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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CENTER FOR MEDICARE

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TO: All Medicare Advantage, Cost Plans, Demonstration, and PACE Organizations

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SUBJECT: Reporting Requirements for HEDIS® Measurement Year (MY) 2020, HOS, and CAHPS® Measures, and Information Regarding HOS and HOS-M for Frailty

Overview

This memorandum contains the Healthcare Effectiveness Data and Information Set (HEDIS) measures required for submission on June 15, 2021, by all Medicare Advantage Organizations (MAOs) and other health plan organizational types listed in Table 1. This memorandum also includes information about which contracts are required to participate in the Medicare Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey administered in 2021, as well as information regarding the timing of HOS and HOS-M survey administration. Finally, we include an update on the timing for release of information on the HOS and HOS-M for fully integrated dual eligible (FIDE) Special Needs Plans (SNPs) that will be used for frailty consideration.

CMS has authority to collect various types of quality data under section 1852(e) of the Act and use this information to develop and publicly post a 5-star rating system for Medicare Advantage (MA) plans based on its authority to disseminate comparative information, including about quality, to beneficiaries under sections 1851(d) and 1860D-1(c) of the Act. As codified at § 422.152(b)(3), Medicare health plans are required to report on quality performance data which CMS can use to help beneficiaries compare plans. Cost plans under section 1876 of the Act are also included in the MA Star Rating system, as codified at § 417.472(k), and are required by regulation (§ 417.472(j)) to make CAHPS survey data available to CMS. Medicare-Medicaid Plans (MMPs) are required to report on quality performance data per the terms of their respective three-way contracts.

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

HEDIS MY 2020 Requirements

As part of the clinical quality reporting requirements, Medicare health plans must submit their HEDIS MY 2020 summary-level data to the National Committee for Quality Assurance (NCQA). Detailed specifications for HEDIS measures are included in the *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans*.

NCQA has added additional codes to capture information from telehealth visits for the 2020 measurement year as announced by NCQA in July 2020 through the HEDIS Volume 2 Technical Specifications release for Measurement Years 2020 and 2021. More information is on NCQA's website, and measures impacted by these adjustments are in Table 2.

All HEDIS MY 2020 audited summary-level data must be submitted to NCQA by 11:59 p.m. Eastern Time on Tuesday, June 15, 2021. There are no late submissions. For Medicare-Medicaid Plans (MMPs), failure to report HEDIS measures may affect quality withhold payments, as articulated in the CMS Core Quality Withhold Technical Notes.

All health plan organizations that are new to HEDIS must become familiar with the requirements for submission to NCQA and make the necessary arrangements to collect the data as soon as possible. Information about the HEDIS audit compliance program is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/. Table 1 indicates which organizational types must report CAHPS, HEDIS, HOS, and HOS-M data.

Table 1: Organizational Type and Quality Measure Reporting Requirements

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

(× = Not required to report ✓ = Required to report)

HEDIS MY 2020 Summary-Level (also called HEDIS contract-level data)

CMS requires all contracts with an effective date of January 1, 2020 or earlier, that are an organization in Table 1, to collect and submit to NCQA audited HEDIS summary-level data (also called HEDIS contract-level data) for the quality measures listed in Table 2. There is no minimum member enrollment for submitting audited HEDIS summary-level data.

Contract Closures: If your Health Plan Management System (HPMS) contract status becomes "Withdrawn Contract" or "Terminated" with a termination date on or before June 15, 2021, then your contract is not required to submit HEDIS MY 2020 data. MMPs that terminate as of December 31, 2020 or after are required to submit HEDIS MY 2020 data if they were in operation for the full 2020 contract year. 1876 Cost contracts that are terminating as of December 31, 2020 and are transferring their enrollees into a MA contract which does not have sufficient data to earn their own 2022 Star Ratings may submit their 2021 HEDIS Cost contract data to NCQA. All other 1876 Cost contracts are required to submit HEDIS MY 2020 data regardless of enrollment closure status. Table 2 footnotes include information about the measure-specific submission exceptions for 1876 Cost contracts.

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

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

Table 2: HEDIS MY 2020 MA Summary Contract-Level Measures for Reporting

	Effectiveness of Care Measures
BCS	Breast Cancer Screening[6]
COL	Colorectal Cancer Screening[6]
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)[6]
PCE	Pharmacotherapy Management of COPD Exacerbation[1]
CBP	Controlling High Blood Pressure[6]
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack[1,6]
SPC	Statin Therapy for Patients with Cardiovascular Disease[1,6]
CDC	Comprehensive Diabetes Care[6]
KED	Kidney Health Evaluation for Patients With Diabetes[6]
SPD	Statin Therapy for Patients With Diabetes[1,6]
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[4,6]
OMW	Osteoporosis Management in Women Who Had a Fracture[6]
AMM	Antidepressant Medication Management[6]
FUH	Follow-Up After Hospitalization for Mental Illness[6]
FUM	Follow-Up After Emergency Department Visit for Mental Illness[6]
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia[6]
TRC	Transitions of Care[1,5,6]

	Effectiveness of Care Measures
FMC	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions[6]
PSA	Non-Recommended PSA-Based Screening in Older Men
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults
DAE	Use of High-Risk Medications in Older Adults
HDO	Use of Opioids at High Dosage
UOP	Use of Opioids from Multiple Providers
HOS	Medicare Health Outcomes Survey
FRM	Falls Risk Management (collected in HOS)
MUI	Management of Urinary Incontinence in Older Adults (collected in HOS)
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 measures
AAP	Adults' Access to Preventive/Ambulatory Health Services
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	Utilization and Risk-Adjusted Utilization measures
FSP	Frequency of Selected Procedures[1]
IAD	Identification of Alcohol and Other Drug Services[1]
ABX	Antibiotic Utilization
PCR	Plan All-Cause Readmissions[1,6]
HFS	Hospitalization Following Discharge from a Skilled Nursing Facility[1,2,6]
AHU	Acute Hospital Utilization[1,6]
EDU	Emergency Department Utilization[1,6]
HPC	Hospitalization for Potentially Preventable Complications[1,6]
	Health Plan Descriptive Information
LDM	Language Diversity of Membership
ENP	Enrollment by Product Line

	Measures Collected Using Electronic Clinical Data Systems
BCS-E	Breast Cancer Screening[6]
COL-E	Colorectal Cancer Screening[6]
DSF	Depression Screening and Follow-Up for Adolescents and Adults[6]
DMS	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults[6]
DRR	Depression Remission or Response for Adolescents and Adults
ASF	Unhealthy Alcohol Use Screening and Follow-Up
AIS	Adult Immunization Status (incorporates the former Pneumococcal Vaccination Coverage for Older Adults (PVC) measure)

1 Section 1876 Cost contracts do not report the following measures: PCE, PBH, SPC, SPD, TRC, FSP, IAD, MPT, PCR, HFS, AHU, EDU, and HPC.

2 The Hospitalization Following Discharge from a Skilled Nursing Facility (HFS) will NOT be reported in the HEDIS MY 2020 patient-level detail data file.

3 Reporting the measures in the Electronic Clinical Data Systems (ECDS) set is voluntary. If they are reported, then the data must be audited. CMS is collecting these data for review only. The ECDS measures will NOT be included in the HEDIS MY 2020 patient-level detail data file. The data collected for these measures will NOT be publicly reported.

4 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) is retired for MY 2021 but is reported for MY 2020.

5 Medication Reconciliation Post-Discharge (MRP) measure is still collected as an indicator in the TRC measure.

6 Additional codes have been added to capture information from telehealth visits. Information is in the *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans*.

HEDIS MY 2020 Patient-Level Detail data files

All organizations that submit HEDIS summary contract-level data are also required to submit audited HEDIS Patient-Level Detail (PLD) data files to CMS's HEDIS PLD contractor. **All HEDIS PLD files must be submitted by 11:59 p.m. Eastern Time on June 15, 2021. There are no late submissions.**

CMS expects that the HEDIS PLD files will contain the member level details for the summary contract-level data files.

CMS will send its annual HPMS Memorandum in December 2020 with additional information about data submission of HEDIS PLD. We anticipate that there will be an optional dry run for HEDIS PLD data submission in April 2021.

MY 2020 Summary Plan Benefit Package (PBP)-Level Reporting for Coordinated Care Plans (CCPs) with Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs)

In 2021, CMS will continue collecting audited summary and PBP level data from each PBP designated as a SNP offered by any CCP. CMS will also collect audited summary PBP-level data for each MMP PBP.

A SNP PBP must have had 30 or more members enrolled as listed in the February 2020 SNP Comprehensive Report (this report can be found at this link: http://www.cms.gov/Research- Statistics-

Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html). SNP PBPs that meet the enrollment criteria must also exist in both the measurement year and reporting years. PBPs that terminated as of December 31, 2020 are not required to report but may still do so voluntarily.

A MMP PBP must have had 30 or more members enrolled as listed in the February 2020 Monthly Enrollment by Plan report (this report can be found at this link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan.html). MMP PBPs that terminated as of December 31, 2020 or after are required to report, if they were in operation for the full 2020 calendar year. All SNP and MMP PBPs must report the HEDIS measures in Table 3. If a contract has multiple qualifying PBPs, then each qualifying PBP in the contract must report the measures in Table 3 in a separate submission. MMP and contracts with SNP PBPs do not have to report any additional PLD files. The required HEDIS PLD file submission at the contract level will already include the detail data about the members in the SNP and MMPs PBPs. Table 3 lists the HEDIS MY 2020 measures for reporting by all SNP and MMP PBPs.

Table 3: HEDIS MY 2020 Measures for Reporting by SNPs and MMP PBPs

	Effectiveness of Care measures
COL	Colorectal Cancer Screening
COA	Care for Older Adults (SNP- and MMP-only measure)
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
PCE	Pharmacotherapy Management of COPD Exacerbation
CBP	Controlling High Blood Pressure
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
OMW	Osteoporosis Management in Women Who Had a Fracture
AMM	Antidepressant Medication Management
FUH	Follow-Up After Hospitalization for Mental Illness
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly
TRC	Transitions of Care
DAE	Use of High-Risk Medications in the Elderly
	Utilization and Risk-adjusted Utilization measures
PCR	Plan All-Cause Readmissions

HEDIS Contacts

Please send all questions about HEDIS measure specifications to NCQA's Policy Clarification Support System at my.ncqa.org. For other CMS information about HEDIS, please email HEDISquestions@cms.hhs.gov.

2021 HOS and HOS-M Reporting Requirements

Who Must Report HOS

The following types of MAOs and other health plan organization types with Medicare contracts in effect on or before January 1, 2020 are **required** to report the Baseline HOS in 2021 if they have a minimum enrollment of 500 members as of February 1, 2021:

- All MAOs, including all coordinated care plans, PFFS contracts, and MSA contracts
- Section 1876 Cost contracts even if they are closed for enrollment
- Employer/union only contracts
- MMPs

In addition, all organizations that reported Cohort 22 Baseline Survey in 2019 are required to administer the Cohort 22 Follow-Up Survey in 2021. In the event of contract consolidations, mergers, or novation, surviving contracts must report Follow-Up HOS for all contracts involved. All eligible members of consolidated, merged, or novated contracts will be resurveyed and the results will be reported as one under the surviving contract. In the event of a contract conversion, the contract must report if their new organization type is required to report.

CMS excludes from HOS Baseline beneficiaries enrolled in I-SNPs at the PBP level. HCPP 1833 Cost contracts are also excluded from the HOS administration.

Who Must Report HOS-M

The HOS-M is an abbreviated version of the Medicare HOS used to assess the physical and mental health functioning of beneficiaries enrolled in Programs of All-Inclusive Care for the Elderly (PACE).

All PACE contracts in effect on or before January 1, 2021 are required by CMS to administer the HOS-M survey in 2021 if they have a minimum enrollment of 30 members. Eligible PACE organizations will receive further correspondence from NCQA regarding HOS-M participation by March 1, 2021.

Timing for HOS and HOS-M Survey Administration

As announced in CMS-1744-IFC, the 2020 HOS survey administration, originally scheduled for April through July 2020, was delayed due to concerns for survey vendor safety at the time the pandemic began. In the April 15, 2020 HPMS memo titled "Delay of the 2020 HOS & HOS-M Surveys for 2021 Frailty Score Calculation," CMS announced the delay also applied to the HOS-M survey. In 2020, the HOS and HOS-M surveys are being fielded August through November. To avoid burdening beneficiaries with back-to-back surveys, CMS will continue to field the HOS and HOS-M surveys on the August through November timeline in 2021 and going forward.

Organizations are required to contract with an approved HOS or HOS-M survey vendor and to notify NCQA of their choice. You will receive further correspondence regarding your HOS and HOS-M participation from NCQA by March 31, 2021. Approved 2021 HOS survey vendors will be listed on www.HOSonline.org.

For additional information on 2021 HOS or HOS-M, please email HOS@cms.hhs.gov.

Optional Reporting of the HOS and/or HOS-M for FIDE SNPs for Frailty Consideration

MAOs that anticipate sponsoring FIDE SNPs in the applicable payment year may elect to report HOS at the PBP level to determine eligibility for a frailty adjustment payment, as discussed in CMS's Advance Notices and Rate Announcements.[1] Voluntary reporting at the plan level will be in addition to standard HOS requirements for quality reporting at the contract level. Plans that meet certain criteria may elect to report HOS-M.

The previously mentioned timeline changes for fielding the HOS applies to FIDE SNPs fielding the survey for frailty consideration as well. Since the 2021 survey will start fielding in August 2021, the HPMS memo we typically send out at the end of September, which contains information specific to optional reporting for FIDE SNPs (including survey selection), will be sent later than in the past. We anticipate this HPMS memo being sent in early 2021.

Questions regarding the HOS and HOS-M for frailty consideration can be submitted to the CMS Risk Adjustment Policy mailbox at RiskAdjustmentPolicy@cms.hhs.gov.

2021 CAHPS Survey Requirements

The following types of organizations are included in the CAHPS survey administration if they have a minimum enrollment of 600 eligible members as of July 1, 2020:

- All MAOs, including all coordinated care plans, PFFS contracts, and MSA contracts
- Section 1876 Cost contracts even if they are closed for enrollment
- Employer/union only contracts
- MMPs

PACE and HCPP 1833 Cost contracts are excluded from the CAHPS administration.

Organizations are required to contract with an approved MA & PDP CAHPS vendor for the 2021 CAHPS survey administration. All approved CAHPS survey vendors for the 2021 survey administration will be listed on www.MA-PDPCAHPS.org. CMS will issue additional HPMS memorandums about the CAHPS survey for 2021. As a reminder, for MMPs, failure to adhere to CAHPS reporting requirements may affect quality withhold payments, as articulated in the CMS Core Quality Withhold Technical Notes.

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

[1] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2013.pdf