage (MA); and (2) assist beneficiaries in finding the best plan for them. The ratings feed into MA Quality Bonus Payments. The Medicare Star Ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers.

HEDIS® data support the agency's goal to hold MA contracts accountable for delivering care in accordance with widely accepted clinical guidelines and standards of care. CMS uses HEDIS® data to obtain the information necessary for the proper oversight of the Medicare Advantage program. NCQA trains and licenses organizations to conduct audits on-site at the MAOs secure record-keeping facilities where they compile their administrative and medical records for the HEDIS data file submissions.

BACKGROUND:

CMS is committed to assessing the quality of care provided by MA contracts. 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.

NCQA designed HEDIS® 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 still 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.

JUSTIFICATION:

1. Need and Legal Basis

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 Quality Bonus Payments to Medicare Advantage plans.

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

The data are used by CMS staff to monitor MAOs' performance, and to inform beneficiaries' plan choices through their display in CMS's 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 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

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. Information about the IDSS is available at the NCQA website.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source. As stated previously above, MAOs have been submitting HEDIS® data to CMS since 1998. 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 and Medicaid 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.

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 HEDIS® measures in the Medicare Part C Star Ratings each year to: (1) incentivize quality improvement in Medicare Advantage (MA), (2) assist beneficiaries in finding the best plan, and (3) 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 HEDIS® data that CMS makes available will not identify beneficiaries. The HEDIS® patient level file is available only to requesters who for confidentiality reasons must sign a CMS Data Use Agreement that include, but are not limited to, submitting a research protocol to ResDAC for approval. Requestors must start the process as outlined by ResDAC.

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

The 60-day notice published in the Federal Register 04/15/2020 (85 FR 21010).

No comments were received

The 30-day notice published in the Federal Register 07/01/2020 (85 FR 39570).

9. Payment/Gifts to Respondents

Respondents will receive no payments or gifts for their participation in this collection of information.

10. Confidentiality

The data collection of HEDIS® quality measures are covered under the System of Records Notice titled, “Health Plan Management System (HPMS)”

SORN #09-70-500 Publication Date 2/14/18.

11. Sensitive Questions

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

12. Burden Estimate (Hours and Wages)

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2018 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.

Table 3 Summary of Wage Estimates for 677 MAOs to collect HEDIS® 2020

Occupation Title	Occupation Code	Mean Hourly Wage ($/hour)	Fringe Benefit ($/hour)	Adjusted Hourly Wage ($/hour)
Database Administrators	15-1141	44.25	44.25	88.50
Medical Records and Health Information Technicians	29-2071	21.16	21.16	42.32

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 162,480 hours (240 hours x 677 contracts) at a cost of $6,876,154 (162,480 hours $42.32/hour) or $10,157 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 54,160 hours (80 hours x 677 contracts) at a cost of $4,793,160 (54,160 hours x $88.50/hours) or $7,080 per contract.

In HEDIS® 2020, the total burden is 216,640 hours at $11,669,314 for 677 MAOs

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to Federal Government

The Federal contract cost for HEDIS® data collection to NCQA is approximately $500,000 annually. CMS funds one GS-14 to be the CMS COR for HEDIS at 20% of a 40-hour weekly work schedule.

Note: $ 130,692/year @ GS-14 step 5 for the Washington-Baltimore-Arlington locality (effective January 2017). See OPM website.

$500,000 (contractor costs)
+ $26,138 (fed labor at 20% of $26,138)
$526,138

15. Changes to Burden

Type of Providers that are required to Submit HEDIS data

All Medicare members covered in the following contracts (Table 1) are included in Medicare HEDIS® reporting. CMS communicates directly with all contracted organizations on HEDIS® reporting requirements, data collection, data submission, and the data files due date (June 15th). 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.

Table 1: Type and Number of Medicare Plans required to report HEDIS

MEDICARE	**HEDIS 2020**	HEDIS 2017
Plan/Contract Type	**Number of Plans**	Number of Plans
Medicare Advantage-Local CCPs (MA)	**591**	434
Section 1876 Cost Contracts	**9**	16
Medical Savings Account (MSA)	**4**	1
Private Fee-for-Service (PFFS)	**5**	7
Demonstrations (MMPs)	**40**	47
Regional CCPs	**28**	10
ALL Plans/Contract Types	**677**	515

Type of HEDIS Measures that are required from MAOs, §1876 Cost Contracts, and Medicare Medicaid Plans

Annually, the MAOs, §1876 Cost Contracts, and Medicare Medicaid Plans are required to submit HEDIS Measures to CMS. The measures are comprised of administrative and health assessment data collected by these providers about their respective members. HEDIS data provide CMS with information that cannot be easily obtained from these providers through other existing CMS databases. The HEDIS quality measures for these providers are typically the same for every year. However, over the past 20 years of the HEDIS program, some measures have been retired and some new measures have been added to the required list of measures. The Star Ratings Program does not include all of the HEDIS measures that are collected on an annual basis. Some measures are collected and not yet publicly reported. Some measures are collected and publicly reported but they are not included in the Star Ratings and the Quality Bonus Payments.

Table 2: HEDIS Measures

HEDIS Measures	Changes from HEDIS 2017* (means that it is still required for HEDIS reporting)
Adult BMI Assessment	Retired
Breast Cancer Screening	
Colorectal Cancer Screening	
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	
Pharmacotherapy Management of COPD Exacerbation[1]	
Controlling High Blood Pressure	
Persistence of Beta-Blocker After a Heart Attack[1] Statin Therapy for Patients with Cardiovascular Disease[1]	
Comprehensive Diabetes Care	
Statin Therapy for Patients with Diabetes[1]	
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Retired/Removed
Osteoporosis Management in Women Who Had a Fracture	
HEDIS Measures	Changes from HEDIS 2017* (means that it is still required for HEDIS reporting)
Antidepressant Medication Management	
Follow-up After Hospitalization for Mental Illness	
Follow-up After Emergency Department Visit for Mental Illness	
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	
Medication Reconciliation Post-Discharge[1]	
Transitions of Care[1]	
Follow-up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions	
Non-Recommended PSA-Based Screening in Older Men	
Potentially Harmful Drug-Disease	

Interactions in the Elderly	
Use of High-Risk Medications in the Elderly	□□
Use of Opioids at High Dosage	New
Use of Opioids from Multiple Providers	New
Medicare HOS (Health Outcomes Survey)	Approved through OMB 0938-0701
Falls Risk Management (collected in HOS Survey)	Approved through OMB 0938-0701
Management of Urinary Incontinence in Older Adults (collected in HOS Survey)	Approved through OMB 0938-0701
Osteoporosis Testing in Older Women (collected in HOS Survey)	Approved through OMB 0938-0701
Physical Activity in Older Adults (collected in HOS Survey)	Approved through OMB 0938-0701
Flu Vaccinations for Adults Ages 65 and Older collected in CAHPS Survey (Consumer Assessment of Healthcare Providers System Survey)	Approved through OMB 0938-0732

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Medical Assistance with Smoking and Tobacco Cessation (collected in CAHPS Survey)	□□
Pneumococcal Vaccination Status for Older Adults (collected in CAHPS Survey)	□□
Adults' Access to Preventive/Ambulatory Health Services	□□
HEDIS Measures	Changes from HEDIS 2017* (□ means that it is still required for HEDIS reporting)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	□□
Frequency of Selected Procedures[1]	□□
Identification of Alcohol and Other Drug Services[1]	□□
Mental Health Utilization[1]	□□
Antibiotic Utilization	□□
Plan All-Cause Readmissions[1]	□□
Hospitalization Following Discharge from a Skilled Nursing Facility[1,3]	□□
Acute Hospital Utilization[1]	□□
Emergency Department Utilization[1]	□□
Hospitalization for Potentially Preventable Complications[1]	□□
Language Diversity of Membership	□□

Total Membership	□□
Board Certification	Removed
Enrollment by Product Line	Removed
Enrollment by State	Removed
Race/Ethnicity Diversity of Membership	Removed

[1] Section 1876 Cost Contracts do not report these measures.

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

[3] he Standardized Healthcare-Associated Infection Ratio measure (HAI) and the Hospitalization Following Discharge from a Skilled Nursing Facility will not be reported in the 2020 HEDIS PLD.

There have been very minor changes in the measurement set for HEDIS. Six measures are removed or retired and two measures are added. The two new measures relate to opioid prescribing, while the Body Mass Index measure and the Rheumatoid Arthritis measure are both removed due to being topped out. Four measures regarding descriptive information about the health plan have been removed since these data can be obtained through other sources.

The hours and the costs are greater in this package because in 2017 there were 515 MAOs and in 2020 there are 677 MAOs. There was also an increase in salary of the persons preparing the data collection and data files for the annual submission of HEDIS® data to CMS on or before June 15th. In HEDIS® 2017, the total burden was 164,000 hours at $8,354,516 for 515 MAOs. The average burden for each MAO in HEDIS® 2017 was 318 hours at $16,222.

By comparison, in HEDIS® 2020, there was a total burden of 216,640 hours at $11,669,314 for 677 MAOs. The average burden for each MAO in HEDIS® 2020 is 320 hours at $17,237.

In summary, when one looks at that in HEDIS 2017, the average burden to each MAO is 318 hours at $16,222, compared with the average burden of 320 hours at $17,237 in HEDIS 2020, it does not work out to be a significant increase.

The total annual burden to the 677 contracts is 216,640 hours at a cost of $11,669,314.

Table 4 Summary of Annual Burden Estimates for HEDIS® 2020 for 677 contracts

	Medical Records	Database	Total
	Technician	Administrator	
Hours	162,480	54,160	216,640
Costs	$6,876,154	$4,793,160	$11,669,314

Table 4 Summary of Annual Burden Estimates for HEDIS® 2017 for 515 contracts

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

16. 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 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.

17. Expiration Date

The expiration date is displayed in all NCQA's published documents printed and electronically for the collection of Medicare HEDIS measures.

18. Certification Statement

There are no exceptions to this certification statement.