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CENTER FOR MEDICARE

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

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SUBJECT: Reporting Requirements for HEDIS® Measurement Year (MY) 2024, 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 13, 2025, by all Medicare Advantage Organizations (MAOs) and other health plan organization 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 2025, as well as information regarding the timing of HOS and HOS-M survey administration. Finally, we include a reminder on the timing for release of information on the HOS and HOS-M to be used by fully integrated dual eligible (FIDE) Special Needs Plans (SNPs) that would like to be considered for frailty payments.

CMS has authority to collect various types of quality data under section 1852(e) of the Social Security Act (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.

HEDIS MY 2024 Requirements

As part of the clinical quality reporting requirements, Medicare health plans must submit their HEDIS MY 2024 summary-level data to the National Committee for Quality Assurance (NCQA). Detailed specifications for HEDIS measures are included in the *HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans*.

***Please note the new date and time for MY 2024*. All HEDIS MY 2024 audited summary-level data must be submitted to NCQA by 9:00 p.m. Eastern Time on June 13, 2025. There are no late submissions.** For 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 organization types must report HEDIS, HOS, HOS-M, and CAHPS.

Table 1: Organization Type and Quality Measure Reporting Requirements

Organization Type	HEDIS	HOS	HOS-M	CAHPS
Section 1876 Cost contracts	✓	✓	×	✓
Demonstration: Medicare-Medicaid Plans (MMPs)	✓	✓	×	✓
HCPP-1833 Cost	×	×	×	×
Local Coordinated Care Plans (LCCP)	✓	✓	×	✓
Medical Savings Account (MSA)	✓	✓	×	✓
Programs of All-Inclusive Care for the Elderly (PACE)	×	×	✓	×
Private Fee-for-Service (PFFS)	✓	✓	×	✓
Employer/Union Only Direct Contract Local CCP	✓	✓	×	✓
Employer/Union Only Direct Contract PFFS	✓	✓	×	✓
Regional Coordinated Care Plans (RCCP)	✓	✓	×	✓

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

HEDIS MY 2024 Summary-Level Data (also called HEDIS contract-level data)

CMS requires all contracts with an effective date of January 1, 2024 or earlier that are an organization type 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 13, 2025, then your contract is not required to submit HEDIS MY 2024 data. MMPs that terminate as of December 31, 2024 or after are required to submit HEDIS MY 2024 data if they were in operation for the full 2024 contract year. All 1876 Cost contracts are required to submit HEDIS MY 2023 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 2024 Summary Contract-Level Measures for Reporting[1]

Effectiveness of Care Measures
PCE - Pharmacotherapy Management of COPD Exacerbation[2]
CBP - Controlling High Blood Pressure
PBH - Persistence of Beta-Blocker Treatment After a Heart Attack[2]
SPC - Statin Therapy for Patients with Cardiovascular Disease[2]
CRE - Cardiac Rehabilitation
GSD - Glycemic Status Assessment for Patients With Diabetes[3]
BPD - Blood Pressure Control for Patients With Diabetes[3]
EED - Eye Exam for Patients with Diabetes[3]
KED - Kidney Health Evaluation for Patients With Diabetes
SPD - Statin Therapy for Patients With Diabetes[2]
OMW - Osteoporosis Management in Women Who Had a Fracture
OSW - Osteoporosis Screening in Older Women
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 Substance Use
SAA - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
TRC - Transitions of Care[2,4]
FMC - Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
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
POD - Pharmacotherapy for Opioid Use Disorder

[1] This does not include any of the HEDIS survey measures such as the measures collected through the HOS. The survey reporting requirements are listed later in the memo.

[2] Section 1876 Cost contracts do not report the following measures: PCE, PBH, SPC, SPD, TRC, PCR, HFS, AHU, EDU, and HPC.

[3] This measure is part of the former Comprehensive Diabetes Care measure set. The measure specifications are the same as in the past.

[4] The Medication Reconciliation Post-Discharge (MRP) measure is still collected as an indicator in the TRC measure.

Access/Availability of Care Measures
AAP - Adults' Access to Preventive/Ambulatory Health Services
IET - Initiation and Engagement of Substance Use Disorder Treatment
Utilization and Risk-Adjusted Utilization Measures
PCR - Plan All-Cause Readmissions[2]
HFS - Hospitalization Following Discharge from a Skilled Nursing Facility[2,5]
AHU - Acute Hospital Utilization[2]
EDU - Emergency Department Utilization[2]
HPC - Hospitalization for Potentially Preventable Complications[2]
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
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults
AIS-E - Adult Immunization Status
SNS-E - Social Need Screening and Intervention
COL-E - Colorectal Cancer Screening
DMS-E - Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults[6]
DRR-E - Depression Remission or Response for Adolescents and Adults[6]
ASF-E - Unhealthy Alcohol Use Screening and Follow-Up[6]

[5] The Hospitalization Following Discharge from a Skilled Nursing Facility (HFS) measure will NOT be reported in the HEDIS MY 2024 patient-level detail data file.

[6] Reporting this measure in the Electronic Clinical Data Systems (ECDS) set is voluntary. If it is reported, then the data must be audited. CMS is collecting these data for review only. This ECDS measure will NOT be included in the HEDIS MY 2024 patient-level detail data file. The data collected for these measures will NOT be publicly reported.

HEDIS MY 2024 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, with the exception of MMPs that terminate as of December 31, 2024. ***Please note the new date and time for MY 2024*. All HEDIS PLD files must be submitted by 9:00 p.m. Eastern Time on June 13, 2025. There are no late submissions.**

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 fall 2024 with additional information about data submission of HEDIS PLD. There will be an optional dry run for HEDIS PLD data submission in April 2025.

MY 2024 Summary Plan Benefit Package (PBP)-Level Reporting for Coordinated Care Plans (CCPs) with Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs)

In 2025, 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 2024 SNP Comprehensive Report (this report can be found at this link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data). SNP PBPs that meet the enrollment criteria must also exist in both the measurement year and reporting years. PBPs that terminate as of December 31, 2024 are not required to report but may still do so voluntarily.

An MMP PBP must have had 30 or more members enrolled as listed in the February 2024 Monthly Enrollment by Plan report (this report can be found at this link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan). MMP PBPs that terminate as of December 31, 2024 or after are required to report, if they were in operation for the full 2024 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. MMPs 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 MMP PBPs. Table 3 lists the HEDIS MY 2024 measures for reporting by all SNP and MMP PBPs.

Table 3: HEDIS MY 2024 Measures for Reporting by SNPs and MMP PBPs

Effectiveness of Care Measures
COA - Care for Older Adults (SNP- and MMP-only measure)[7]
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 Measure
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 questions about HEDIS, please email HEDISquestions@cms.hhs.gov.

2025 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, 2024 are **required** to report the Cohort 28 Baseline HOS in 2025 if they have a minimum enrollment of 500 members in February 2025 as reflected in the March 2025 monthly enrollment file[8] at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData:

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

[7] Advance Care Planning indicator was removed from Care for Older Adults (COA).
[8] The March 2025 monthly enrollment file at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData reflects enrollment in each contract as of the plan submission enrollment cut-off date for payment which is in February 2025.

In addition, all organizations that reported Cohort 26 Baseline Survey in 2023 are required to administer the Cohort 26 Follow-Up Survey in 2025. In the event of contract consolidations, mergers, or novations, 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 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 beneficiaries enrolled in I-SNPs at the PBP level from the HOS Baseline survey. HCPP 1833 Cost contracts are also excluded from the HOS administration.

MAOs will receive further correspondence regarding HOS participation from NCQA by March 28, 2025.

Who Must Report HOS-M

The HOS-M is an abbreviated version of the HOS used to assess the physical and mental health functioning of beneficiaries enrolled in PACE.

All PACE contracts in effect on or before January 1, 2024 are required by CMS to administer the HOS-M survey in 2025 if they have a minimum enrollment of 30 members as of February 2025 as reflected in the March 2025 monthly enrollment file at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData. Eligible PACE organizations will receive further correspondence from NCQA regarding HOS-M participation by March 3, 2025.

HOS and HOS-M Survey Administration

Organizations are required to contract with an approved HOS or HOS-M survey vendor and notify NCQA of their choice. Approved 2025 HOS and HOS-M survey vendors will be listed on www.HOSonline.org.

For additional information on 2025 HOS or HOS-M, please email HOS@cms.hhs.gov.

Optional Reporting of the HOS 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 their eligibility for a frailty adjusted payment, as discussed in CMS's Advance Notices and Rate Announcements.[9] 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, including a minimum PBP enrollment of 50 members as of February 2025 as reflected in the March 2025 monthly enrollment file at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData, may elect to report HOS-M. MAOs may elect to report HOS or HOS-M at the PBP level even if the MA contract is not required to report Baseline HOS due to low enrollment.

[9] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents

The HPMS memorandum containing information on optional reporting for FIDE SNPs and participation in the HOS or HOS-M for frailty consideration will be sent in early 2025. Please note that eligible FIDE SNPs that wish to participate in the 2025 HOS or HOS-M for frailty consideration must make their survey selection through HPMS unless otherwise noted. All selections must be submitted by the date indicated in the memorandum.

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.

2025 CAHPS Survey Requirements

The following organization types are included in the CAHPS survey administration if they have a minimum enrollment of 600 eligible members as of July 1, 2024:

- All MAOs, including all CCPs, 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. Beneficiaries enrolled in I-SNPs are excluded from sampling.

Organizations are required to contract with an approved MA & PDP CAHPS vendor for the 2025 CAHPS survey administration. All approved CAHPS survey vendors for the 2025 survey administration will be listed on www.MA-PDPCAHPS.org. CMS will issue additional information through HPMS about the CAHPS survey for 2025. 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.