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*2013-2015 Cohort 16*  
**MEDICARE  
ADVANTAGE  
ORGANIZATION  
PERFORMANCE  
MEASUREMENT  
REPORT**

**MEDICARE HEALTH**

**OUTCOMES SURVEY**

**CENTERS  
FOR MEDICARE  
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SERVICES**

**HEALTH  
SERVICES  
ADVISORY  
GROUP**



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



## CENTER FOR MEDICARE

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July 2016

Medicare Advantage Organizations,

The Centers for Medicare & Medicaid Services (CMS) is pleased to provide you with your Medicare Advantage Organization's (MAO) performance measurement results for *2013-2015 Cohort 16* of the Medicare Health Outcomes Survey (HOS). The *2013-2015 Cohort 16 Performance Measurement Report* includes results from the Medicare HOS Versions 2.5 and 3.0. The report presents performance measurement results for MAOs based on data from the Medicare HOS *2013 Cohort 16 Baseline* and *2015 Cohort 16 Follow Up* surveys describing changes in health status over time for beneficiaries. CMS encourages MAOs to examine their results for use in quality improvement activities.

The Performance Measurement Report is distributed to help MAOs understand and find their HOS results for key health indicators. Information on the HOS measures used in the Medicare Star Ratings, as well as additional resources to assist MAOs in their quality improvement efforts, is included in the report. The *2013-2015 Cohort 16 Performance Measurement Report* also includes a Reader's Guide, What's New in the HOS, as well as trend information over recent years for your individual MAO.

For more program information, you may submit inquiries to [hos@HCQIS.org](mailto:hos@HCQIS.org) or contact Health Services Advisory Group (HSAG) through the HOS Information and Technical Support telephone line at (888) 880-0077, and you may visit CMS' HOS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/index.html>.

Sincerely,

Elizabeth Goldstein, PhD  
Director  
Division of Consumer Assessment & Plan Performance

# MEDICARE HEALTH OUTCOMES SURVEY

## SAMPLE MAO REPORT

The following is a **sample** version of the *Cohort 16* Performance Measurement Report made available to all Medicare Advantage Organizations (MAOs) participating in the *2013 Cohort 16 Baseline* and *2015 Cohort 16 Follow Up* Medicare Health Outcomes Surveys.

The figures, tables, and text in this document contain example MAO and state level data; however, all references to the *HOS Total* reflect **actual** data.

The Medicare HOS Information and Technical Support Telephone Line (1-888-880-0077), as well as the HOS email address ([hos@HCQIS.org](mailto:hos@HCQIS.org)), are available to provide assistance with report questions and interpretation. A full description of the HOS program may be found at [www.HOSonline.org](http://www.HOSonline.org).

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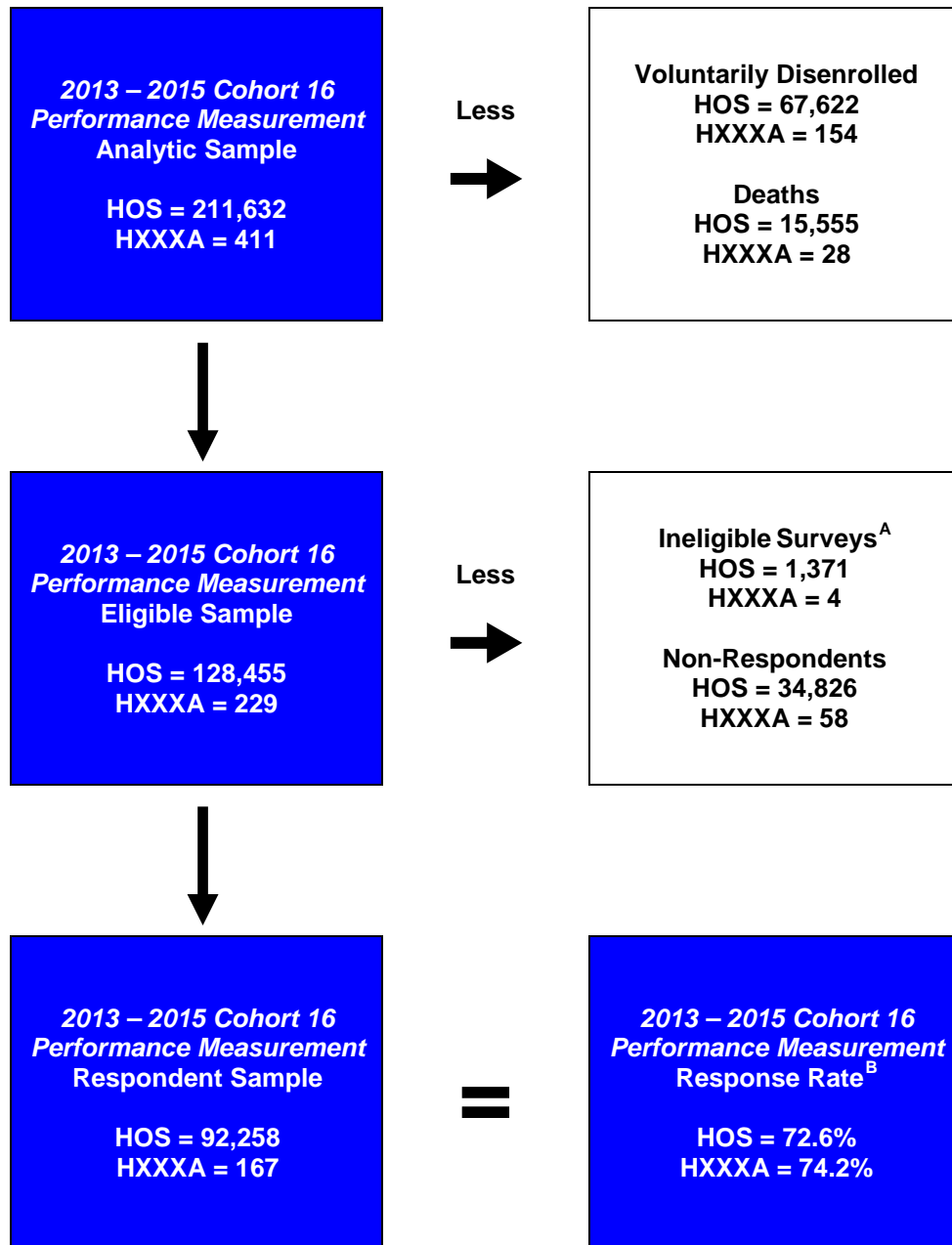
## Executive Summary

This Medicare Health Outcomes Survey (HOS) *2013-2015 Cohort 16 Performance Measurement* Report presents aggregate results for participating Medicare Advantage Organizations (MAOs), as well as results for MAO HXXXXA based on data from the HOS *2013 Cohort 16 Baseline* and *2015 Cohort 16 Follow Up* surveys. The HOS performance measurement results describe change in health status over time for beneficiaries. The *2013 Cohort 16 Baseline* included a random sample of 578,074 beneficiaries, consisting of both the aged and disabled, from 495 MAOs. Of the 578,074 individuals sampled, 47.2% (272,936) completed the baseline survey. A completed survey was defined as one that could be used to calculate a physical component summary (PCS) or mental component summary (MCS) score. Of the 272,936 respondents, 228,934 were seniors (age 65 or older) who returned a completed survey. During the two years between the baseline and follow up surveys, several MAOs discontinued offering managed care to Medicare beneficiaries or consolidated with other MAOs. As a result of these changes, there remained 364 contract reporting units (MAOs), comprising 211,632 baseline respondents in the HOS *Cohort 16*. This group of 211,632 seniors comprises the *Cohort 16 Performance Measurement* analytic sample.

At the time of follow up, 128,455 beneficiaries were seniors who had completed a baseline survey and were still enrolled in their original MAO. These beneficiaries are referred to as the *Cohort 16 Performance Measurement* eligible sample since they were alive and eligible for remeasurement. After removing 1,371 beneficiaries who were determined to be ineligible at follow up, 127,084 beneficiaries remained. A total of 92,258 beneficiaries returned a follow up survey with a calculable PCS or MCS score, yielding a follow up response rate of 72.6%. These 92,258 beneficiaries comprise the *Cohort 16 Performance Measurement* respondent sample. Figure 1 on the following page depicts the distribution of the sample and the response rates for the national HOS sample and your MAO.

On the following pages of this Executive Summary you will find results for your MAO HXXXXA, StateXX, and the HOS Total respondent sample across key indicators of beneficiary health status. For instance, the primary physical and mental health results are included as well as trend results for the current and previous two cohorts. In addition, the Executive Summary provides the distribution of beneficiary responses at baseline and follow up for general and comparative health, chronic medical conditions, healthy days, and obesity measures. More detailed information about the results is provided in the “*Cohort 16 Performance Measurement Results*” section of the report. For MAOs with a small number of respondents, caution should be exercised when drawing conclusions from the results throughout this follow up report. Note that the state level statistics in any figures and tables are *not applicable* (NA) for Regional Preferred Provider Organization (RPPO) and Private Fee-for-Service (PFFS) contracts. For reporting purposes, these types of plans are not included in any specific state numbers; however, they are included in the HOS Total.

**Figure 1: Distribution of the Performance Measurement Sample and Response Rates for HOS Total and MAO HXXXA**



<sup>A</sup> Beneficiaries with ineligible surveys at follow up met one of the following criteria: not enrolled in the MAO; had an incorrect address and phone number; or had a language barrier.

<sup>B</sup> Response Rate = [Respondent Sample/(Eligible Sample-Ineligible Surveys)] x 100%.



## HOS Performance Measurement Results

The HOS national average, also referred to as the HOS Total, is based on all MAOs that participated in performance measurement. Outliers are those MAOs that performed significantly better or significantly worse than expected when compared to the national average. MAOs may be outliers on a measure of physical health, mental health, or both. The overall measure of change in physical health is calculated by combining death status and PCS score. Change in mental health is calculated with the MCS score.

For the *2013-2015 Cohort 16 Performance Measurement*, statistical assessment of the case-mix adjusted results for mortality and PCS revealed 20 outlier MAOs. There were 7 outlier MAOs designated as “better than expected” and 13 outlier MAOs designated as “worse than expected” compared to the national average. For MCS, statistical assessment of the case-mix adjusted results revealed 22 outlier MAOs. There were 7 outlier MAOs designated as “better than expected” and 15 outlier MAOs designated as “worse than expected” compared to the national average. More performance measurement results and details are provided in Tables 1 and 2 below and in the “*Cohort 16 Performance Measurement Results*” section.

## Trends in Performance Measurement Results for MAO HXXXXA

Table 1 presents the trends in the physical health performance measurement results for your MAO. The current cohort results are provided and, when available, results for the past two cohorts are also shown for comparison. Note that the Medicare Star Ratings measure for *Improving or Maintaining Physical Health* is derived from the combined “Percent Better+Same” result in Table 1. You can find more information about the Medicare Star Ratings in the “HOS and the Star Ratings” section.

**Table 1: Trends in Physical Health Results over Three Cohorts for MAO HXXXXA**

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
<i>2013-2015 Cohort 16</i>	16.56%	50.26%	33.18%	66.82%	↔
<i>2012-2014 Cohort 15</i>	17.24%	49.84%	32.92%	67.08%	↔
<i>2011-2013 Cohort 14</i>	18.16%	50.36%	31.48%	68.52%	↔

NA indicates that the MAO did not have results for the specified cohort.

\* The percent better, same, worse, or better+same refers to beneficiary health status within an MAO.

\*\* The statistical significance of each performance result for the MAO is indicated by one of the following symbols:

- ⬆ MAO performed significantly better than expected (higher than the national average)
- ⬇ MAO performed significantly worse than expected (lower than the national average)
- ↔ MAO performed as expected (the same as the national average)

Table 2 below presents the trends in the mental health performance measurement results for your MAO. Results for the current cohort and, when available, the past two cohorts are shown. Note that the Medicare Star Ratings measure for *Improving or Maintaining Mental Health* is the combined “Percent Better+Same” result in Table 2.

**Table 2: Trends in Mental Health Results over Three Cohorts for MAO HXXXXA**

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2013-2015 Cohort 16	21.52%	62.45%	16.03%	83.97%	↔
2012-2014 Cohort 15	19.17%	58.94%	21.88%	78.12%	↔
2011-2013 Cohort 14	18.43%	61.07%	20.49%	79.51%	↔

NA indicates that the MAO did not have results for the specified cohort.

Please note: There were changes to the survey format in the 2015 HOS 3.0 that resulted in an increase in MCS scores for the Cohort 16 Follow Up mail mode administration.

\* The percent better, same, worse, or better+same refers to beneficiary health status within an MAO.

\*\* The statistical significance of each performance result for the MAO is indicated by one of the following symbols:

▲ MAO performed significantly better than expected (higher than the national average)

▼ MAO performed significantly worse than expected (lower than the national average)

↔ MAO performed as expected (the same as the national average)

## Health Status Summary for MAO HXXXXA

### General Health and Comparative Health

Table 3 describes baseline and follow up results for the general and comparative health status of beneficiaries in your MAO HXXXXA, StateXX, and the HOS Total. Populations with increases in the proportion of beneficiaries from baseline to follow up who indicated that their *general health* was “Fair” or “Poor” or that their *physical or mental health compared to one year ago* was “Slightly worse” or “Much worse” may assume greater risk for mortality.<sup>1,2</sup>

**Table 3: 2013-2015 Cohort 16 Performance Measurement Distributions of Beneficiaries with Worse Self-Rated General and Comparative Health Status for MAO HXXXXA, StateXX, and HOS Total**

	General Health		Comparative Physical		Comparative Mental	
	Fair or		Slightly Worse or		Slightly Worse or	
	Poor		Much Worse		Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
HXXXXA	21.0%	22.4%	20.7%	29.4%	8.0%	11.5%
StateXX	22.4%	24.0%	22.9%	27.6%	10.9%	12.1%
HOS Total	22.4%	25.1%	23.1%	26.4%	11.2%	11.4%

Chronic Medical Conditions

Table 4 shows the percentage of beneficiaries with multiple (i.e., two or more) chronic medical conditions at baseline and follow up for your MAO HXXXXA, StateXX, and the HOS Total. Research demonstrates that having a greater number of chronic conditions increases the risks of the following outcomes: mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice.<sup>3</sup> It may be useful to compare the relative differences in the results from baseline to follow up for your MAO HXXXXA, StateXX, and the HOS Total.

**Table 4: 2013-2015 Cohort 16 Performance Measurement Distribution of Beneficiaries with Multiple Chronic Medical Conditions<sup>§</sup> for MAO HXXXXA, StateXX, and HOS Total**

	Multiple Chronic Medical Conditions <sup>§</sup>	
	Baseline	Follow Up
HXXXXA	76.6%	80.9%
StateXX	72.4%	76.1%
HOS Total	75.0%	77.5%

§ Multiple chronic medical conditions are defined as having two or more conditions.

Healthy Days Measures

Table 5 shows the percentages of beneficiaries in your MAO HXXXXA, StateXX, and the HOS Total with 14 or more days of poor *physical health*, *mental health*, or *activity limitations in the past 30 days*. In general, 14 or more days of poor health or activity limitations are considered indicative of poor well-being.<sup>4</sup> Healthy Days Measures serve as indicators of populations with greater risk for disease or injury. MAOs may use responses to Healthy Days Measures to identify beneficiaries in poor health who may have undiagnosed conditions or are having difficulty managing their chronic diseases. It may be useful to compare the relative differences in the results for your MAO HXXXXA, StateXX, and the HOS Total.

**Table 5: 2013-2015 Cohort 16 Performance Measurement Distribution of Beneficiaries with Worse Health for the Healthy Days Measures for MAO HXXXXA, StateXX, and HOS Total**

	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental Health		14 or More Days of Activity Limitations	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
HXXXXA	11.7%	18.7%	6.7%	10.7%	8.8%	11.7%
StateXX	15.0%	18.3%	7.8%	10.3%	11.7%	13.6%
HOS Total	16.1%	18.9%	8.9%	9.8%	10.6%	12.5%

Clinical Measures

Table 6 illustrates the distribution of underweight, overweight, and obese beneficiaries across baseline and follow up for your MAO HXXXXA, StateXX, and the HOS Total. These Body Mass Index (BMI) categories are considered unhealthy and are associated with increased chronic diseases, and in the case of the underweight, increased mortality for the elderly. It may be useful to compare the proportion of beneficiaries who are in these unhealthy BMI categories for your MAO HXXXXA, StateXX, and the HOS Total.

**Table 6: 2013-2015 Cohort 16 Performance Measurement Distribution of Beneficiaries in Extreme Categories of the BMI Measures for MAO HXXXXA, StateXX, and HOS Total**

	Underweight (BMI < 20)		Overweight (BMI 25 to 29.99)		Obese (BMI ≥ 30)	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
HXXXXA	6.1%	3.8%	39.9%	40.8%	31.3%	33.8%
StateXX	5.3%	4.6%	37.8%	39.3%	28.0%	27.3%
HOS Total	4.3%	5.0%	38.7%	37.7%	29.7%	29.5%

## Reader's Guide

This Reader's Guide is provided to help Medicare Advantage Organizations (MAOs) use their Medicare Health Outcomes Survey (HOS) Performance Measurement Reports. This section will guide the reader through the report sections, such as the Centers for Medicare & Medicaid Services (CMS) Medicare Star Ratings, and answer general questions about the reports and data. For further assistance, please refer to the Technical Assistance information below. Additionally, the "What's New in the HOS" section in this report has information about new website content, webinars, and HOS program updates.

### Technical Assistance

The Medicare HOS Information and Technical Support Telephone Line (1-888-880-0077) and the Email Address ([hos@HCQIS.org](mailto:hos@HCQIS.org)) are available to provide assistance with report questions and interpretation. Additionally, the CMS HOS website provides general information on the program (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/index.html>). A full description of the HOS program is available at [www.HOSonline.org](http://www.HOSonline.org).

### How to Use the Information Contained in this Report

The reports are designed to help MAOs identify opportunities to reduce health disparities and explore potential programmatic interventions aimed at maintaining or improving the overall health of their Medicare population. Health status indicators are displayed within demographic groups to emphasize where beneficiaries are doing poorly. This extra detail is included to help plans identify potential areas for further investigation.

### What information can I find in this Performance Measurement Report?

The results for key health indicators derived from the cohort of beneficiaries at baseline and the two-year follow up are provided in this report. Please refer below for a description of each report section and to the Table of Contents for the specific section pages.

- **Executive Summary:** highlights the sample distribution and response rates. Physical and mental health results describing changes over time, and baseline and follow up results for other key indicators are provided. Additionally, the MAO reports contain trend tables with the results for the most recent three cohorts, where available.
- **What's New in the HOS:** introduces new and updated HOS program information, such as self-paced training webinars and website resources, for MAOs and other data users.
- **HOS and the Star Ratings:** discusses the HOS measures that are currently used by CMS for the Medicare Star Ratings. Three of the measures are reported in the HOS Baseline Report and two of the measures are reported in the HOS Performance Measurement Report. Please note that the MAO *Improving Bladder Control* (MUI Treat Rate) measure in the baseline report was revised in 2015 and will not be reported in the 2016 or 2017 Medicare Star Ratings. Beginning with the 2012 Medicare Star Ratings, the *Osteoporosis Testing in Older Women* measure moved to the display measures on the CMS website and is not part of the Star Ratings.

- **Cohort 16 Distribution of the Sample and Response Rates:** summarizes the number of participating beneficiaries and the response rates at the MAO and national levels.
- **Cohort 16 Performance Measurement Results:** provides detailed result tables for the primary physical and mental health outcomes measures and other health indicators. Data estimates are provided to the second decimal place for the change score measures (better, same, and worse results) as these estimates are used in the Medicare Star Ratings. This section also provides demographic tables with values highlighted in **red** to indicate sub-groups that are worse off at follow up compared to their baseline. Question numbers in the measure definitions are from the 2015 HOS 3.0 at follow up and may differ from those in the 2013 HOS 2.5 at baseline.
- **Appendix 1:** describes the program, the questions used in the calculation of physical component summary (PCS) and mental component summary (MCS) scores, and the case-mix adjusted outcomes for the performance measurement results.
- **Appendix 2:** displays graphs for selected survey questions. Please note that the percentages in the graphs may not add to 100% due to rounding.
- **Appendix 3:** includes information about the HOS Partners involved in the survey management, instrument design, sampling, administration, report production, and research activities.
- **References:** lists journal articles, technical reports, and website references that are provided throughout the report.

**Where can I find additional HOS Program information, such as sampling methodology, and timelines for the reporting and data distribution?**

An overview of the HOS Program, the sampling schedule, and program timelines, are available on the “Program” page of the HOS website. A table of MAO report and data distribution is provided in the “Data Dissemination” section under the “Data” page of the website.

**Are HOS measures part of the CMS Medicare Star Ratings?**

HOS measures are included in the Medicare Star Ratings, which CMS developed to provide consumer information about MAOs and to reward health plans. CMS displays MAO information in the Medicare Plan Finder (MPF) tool on the <http://www.medicare.gov/find-a-plan> website and awards quality bonus payments to high performing health plans. For information about the Star Ratings, refer to the “HOS and the Star Ratings” section in this report.

**How are the Performance Measurement Reports distributed?**

All report distribution occurs electronically to participating MAOs through the CMS Health Plan Management System (HPMS), which requires an HPMS User ID. Downloads of the MAO report include summary-level data in a CSV file that can be opened in Excel and contains contract-level survey responses, demographic data, and the two HOS functional health measures from the Medicare Star Ratings. If assistance is required regarding HPMS access, please contact CMS at [hpms\\_access@cms.hhs.gov](mailto:hpms_access@cms.hhs.gov).

### **When will MAOs receive beneficiary level data for *Cohort 16 Performance Measurement*?**

The merged baseline and follow up beneficiary level data will be distributed to MAOs in the Fall of 2016. After distribution of their reports, MAOs are notified via the HPMS about the availability of their merged data and how to request it.

### **Where can I find overall survey results information for earlier HOS cohorts that can be compared to the information in this report?**

The “Survey Results” section under the “Survey” page on the HOS website provides a table depicting general status information at the national HOS level, including sample sizes, completed surveys, and response rates, for the baseline and follow up cohorts administered and reported to date. Participating MAOs may also access their earlier reports through the HPMS.

### **Where can I find the 2015 NCQA HEDIS® Measure results?**

The 2015 National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)<sup>5</sup> results for four measures are reported in the “NCQA HEDIS Measures” section in the *HOS 2015 Cohort 18 Baseline Report*. Specific elements of these measures are used for the Medicare Star Ratings. Additional information about the Medicare Star ratings is also available in the “HOS and the Star Ratings” section of the report.

### **Need More Help?**

- MAOs are encouraged to contact the HOS Technical Support Team at Health Services Advisory Group at [hos@HCQIS.org](mailto:hos@HCQIS.org) with questions.
- Additional information about peer-reviewed articles, technical reports, and manuals related to the HOS is available on the “Resources” page of the HOS website ([www.HOSonline.org](http://www.HOSonline.org)). Consult the “Home” page for a listing of new reports and general updates.
- A glossary consisting of definitions relevant to the Medicare HOS may be accessed from the “Glossary” link at the bottom of site webpages.
- The Medicare 2013 HOS 2.5 and 2015 HOS 3.0 questionnaires may be downloaded from the “Survey” page of the HOS website. In addition, the HOS questionnaires may also be found in the NCQA HEDIS 2013 and 2015, Volume 6 Specifications for the Medicare Health Outcomes Survey Manuals.<sup>6,7</sup> Copies of these manuals, as well as other HEDIS Volume 6 publications, may be purchased by calling the NCQA Customer Support Telephone Line at 1-888-275-7585 or via NCQA’s Secure Online Order Center ([www.ncqa.org](http://www.ncqa.org)). Beginning in 2015, the manual is available online for download from the “Survey Administration” section of the “Program” page on the HOS website ([www.HOSonline.org](http://www.HOSonline.org)).



## What's New in the HOS

### Implementation of HOS 3.0

In 2015, CMS implemented the Medicare HOS 3.0. Like the previous versions (HOS 2.0 and 2.5), the HOS 3.0 uses the Veterans RAND 12-Item Health Survey (VR-12) as the core physical and mental health outcomes measures and the four HEDIS Effectiveness of Care measures are the *Osteoporosis Testing in Older Women*, *Physical Activity in Older Adults*, *Management of Urinary Incontinence in Older Adults*, and *Fall Risk Management* measures. Modifications from the previous version (HOS 2.5) included: changes to questions about leakage of urine, osteoporosis testing in older women, sleep duration and quality, and primary language spoken in the home. In a formatting change, the new survey uses a two column layout for each page. The 2015 HOS 3.0 is available on the “Survey” page of the HOS website ([www.HOSonline.org](http://www.HOSonline.org)).

### HOS Website Enhancements

To improve access, usability, and function, the HOS website ([www.HOSonline.org](http://www.HOSonline.org)) has been migrated to a new web content management platform, and site design enhancements have been implemented.

The HOS website is a resource that provides:

- Historical overview of the project
- Updates on project activities
- Reports of ongoing research efforts
- Access to public use files and supporting documentation
- Clearinghouse of electronic information about journal articles, bibliographies, and technical reports relating to the HOS
- Links to project partners

### Semiannual HOS e-Newsletters

The HOS e-Newsletters contain information about HOS products, services, and timelines; program updates; availability of new self-paced training programs; and other relevant topics, such as sharing of best practices. E-Newsletters are circulated semiannually, in winter and summer, to MAO contacts and users of the HOS technical support, and are posted on the HOS website. If you would like to receive the e-Newsletters, contact the HOS Information and Technical Support team at [hos@HCQIS.org](mailto:hos@HCQIS.org).

### Self-Paced Training Webinars

A series of basic to advanced self-paced training webinars are available on the HOS website ([www.HOSonline.org](http://www.HOSonline.org)). The webinars run approximately 30 minutes in length and may be accessed at any time at the convenience of the user. To access the webinars, go to the “Trainings” section under the “Resources” page on the HOS website.



- **Introduction to the Medicare Health Outcomes Survey (HOS):** A basic training session appropriate for MAOs that are new to the HOS or those wanting to obtain an overview of the HOS. In addition, the introductory training program provides some practical guidance about how to obtain HOS reports and data.
- **Getting the Most from Your Medicare Health Outcomes Survey (HOS) Baseline Report:** An intermediate training session that builds on the information from the basic tutorial described above. The session discusses maximizing the use of the HOS Baseline Report to provide information on the health of beneficiaries and incorporating chronic care improvement programs (CCIPs) in quality improvement activities.
- **Using Your Medicare Health Outcomes Survey (HOS) Data:** An intermediate training session assisting MAOs with using their HOS data to identify priorities and assess the impact of interventions. It also demonstrates the advantages of linking HOS data with your own MAO data.
- **Understanding the Medicare Health Outcomes Survey (HOS) Performance Results Used in the MA Plan Ratings:** An advanced training session describing the methodology used in calculating the Performance Measurement Results. The tutorial discusses the primary health outcomes collected from the survey, the PCS and MCS scores, and how they are used to describe changes in the functional status of MAO beneficiaries over a two-year period. It also discusses how the HOS results are used in the Medicare Advantage (MA) Plan Ratings, also called the Medicare Star Ratings.

## Veterans RAND 12-Item Health Survey (VR-12) Website

Information about the VR-36, VR-12, and VR-6D instruments is available on the Boston University School of Public Health website. The website offers details on development, applications, and references for the VR-12, which is the core health outcomes measure in the Medicare HOS and HOS-M. For information about the instruments and to request permission to use the documentation and scoring algorithms, go to: <http://www.bu.edu/sph/research/research-landing-page/vr-36-vr-12-and-vr-6d>.

## Frequently Asked Questions (FAQs)

The “FAQs” link at the bottom of site webpages on the HOS website provides answers to frequently asked questions about the Medicare HOS. Examples are questions about how to find the HOS questionnaires, how MAOs may obtain their reports and data, and where to find quality improvement ideas and self-paced training webinars about the HOS. Information is also provided about the types of files available for researchers and how to obtain the files.

## CMS Approved Survey Vendors

The “Survey Vendors” section under the “Program” page on the HOS website provides a list of CMS approved survey vendors. There are eight survey vendors approved to administer the HOS.

## **Participating MAOs**

The current list of participating MAOs is found in the MAO Performance Measurement Contract List available on the “Survey Results” section under the “Survey” page of the HOS website ([www.HOSonline.org](http://www.HOSonline.org)).

## **National Cancer Institute (NCI) SEER-MHOS Linked Data Sets**

The Surveillance, Epidemiology, and End Results (SEER) and the Medicare Health Outcomes Survey (MHOS) linked data sets are available for researchers. The data sets contain data from cancer patient surveillance linked with patient-reported outcome measures. These data provide researchers with the potential to investigate the health status and Health-Related Quality of Life (HRQOL) of older adults enrolled in MAOs with and without a cancer diagnosis. The SEER-MHOS data sets include SEER data linked with HOS data from baseline and follow up surveys collected during the same time period. Direct person identifiers (i.e., name, address, SSN, and the Medicare Health Insurance Claim number) and plan identifiers (i.e., contract number and plan name) are removed from the linked datasets. Researchers who are interested in using this linked data in their investigations may go to the following website for information: <http://outcomes.cancer.gov/surveys/seer-mhos>.

## HOS and the Star Ratings

### Medicare Star Ratings

CMS developed the Medicare Star Ratings to help consumers compare health plans and providers based on quality and performance, to make accurate data more transparent and standardized among plans, and to reward top-performers. Consumers can use the Medicare Plan Finder (MPF) tool ([www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan)) to search for health plans in their geographic area and compare cost estimates and coverage information. CMS rates the relative quality of service and care provided by MAOs based on a five-star ratings scale that uses HOS measures combined with other measurement results. Up to 47 unique quality measures are included in the 2016 Medicare Part C and D Star Ratings. These measures include: providing preventive services, managing chronic illness, access to care, HEDIS measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) survey, and responsiveness.

The Medicare Part C Star Ratings include five contract level HOS measures: two measures of functional health and three HEDIS Effectiveness of Care measures. The HEDIS Effectiveness of Care measure *Improving Bladder Control* will not be reported in the 2016 or 2017 Medicare Star Ratings due to revisions to the measure; therefore, there will only be four HOS measures included these years.

The functional health measures are reported in each MAO's annual HOS Performance Measurement Report. The results are derived from the Veterans RAND 12-Item Health Survey (VR-12) portion of the HOS, which serves as the core source for the PCS and MCS scores. The final measures are based on the case-mix adjusted PCS and MCS score changes between baseline and follow up surveys, as well as death status. The *Improving or Maintaining Physical Health* measure is the "Physical Health Percent Better or Same" result in the Performance Measurement Report, and the *Improving or Maintaining Mental Health* measure is the "Mental Health Percent Better or Same" result.

The HEDIS Effectiveness of Care measures are reported in each MAO's annual HOS Baseline Report. These measures are calculated from questions about information and care beneficiaries receive from their healthcare providers, using data for the baseline and follow up cohorts from the same measurement year (i.e., a round of data). Responses are used to derive the following HEDIS measures: Management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women. CMS uses two components of these four measures for the Medicare Star Ratings. Further information is available in the "NCQA HEDIS Measures" section of the HOS Baseline Report:

- *Improving Bladder Control* is the Treatment of Urinary Incontinence rate (not reported in 2016 or 2017)
- *Monitoring Physical Activity* measure is the Advising Physical Activity rate
- *Reducing the Risk of Falling* measure is the Managing Fall Risk rate

## 2016 and 2017 Medicare Part C Star Ratings

The HOS cohorts related to data collection, report dissemination, and CMS Medicare Part C Star Ratings results are provided in the Medicare HOS Survey Administration Timeline Table below. This information will guide MAOs in understanding the sources of data used for specific Medicare Star Ratings Measures.

The 2016 Medicare Part C Star Ratings will be used by CMS as the basis for quality bonus payments to reward high performing contracts in the MA program in the 2017 quality bonus payment year. The 2017 quality bonus payments are based on two HOS datasets (refer to the **yellow** highlighted section in the table below). For instance, the HOS *2012-2014 Cohort 15 Merged Baseline and Follow Up* dataset was used for the two PCS and MCS functional health measures, and the combined *2014 Cohort 17 Baseline and 2014 Cohort 15 Follow Up* dataset was used for the two HEDIS Effectiveness of Care measures.

The 2017 Medicare Part C Star Ratings will be used by CMS as the basis for quality bonus payments in the 2018 quality bonus payment year (refer to the **green** highlighted section in the Table below). For the 2018 quality bonus payments, the *2013-2015 Cohort 16 Merged Baseline and Follow Up* dataset will be used for the two functional health measures, and the combined *2015 Cohort 18 Baseline and 2015 Cohort 16 Follow Up* dataset will be used for the two HEDIS Effectiveness of Care measures.

For more information about the Medicare Star Ratings, go to the CMS website at <http://go.cms.gov/partcanddstarratings>. For any questions related to Medicare Part C and D Star Ratings, you may send an email inquiry directly to [PartCandDStarRatings@cms.hhs.gov](mailto:PartCandDStarRatings@cms.hhs.gov). Please be sure to include your contract number in the email.

Medicare HOS Survey Administration and Star Ratings Timeline								
	Data Collection		HOS Reports		Medicare Part C Star Ratings			Quality Bonus
	Base-line	Follow Up	Base-line	Follow Up	2-yr PCS/MCS Change	HEDIS Measures*	Rating Year	Payment Year
2018	Cohort 21	Cohort 19	Cohort 20	Cohort 18	2014-2016 Cohort 17	2016 Cohort 19 Baseline & 2016 Cohort 17 Follow Up	2018	2018
2017	Cohort 20	Cohort 18	Cohort 19	Cohort 17	2013-2015 Cohort 16	2015 Cohort 18 Baseline & 2015 Cohort 16 Follow Up	2017	2017
2016	Cohort 19	Cohort 17	Cohort 18	Cohort 16	2012-2014 Cohort 15	2014 Cohort 17 Baseline & 2014 Cohort 15 Follow Up	2016	2016
2015	Cohort 18	Cohort 16	Cohort 17	Cohort 15	2011-2013 Cohort 14	2013 Cohort 16 Baseline & 2013 Cohort 14 Follow Up	2015	2015
2014	Cohort 17	Cohort 15	Cohort 16	Cohort 14	2010-2012 Cohort 13	2012 Cohort 15 Baseline & 2012 Cohort 13 Follow Up	2014	2014

\* Four HEDIS Effectiveness of Care Measures collected by the HOS are calculated from the combined round of baseline and follow up data by reporting year: Management of Urinary Incontinence in Older Adults; Physical Activity in Older Adults; Fall Risk Management; and Osteoporosis Testing in Older Women. Beginning with the 2012 Medicare Star Ratings, the Osteoporosis Testing in Older Women measure has moved to the display measures on the CMS website and is not part of the Star Ratings.

**Note:** The MUI measure was revised in 2015 and will not be reported for the 2016 or 2017 Medicare Star Ratings.

## MAO Resources for Best Practices and the Star Ratings

A resource guide titled “Opportunities for Improving Medicare HOS Results through Practices in Quality Preventive Health Care for the Elderly” is available on the HOS website at [http://hosonline.org/globalassets/hos-online/publications/opportunities\\_for\\_improving\\_medicare\\_hos\\_results\\_2012.pdf](http://hosonline.org/globalassets/hos-online/publications/opportunities_for_improving_medicare_hos_results_2012.pdf).<sup>8</sup> This guide helps MAOs develop and apply strategies that address the HOS items used in the CMS Medicare Part C Star Ratings including an overview of the HOS, national performance results on HOS items included in the Medicare Part C Star Ratings, best practices in promoting quality preventive health care for the elderly, and HOS resources available to MAOs. Section 1 discusses the prevalence of conditions measured by the HOS items and summarizes national HOS results to highlight opportunities for improvement and intervention strategies. Section 2 provides examples of interventions that some MAOs have used to promote patient/physician communication, screening services, or maintenance of functional status among their beneficiaries.

A companion literature review titled “Functional Status in Older Adults: Intervention Strategies for Impacting Patient Outcomes” is available on the HOS website at [http://www.hosonline.org/globalassets/hos-online/publications/functional\\_status\\_in\\_older\\_adults\\_2011.pdf](http://www.hosonline.org/globalassets/hos-online/publications/functional_status_in_older_adults_2011.pdf).<sup>9</sup> This literature review synthesizes selected articles about functional status outcomes in older adults and supplements the resource guide. The articles include outcomes that target assessments of health from well-established questionnaires spanning the physical to psychological. In addition, outcome measures include Activities of Daily Living (ADLs) that capture functional limitations in MA recipients. The articles were selected because they describe interventions that could impact functional status outcomes in elderly populations.

Both the resource guide and literature review may be downloaded from the “Trainings” section under the “Resources” page on the HOS website at [www.HOSonline.org](http://www.HOSonline.org).

## Cohort 16 Distribution of the Sample and Response Rates

The *Medicare HOS 2013 Cohort 16 Baseline* included a random sample of 578,074 beneficiaries, including both the aged and disabled, from 495 MAOs. Of those 578,074 individuals sampled, 47.2% (272,936) completed the baseline survey. A completed survey was defined as one that could be used to calculate a PCS or MCS score. Of those 272,936 respondents, 228,934 were seniors (age 65 or older) who returned a completed survey. During the two years between the *2013 Cohort 16 Baseline* survey and the *2015 Cohort 16 Follow Up* survey, several MAOs discontinued offering managed care to Medicare beneficiaries, or consolidated with other MAOs. As a result of these changes, 364 reporting units (MAOs), comprising 211,632 senior baseline respondents, remained in the HOS. For purposes of MAO comparisons, this group of 211,632 beneficiaries comprises the *Cohort 16 Performance Measurement* analytic sample.

The performance measurement results are based on the analytic sample of 211,632 (see Figure 2) and not the entire population sampled at baseline and follow up. At the national level, 15,555 beneficiaries died between baseline and the two-year follow up. Another 67,622 beneficiaries voluntarily disenrolled from their MAOs during the same two-year period. The remaining 128,455 seniors were still alive and enrolled in their original MAO at the time of follow up. These beneficiaries are referred to as the *Cohort 16 Performance Measurement* eligible sample. From the eligible sample, 1,371 beneficiaries were determined to be ineligible at follow up.<sup>C</sup> Of the remaining 127,084 beneficiaries, 34,826 did not respond and 92,258 returned a follow up survey that could be used to calculate a PCS or MCS score. These 92,258 individuals comprise the *Cohort 16 Performance Measurement* respondent sample, yielding a follow up response rate of 72.6%.<sup>D</sup>

Focusing on the 364 reporting units (MAOs) at follow up, the average number of respondents per MAO was 253, with a range of 2 to 3,848 respondents. Twenty-five percent of MAOs had 315 or more respondents, while 25% had 126 or less. Ten percent of the MAOs had 398 or more respondents, and 10% had 68 or fewer respondents. Based on the analytic criteria, the mean MAO level response rate at follow up was 71.0%, with a range of 33.3% to 84.6%. Twenty-five percent of MAOs had a response rate of 75.3% or greater, while 25% had a response rate of 68.0% or less. Ten percent of the MAOs had a response rate of 78.1% or higher, and 10% had a response rate of 63.3% or lower.

MAOs with a small number of respondents should exercise **caution** when drawing conclusions from the results as the sample size may be insufficient to allow meaningful interpretation.

<sup>C</sup> Ineligible beneficiaries at follow up met one of the following criteria: not enrolled in the MAO; had an incorrect address and phone number; or had a language barrier.

<sup>D</sup> The overall baseline and follow up response rates in the report are calculated after data processing and score calculation. Initial overall survey completion rates were calculated by NCQA following each data collection and used the criteria of at least 80% completion of survey items and all 6 Activity of Daily Living (ADL) questions answered. These initial rates may be reported elsewhere and will differ from the overall response rates in this report.

## MAO HXXXXA

The original baseline sample size for your MAO HXXXXA was 1,157; however, 746 beneficiaries were not included in the analytic sample because they did not complete the baseline survey, were not seniors, or were determined to be ineligible beneficiaries at baseline.<sup>E</sup> Therefore, your MAO's analytic sample size is 411. Of the 411 beneficiaries in your MAO's analytic sample, 154 voluntarily disenrolled from your MAO and 28 died between baseline and follow up. Of the 229 beneficiaries sent a follow up survey, 4 were determined to be ineligible. Of the remaining 225 beneficiaries, there were 58 who did not complete the survey and 167 who returned a completed follow up survey. This represented an overall follow up response rate of 74.2% for your MAO, as compared with the HOS follow up response rate of 72.6%.

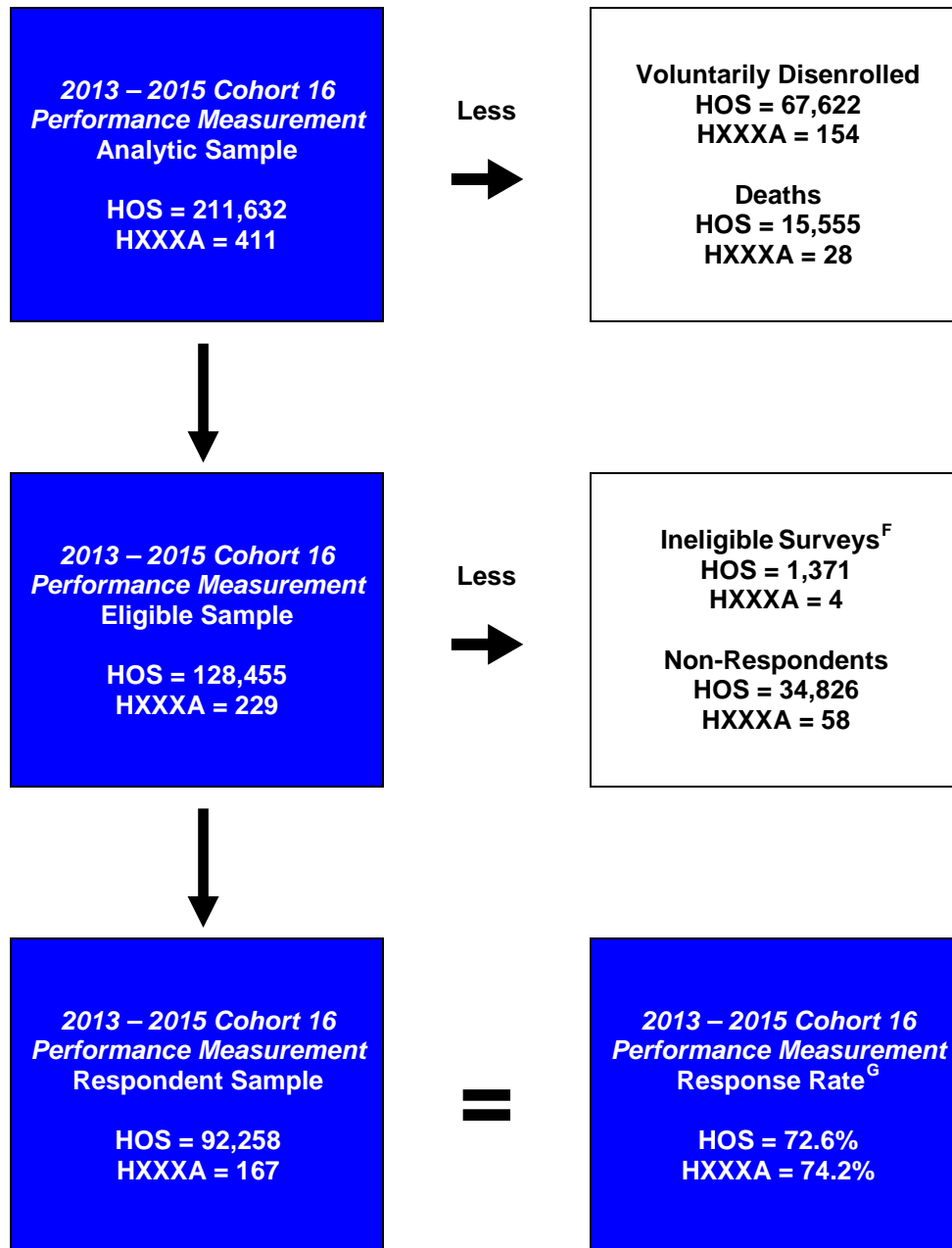
On the following page, Figure 2 presents the Distribution of the Performance Measurement Sample and Response Rates for the HOS Total, as well as for your MAO HXXXXA.

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<sup>E</sup> Ineligible beneficiaries at baseline met one of the following criteria: deceased; not enrolled in the MAO; had an incorrect address and phone number; had a language barrier, or were removed from sample.



**Figure 2: Distribution of the Performance Measurement Sample and Response Rates for HOS Total and MAO HXXXA**



<sup>F</sup> Beneficiaries with ineligible surveys at follow up met one of the following criteria: not enrolled in the MAO; had an incorrect address and phone number; or had a language barrier.

<sup>G</sup> Response Rate = [Respondent Sample/(Eligible Sample-Ineligible Surveys)] x 100%.



## ***Cohort 16 Performance Measurement Results***

The HOS 2013-2015 Cohort 16 Performance Measurement results describe change in health status over time for beneficiaries in your MAO HXXXXA. Health outcomes are assessed for a randomly selected set of beneficiaries from each participating MAO contract over a two-year interval, with a baseline measure and a two-year follow up. In general, functional health status, as measured by the PCS score, is expected to decline over time in older age groups, while mental health status as measured by the MCS score is not. The presence of one or more chronic medical conditions is associated with declines in both scores.<sup>10</sup> Though individual health status outcomes depend on individual medical care and personal circumstances, MAO performance may change over time, and is reported in the performance measurement results.

Case-mix variables of demographics and health as well as selected survey design variables are risk adjusted to make equitable health outcome comparisons across MAOs.<sup>6</sup> Risk-adjustment is a statistical technique that adjusts for variations in patient outcomes that stem from differences in existing patient characteristics rather than differences in performance between MAOs. The risk-adjusted outcomes are aggregated for the respondents in your MAO, and yield the MAO level performance measurement results.

The performance measurement analysis compares the percentages of beneficiaries in the MAO who are better, the same, or worse than expected at the two-year follow up in comparison to the national average for both physical and mental health. Death and PCS scores are combined into one overall measure of change in physical health, while mental health is measured by MCS scores alone. There are six main categories of actual health outcomes used in the performance measurement analysis:

1. Alive and physical health better
2. Alive and physical health the same
3. Dead or physical health worse
4. Mental health better
5. Mental health the same
6. Mental health worse

Beneficiaries who were seniors age 65 or older, and who completed the HOS at baseline with a calculable PCS or MCS score, were included in the performance measurement analysis. The MAO two-year death rate was determined from the performance measurement analytic sample. Beneficiaries who also had a calculable PCS or MCS score at follow up were included in the beneficiary level change score analysis.

Beneficiary level results were aggregated to derive the MAO and HOS national percentage values. The HOS national average is based on all MAOs that participated in performance measurement. Outliers are those MAOs that performed significantly better or significantly worse than expected when compared with the national average. MAOs may be outliers on a measure of physical health or on a measure of mental health. An MAO that differed from the HOS national average by less than  $\pm 2$  standard deviations over the two-year period (based on

case-mix adjusted results), is performing the same as expected. An MAO that had a significantly *higher* proportion of beneficiaries whose health remained stable or improved (Alive and PCS better or same; MCS better or same) over the two-year period is a positive outlier. An MAO that had a significantly *lower* proportion of beneficiaries whose health improved or remained stable over the two-year period is a negative outlier. For detailed information on the calculation of performance measurement results, see Appendix 1.

## Physical Health

Performance measurement results for physical health combine risk-adjusted two-year mortality rates and changes in PCS scores for the primary physical health outcome (Alive and PCS better or same). Over the two-year follow up period, 16.36% of beneficiaries at the national level had better physical health than expected, 51.46% were the same as expected, and 32.18% were worse than expected, compared with the national average. The case-mix adjusted results for mortality and PCS reveal that at the national level, MAOs differed significantly on both the mortality and PCS measures. An overall *F* test showed that mortality differed significantly at the MAO level ( $p < 0.0001$ ). “PCS better or same” differed significantly across all MAOs ( $p = 0.0486$ ), as did “PCS better” ( $p = 0.0008$ ).

Given that the physical health measures of both “Death” and “PCS better or same” differed significantly at the MAO level, an outlier analysis for the primary outcome (Alive and PCS better or same) was performed using t-tests. In the *Cohort 16 Performance Measurement* results, there were a total of 20 PCS outliers; 7 MAOs were identified as performing better than expected and 13 MAOs were identified as performing worse than expected, compared with the national average for physical health.

### *How Is Your MAO Doing?*

On the next page, Table 7 depicts the Physical Health Performance Measurement results for your MAO HXXXXA, each MAO in the state, the state, and HOS Total. Note that the Medicare Star Ratings measure for *Improving or Maintaining Physical Health* is derived from the combined “Percent Better+Same” results (67.82% for the HOS Total in the table).

*In terms of physical health, your MAO performed as expected when compared to the HOS national average.*

**Table 7: 2013-2015 Cohort 16 Physical Health Performance Measurement Results for MAOs in the state, StateXX and HOS Total**

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
HXXXXA	16.56%	50.26%	33.18%	66.82%	↔
HXXXXB	15.78%	52.80%	31.42%	68.58%	↔
HXXXXC	15.99%	49.12%	34.89%	65.11%	↔
HXXXXD	18.15%	49.51%	32.33%	67.67%	↔
HXXXXE	17.79%	50.67%	31.54%	68.46%	↔
StateXX	16.60%	50.42%	32.97%	67.03%	
HOS Total	16.36%	51.46%	32.18%	67.82%	

\* The percent better, same, worse, or better+same refers to beneficiary health status within an MAO.

\*\* The statistical significance of the performance result for the MAO is indicated by one of the following symbols:

↑ MAO performed significantly better than expected (higher than the national average)

↓ MAO performed significantly worse than expected (lower than the national average)

↔ MAO performed as expected (the same as the national average)

Data estimates are provided to the second decimal place for PCS and MCS change score measures as these estimates are used in the Medicare Star Ratings.

## Mental Health

Performance measurement results for mental health are based on risk-adjusted two-year changes in MCS scores for the primary mental health outcome (MCS better or same). Over the two-year follow up period for mental health (MCS) at the national level, 21.24% of beneficiaries were better than expected, 63.99% were the same as expected, and 14.77% were worse than expected. The case-mix adjusted results for MCS reveal that at the national level MAOs differed significantly on this measure also. An overall *F* test showed that “MCS better or same” differed significantly at the MAO level ( $p = 0.0016$ ), as did “MCS better” ( $p < 0.0001$ ).

Given that the primary mental health outcome measure (MCS better or same) differed significantly at the MAO level, outlier analysis for MCS was performed using t-tests. In the *Cohort 16 Performance Measurement* results, there were a total of 22 MCS outliers: 7 MAOs were identified as performing better than expected and 15 MAOs were identified as performing worse than expected compared with the national average for the mental health.

The MCS may also be used as a screening tool for depression risk. Previous research suggested that individuals from a sample of the 1998 U.S. general population who have an MCS score of 42 or below are at increased risk for depression.<sup>10</sup> However, more recent results from a Medicare population suggest an MCS score of 48 or below provides a reasonably predictive cut-off for depression risk in the elderly Medicare population.<sup>11</sup>

### *How Is Your MAO Doing?*

On the next page, Table 8 depicts the Mental Health Performance Measurement results for your MAO HXXXXA, each MAO in the state, the state, and HOS Total. Note that the Medicare Star Ratings measure for *Improving or Maintaining Mental Health* is derived from the combined “Percent Better+Same” result (85.23% for the HOS Total in the table).

*In terms of mental health, your MAO performed as expected when compared to the HOS national average.*

**Table 8: 2013-2015 Cohort 16 Mental Health Performance Measurement Results for MAOs in the state, StateXX and HOS Total**

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
HXXXXA	21.52%	62.45%	16.03%	83.97%	↔
HXXXXB	20.81%	63.36%	15.83%	84.17%	↔
HXXXXC	23.34%	61.90%	14.76%	85.24%	↔
HXXXXD	22.69%	61.78%	15.53%	84.47%	↔
HXXXXE	21.07%	63.26%	15.67%	84.33%	↔
StateXX	21.42%	63.44%	15.13%	84.87%	
HOS Total	21.24%	63.99%	14.77%	85.23%	

Please note: There were changes to the survey format in the 2015 HOS 3.0 that resulted in an increase in MCS scores for the Cohort 16 Follow Up mail mode administration.

\* The percent better, same, worse, or better+same refers to beneficiary health status within an MAO.

\*\* The statistical significance of the performance result for the MAO is indicated by one of the following symbols:

↑ MAO performed significantly better than expected (higher than the national average)

↓ MAO performed significantly worse than expected (lower than the national average)

↔ MAO performed as expected (the same as the national average)

Data estimates are provided to the second decimal place for PCS and MCS change score measures as these estimates are used in the Medicare Star Ratings.

## Demographics

Table 9 presents the distribution of beneficiaries' age, gender, race, marital status, educational level, annual household income, and Medicaid status at baseline and follow up for your MAO and the HOS Total respondent sample.

**Table 9: 2013-2015 Cohort 16 Performance Measurement Demographics for MAO HXXXXA and HOS Total at Baseline and Follow Up**

	MAO HXXXXA		HOS Total	
	Baseline	Follow Up	Baseline	Follow Up
<b>Age</b>	(N=167)	(N=167)	(N=92,258)	(N=92,258)
65-69	28.7%	15.0%	29.8%	17.0%
70-74	27.5%	26.3%	27.7%	30.4%
75-79	13.2%	23.4%	19.8%	22.4%
80-84	18.6%	18.0%	13.5%	16.4%
85+	12.0%	17.4%	9.1%	13.8%
<b>Gender</b>	(N=167)	(N=167)	(N=92,258)	(N=92,258)
Male	39.5%	39.5%	41.1%	41.1%
Female	60.5%	60.5%	58.9%	58.9%
<b>Race</b>	(N=167)	(N=167)	(N=92,258)	(N=92,258)
White	90.4%	90.4%	84.6%	84.6%
Black	5.4%	5.4%	8.3%	8.3%
Other/Unknown	4.2%	4.2%	7.0%	7.0%
<b>Marital Status</b>	(N=164)	(N=163)	(N=90,360)	(N=89,179)
Married	59.8%	56.4%	56.3%	53.8%
Widowed	25.0%	26.4%	24.3%	27.4%
Divorced or Separated	11.6%	13.5%	15.3%	14.8%
Never Married	3.7%	3.7%	4.1%	4.0%
<b>Education</b>	(N=163)	(N=160)	(N=89,975)	(N=88,135)
Did Not Graduate HS	19.6%	20.0%	19.6%	19.3%
High School Graduate	35.6%	36.3%	33.7%	34.0%
Some College	23.9%	25.0%	24.5%	24.2%
4 Year Degree or Beyond	20.9%	18.8%	22.2%	22.5%
<b>Annual Household Income</b>	(N=152)	(N=152)	(N=84,365)	(N=81,871)
Less than \$10,000	11.8%	13.2%	11.0%	10.3%
\$10,000-\$19,999	15.1%	13.2%	18.9%	17.6%
\$20,000-\$29,999	20.4%	16.4%	17.2%	16.5%
\$30,000-\$49,999	19.1%	19.1%	21.4%	21.5%
\$50,000 or More	22.4%	27.6%	21.1%	22.3%
Don't Know	11.2%	10.5%	10.5%	11.8%
<b>Medicaid Status</b>	(N=167)	(N=167)	(N=92,256)	(N=92,251)
Medicaid	11.4%	16.2%	15.7%	16.5%
Non-Medicaid	88.6%	83.8%	84.3%	83.5%

## General Health and Comparative Health

### Definition of Measures

- General health status is a self-reported measure of health perception using ratings of “Excellent,” “Very good,” “Good,” “Fair,” or “Poor.”<sup>12</sup> This measure is found in Question 1 of the 2015 HOS 3.0.
- Two measures of physical and mental health compared with one year ago use ratings of “Much better,” “Slightly better,” “About the same,” “Slightly worse,” or “Much worse.” These measures are found in Questions 8 and 9 of the 2015 HOS.

General self-rated health status is a valid and reliable method for assessing health across different populations.<sup>2</sup> Individuals who indicate that their general health was “Fair” or “Poor,” or that their physical or mental health compared with one year ago was “Slightly worse” or “Much worse,” are known to be at increased risk for near future hospitalization, use of mental health services, and mortality.<sup>2,13,14</sup>

### How Is Your MAO Doing?

Table 10 presents the distribution of beneficiaries across *self-rated general health, physical health compared to one year ago, and mental health compared to one year ago* for MAO HXXXXA and the HOS Total respondent sample at baseline and follow up.

**Table 10: 2013-2015 Cohort 16 Performance Measurement Frequency of Self-Rated General and Comparative Health Responses for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Self-Rated Health Status	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
<b>General Health</b>				
Excellent to Good*	132 (79.0%)	128 (77.6%)	70,448 (77.6%)	68,289 (74.9%)
Fair or Poor	35 (21.0%)	37 (22.4%)	20,334 (22.4%)	22,826 (25.1%)
<b>Comparative Health-Physical</b>				
Much Better to About the Same**	130 (79.3%)	113 (70.6%)	70,673 (76.9%)	66,026 (73.6%)
Slightly Worse or Much Worse	34 (20.7%)	47 (29.4%)	21,246 (23.1%)	23,668 (26.4%)
<b>Comparative Health-Mental</b>				
Much Better to About the Same**	150 (92.0%)	139 (88.5%)	80,738 (88.8%)	78,368 (88.6%)
Slightly Worse or Much Worse	13 ( 8.0%)	18 (11.5%)	10,199 (11.2%)	10,108 (11.4%)

\* Categories for general health included “Excellent,” “Very good,” or “Good.”

\*\* Categories for comparative health included “Much better,” “Slightly better,” or “About the same.”

## Depression

### Definition of Measure

- For the depression measure, the HOS includes two questions (Questions 39a and 39b in the 2015 HOS 3.0) that serve as a depression screen. Each question is assigned points depending on the response given, from zero (“not at all”) to 3 (“nearly every day”). A Medicare beneficiary is considered to have a positive depression screen when scoring three or greater on the sum of the points from the two depression questions.

Individuals with a positive depression screen may be at risk for depressive disorders. Depression is undetected and under-diagnosed in the majority of the elderly Medicare population, and is a significant health problem that has been linked to poor health outcomes.<sup>11,15</sup> Depression is also significantly associated with other psychological dysfunction, as well as the presence of common chronic medical conditions, such as diabetes.<sup>16,17</sup> Depression screening tools, such as the one used in the HOS, have been developed for use in clinical settings to rapidly identify individuals at risk for major depression. It is recommended that those with positive depression screens be followed-up by more comprehensive diagnostic evaluations to identify whether or not they have major depression.<sup>18</sup> Due to the change in the depression screening questions in 2013, estimates of the proportion with positive depression screens from the 2013 and subsequent surveys should not be compared to estimates produced using past HOS versions (see Questions 36-39 on the 2012 HOS 2.0 Instrument and Glossary description of the depression screen on the HOS website<sup>19,20</sup>).

### How Is Your MAO Doing?

Table 11 depicts the percentage of beneficiaries with a positive depression screen, and the distribution of responses to the two individual depression questions for MAO HXXXXA, and the HOS Total respondent sample at baseline and follow up.

**Table 11: 2013-2015 Cohort 16 Performance Measurement Frequency of Positive Depression Screen Responses for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Depression Screening Questions	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
<b>Little interest or pleasure in doing things in past two weeks</b>				
Not at all (0 pt)	131 (80.4%)	117 (74.1%)	67,018 (73.9%)	62,420 (70.7%)
Several days (1 pt)	21 (12.9%)	27 (17.1%)	14,964 (16.5%)	16,497 (18.7%)
More than half the days (2 pt)	5 (3.1%)	5 (3.2%)	5,045 (5.6%)	5,121 (5.8%)
Nearly every day (3 pt)	6 (3.7%)	9 (5.7%)	3,718 (4.1%)	4,265 (4.8%)
<b>Feeling down, depressed, or hopeless in past two weeks</b>				
Not at all (0 pt)	132 (82.0%)	122 (75.8%)	71,050 (78.5%)	67,907 (76.8%)
Several days (1 pt)	20 (12.4%)	26 (16.1%)	13,593 (15.0%)	14,928 (16.9%)
More than half the days (2 pt)	3 (1.9%)	4 (2.5%)	3,509 (3.9%)	3,312 (3.7%)
Nearly every day (3 pt)	6 (3.7%)	9 (5.6%)	2,310 (2.6%)	2,324 (2.6%)
<b>Positive Depression Screen*</b>	11 (6.9%)	16 (10.3%)	8,399 (9.4%)	8,946 (10.2%)

\* A positive depression screen is defined as scoring 3 points or greater on the sum total of the two depression questions listed.



## Pain

### Definition of Measure

- Three questions measure self-reported pain over the previous seven days. In the 2015 HOS 3.0, Question 36 asks how much pain interfered with day-to-day activities and Question 37 asks how often pain kept the beneficiary from socializing. Both Questions 36 and 37 have five possible categorical responses. Question 38 asks the beneficiary to rate his or her average pain, ranging from 1 (“no pain”) to 10 (“worst imaginable pain”).

Self-reported pain is common among seniors. Without proper pain management, opioid abuse<sup>21,22</sup> and alcohol abuse<sup>23</sup> are increasing among seniors as they attempt to control their pain. Pain screening is the initial step in establishing an appropriate pain management program for elderly beneficiaries. In fact, The Joint Commission requires universal pain screening in accredited hospitals, clinics, and long-term care facilities.<sup>24</sup>

### How Is Your MAO Doing?

Table 12 shows the distribution of self-rated pain scores, grouped into categories, for MAO HXXXXA and the HOS Total respondent sample at baseline and follow up.

**Table 12: 2013-2015 Cohort 16 Performance Measurement Frequency of Self-Rated Pain Score for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Pain Score	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
1 (None)	37 (22.7%)	39 (24.4%)	28,560 (31.6%)	25,315 (28.8%)
2-4	85 (52.1%)	80 (50.0%)	38,551 (42.6%)	38,974 (44.4%)
5-7	31 (19.0%)	34 (21.3%)	16,780 (18.6%)	17,160 (19.5%)
8-10	10 (6.1%)	7 (4.4%)	6,521 (7.2%)	6,405 (7.3%)

Table 13 illustrates the relationship between the reported extent that pain interfered with day-to-day activities and the mean unadjusted PCS score for MAO HXXXXA and the HOS Total respondent sample at baseline and follow up.

**Table 13: 2013-2015 Cohort 16 Performance Measurement Mean Unadjusted PCS Score at Baseline and Follow Up by Extent Pain Interfered with Day-to-Day Activities at Follow Up for MAO HXXXXA and HOS Total**

Extent Pain Interfered with Day-to-Day Activities	MAO HXXXXA		HOS Total	
	Baseline Mean (SD)	Follow Up Mean (SD)	Baseline Mean (SD)	Follow Up Mean (SD)
Not at All	48.3 ( 7.9)	48.2 ( 7.3)	47.5 ( 8.9)	48.0 ( 8.5)
A Little Bit	39.7 (11.3)	37.6 (10.2)	41.0 (10.0)	39.7 ( 9.2)
Somewhat	35.8 ( 8.6)	32.0 ( 8.1)	35.1 (10.3)	32.0 ( 8.9)
Quite a Bit	29.6 ( 6.2)	25.7 ( 8.5)	29.9 (10.4)	25.3 ( 8.3)
Very Much	29.7 (14.0)	22.1 ( 8.1)	25.9 (10.7)	20.6 ( 8.6)

Table 14 shows the relationship between the reported extent that pain interfered with socialization with others and the mean unadjusted MCS score for MAO HXXXXA and the HOS Total respondent sample at baseline and follow up only.

**Table 14: 2013-2015 Cohort 16 Performance Measurement Mean Unadjusted MCS Score at Baseline and Follow Up by Extent Pain Interfered with Socializing with Others at Follow Up for MAO HXXXXA and HOS Total**

Extent Pain Interfered with Socializing with Others	MAO HXXXXA		HOS Total	
	Baseline Mean (SD)	Follow Up Mean (SD)	Baseline Mean (SD)	Follow Up Mean (SD)
Never	55.5 ( 8.6)	56.9 ( 7.7)	55.9 ( 8.1)	57.5 ( 7.1)
Rarely	56.1 ( 7.5)	55.4 ( 8.3)	51.1 (10.0)	52.1 ( 9.6)
Sometimes	50.4 ( 7.4)	48.2 ( 8.6)	47.1 (11.1)	46.9 (10.7)
Often	42.4 (16.9)	33.5 (14.7)	43.1 (12.4)	41.5 (12.3)
Always	42.5 (21.8)	15.0 ( 7.2)	40.0 (13.6)	35.9 (14.1)

## Chronic Medical Conditions

### *Definition of Measure*

- The chronic medical condition questions measure the prevalence of chronic disease across the beneficiary's lifespan. These measures are found in Questions 20-34 of the 2015 HOS 3.0. Depression was added to the chronic condition list in 2013. The presence of many common chronic medical conditions is assessed in the HOS using the question: "Has a doctor ever told you that you had (the specified condition)?" Beneficiaries who answered "Yes" were counted as having the condition.

For older adults, chronic medical conditions reduce the quality of life, accelerate a decline in functioning, and can lead to conflicting medical advice and higher health care costs.<sup>25,26</sup>

Research on chronic conditions in the Medicare managed care elderly found that arthritis of the hip/knee contributed to a greater decline in beneficiaries' physical health, compared with other chronic conditions in the HOS.<sup>27</sup> Increasing age is a risk factor for the development of Type 2 Diabetes Mellitus (DM), as well as for the development of complications of DM.<sup>28</sup> In addition, cardiovascular disease (CVD) is the leading cause of morbidity and mortality among diabetics.<sup>29</sup>

The increased cost associated with chronic disease is an important factor driving overall Medicare spending.<sup>30</sup> According to the U.S. Department of Health and Human Services, two of three adults over the age of 65 have multiple chronic conditions and the need for coordinated care.<sup>31</sup> An important feature of the Medicare HOS is the ability to report and quantify various chronic medical conditions in the Medicare Advantage (MA) population.

### *How Is Your MAO Doing?*

Table 15 shows the prevalence of 15 chronic medical conditions for MAO HXXXXA and the HOS Total respondent sample. The chronic medical conditions are quantified in the HOS when beneficiaries positively respond to the question, "Has a doctor ever told you that you had (the specified condition)?"

**Table 15: 2013-2015 Cohort 16 Performance Measurement Prevalence of Chronic Medical Conditions for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Medical Conditions	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
Hypertension	113 (67.7%)	110 (68.8%)	61,281 (66.8%)	60,353 (67.5%)
Arthritis - Hip or Knee	69 (42.3%)	69 (43.4%)	37,947 (41.6%)	39,373 (44.2%)
Arthritis - Hand or Wrist	52 (31.7%)	63 (39.1%)	31,647 (34.7%)	32,406 (36.4%)
Diabetes	39 (23.5%)	44 (27.3%)	23,035 (25.2%)	23,317 (26.1%)
Sciatica	38 (23.0%)	40 (24.8%)	19,806 (21.7%)	21,649 (24.3%)
Other Heart Conditions	31 (19.1%)	31 (19.5%)	18,607 (20.4%)	19,802 (22.3%)
Osteoporosis	31 (18.9%)	27 (16.9%)	18,036 (19.8%)	18,870 (21.2%)
Pulmonary Disease	34 (20.6%)	33 (20.6%)	13,772 (15.0%)	15,436 (17.2%)
Depression	17 (10.4%)	23 (14.4%)	14,843 (16.3%)	14,600 (16.4%)
Any Cancer (except skin cancer)	21 (12.7%)	20 (12.7%)	13,908 (15.2%)	13,576 (15.7%)
Coronary Artery Disease	17 (10.3%)	16 (10.3%)	11,703 (12.9%)	12,440 (14.1%)
Myocardial Infarction	16 ( 9.6%)	11 ( 6.9%)	7,778 ( 8.5%)	8,091 ( 9.1%)
Congestive Heart Failure	10 ( 6.1%)	17 (10.6%)	6,378 ( 7.0%)	7,667 ( 8.6%)
Stroke	8 ( 4.8%)	11 ( 6.8%)	6,331 ( 6.9%)	6,713 ( 7.5%)
Gastrointestinal Disease	8 ( 4.8%)	4 ( 2.5%)	4,302 ( 4.7%)	4,206 ( 4.7%)

Table 16 presents the frequencies of beneficiaries who reported none, one, two, three, or four or more chronic medical conditions at baseline and follow up for your MAO and the HOS Total respondent sample.

**Table 16: 2013-2015 Cohort 16 Performance Measurement Number of Chronic Medical Conditions for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Number of Conditions	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
None	13 ( 7.8%)	14 ( 8.6%)	7,807 ( 8.5%)	6,766 ( 7.5%)
1 Condition	26 (15.6%)	17 (10.5%)	15,243 (16.5%)	13,519 (15.0%)
2 Conditions	30 (18.0%)	40 (24.7%)	18,056 (19.6%)	16,969 (18.8%)
3 Conditions	39 (23.4%)	32 (19.8%)	16,139 (17.5%)	15,833 (17.6%)
4 or More Conditions	59 (35.3%)	59 (36.4%)	35,011 (37.9%)	37,049 (41.1%)

In Table 17, the means and standard deviations (SD) for unadjusted PCS and MCS scores at follow up are presented, grouped by the number of chronic medical conditions reported, for your MAO and the HOS Total respondent sample.

**Table 17: 2013-2015 Cohort 16 Performance Measurement Mean Unadjusted PCS and MCS Scores at Follow Up by Number of Chronic Medical Conditions at Follow Up for MAO HXXXXA and HOS Total**

Number of Conditions†	Mean (SD) Unadjusted PCS		Mean (SD) Unadjusted MCS	
	MAO HXXXXA	HOS Total	MAO HXXXXA	HOS Total
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
None	50.8 ( 7.7)	49.5 ( 8.1)	60.2 ( 3.7)	57.5 ( 6.5)
1 Condition	42.7 ( 7.0)	47.0 ( 9.4)	57.5 ( 6.3)	56.9 ( 7.2)
2 Conditions	41.9 (11.0)	44.0 (10.3)	57.1 ( 6.0)	56.2 ( 8.2)
3 Conditions	39.8 ( 9.4)	40.5 (11.0)	54.4 ( 8.9)	55.2 ( 9.2)
4 or More Conditions	32.9 (12.0)	33.2 (11.5)	49.0 (13.7)	51.0 (11.8)

† If no beneficiaries reported for a category, the result is *not applicable* (NA). If only one member reported in a category, the standard deviation (SD) was *not calculated* (NC).

## Activities of Daily Living

### Definition of Measure

- ADLs refer to a set of common daily tasks that are necessary for personal self-care and independent living.<sup>32</sup> ADLs include bathing, dressing, eating, getting in or out of chairs, walking, and using the toilet. These measures are found in Question 10 of the 2015 HOS 3.0. Impairment with ADLs is defined as beneficiaries who reported either difficulty or inability to perform the specific ADL (“Yes, I have difficulty” or “I am unable to do this activity”).
- Instrumental Activities of Daily Living (IADLs) assess independent living skills that are more complex than ADLs.<sup>33,34</sup> IADLs include preparing meals, managing money, and taking medications. These measures are in Question 11 of the 2015 HOS 3.0. For IADLs, impairment is defined as beneficiaries who reported difficulty performing the specific IADL (“Yes, I have difficulty”).

### How Is Your MAO Doing?

Table 18 shows the numbers and percentages of beneficiaries with impairment in each of the six ADLs and three IADLs for your MAO and the HOS Total respondent sample at baseline and follow up, where available.

**Table 18: 2013-2015 Cohort 16 Performance Measurement Prevalence of Impaired ADLs and IADLs for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Impairment Type	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
<b>Activities of Daily Living</b>				
Ability Walking	46 (27.5%)	53 (32.9%)	24,718 (26.8%)	28,737 (32.2%)
Ability Getting In/Out of Chairs	28 (16.8%)	31 (19.3%)	16,998 (18.4%)	18,655 (20.8%)
Ability Bathing	19 (11.4%)	21 (13.0%)	10,546 (11.4%)	12,266 (13.7%)
Ability Dressing	16 ( 9.6%)	19 (11.8%)	8,388 ( 9.1%)	9,250 (10.3%)
Ability Using the Toilet	10 ( 6.0%)	12 ( 7.4%)	6,138 ( 6.7%)	6,860 ( 7.7%)
Ability Eating	5 ( 3.0%)	11 ( 6.9%)	3,317 ( 3.6%)	3,926 ( 4.4%)
<b>Instrumental Activities of Daily Living*</b>				
Preparing Meals	11 ( 7.2%)	13 ( 8.9%)	7,218 ( 8.6%)	8,079 (10.0%)
Managing Money	6 ( 3.8%)	7 ( 4.7%)	4,140 ( 4.7%)	3,901 ( 4.6%)
Taking Medications as Prescribed	4 ( 2.5%)	8 ( 5.2%)	3,671 ( 4.1%)	3,743 ( 4.4%)

\* Respondents who indicated “I don’t do this activity” to IADL questions were removed from the denominator.

Table 19 presents the frequencies of ADL and IADL impairments at baseline and follow up for your MAO and the HOS Total respondent sample. The ability to perform ADLs is predictive of current disease status and mortality risk,<sup>35,36</sup> while IADLs recognize earlier changes in functioning, and can indicate the need for intervention or further medical work-up.<sup>34</sup>

**Table 19: 2013-2015 Cohort 16 Performance Measurement Number of ADL and IADL Impairments for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Number of Impairments	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
<b>Activities of Daily Living</b>				
None	112 (67.1%)	98 (60.5%)	63,529 (68.9%)	57,135 (63.3%)
1 ADL Impairment	26 (15.6%)	31 (19.1%)	10,710 (11.6%)	13,089 (14.5%)
2 ADL Impairments	14 ( 8.4%)	12 ( 7.4%)	7,694 ( 8.3%)	8,393 ( 9.3%)
3 or More ADL Impairments	15 ( 9.0%)	21 (13.0%)	10,325 (11.2%)	11,662 (12.9%)
<b>Instrumental Activities of Daily Living*</b>				
None	148 (90.8%)	141 (88.1%)	79,886 (87.8%)	76,710 (86.6%)
1 IADL Impairment	10 ( 6.1%)	13 ( 8.1%)	8,102 ( 8.9%)	8,885 (10.0%)
2 IADL Impairments	4 ( 2.5%)	3 ( 1.9%)	2,034 ( 2.2%)	2,093 ( 2.4%)
3 IADL Impairments	1 ( 0.6%)	3 ( 1.9%)	953 ( 1.0%)	884 ( 1.0%)

\*Respondents who indicated “I don’t do this activity” to IADL questions were removed from the denominator.

Table 20 presents means and SDs for unadjusted PCS and MCS scores by the number of ADL and IADL impairments at follow up for your MAO and the HOS Total respondent sample. Multiple ADL impairments are associated with substantially lower PCS and MCS scores for the HOS respondents.

**Table 20: 2013-2015 Cohort 16 Performance Measurement Mean Unadjusted PCS and MCS Scores at Follow Up by Number of ADL and IADL Impairments at Follow Up for MAO HXXXXA and HOS Total**

Impairment Type†	Mean (SD) Unadjusted PCS		Mean (SD) Unadjusted MCS	
	MAO HXXXXA	HOS Total	MAO HXXXXA	HOS Total
<b>Activities of Daily Living</b>				
None	44.6 ( 8.9)	45.9 ( 8.9)	55.9 ( 8.0)	56.5 ( 7.6)
1 ADL Impairment	35.5 (10.0)	33.6 ( 9.4)	53.7 (10.1)	53.7 (10.4)
2 ADL Impairments	34.1 ( 9.2)	29.1 ( 9.0)	55.7 (11.2)	51.3 (11.4)
3 or More ADL Impairments	22.0 ( 6.7)	24.4 ( 8.6)	43.2 (15.4)	44.2 (13.2)
<b>Instrumental Activities of Daily Living*</b>				
None	41.3 (10.4)	42.1 (11.1)	55.5 ( 8.2)	55.7 ( 8.6)
1 IADL Impairment	24.9 ( 8.4)	27.0 (10.2)	44.9 (16.1)	46.8 (12.2)
2 IADL Impairments	32.2 (19.3)	27.4 ( 9.5)	45.4 (20.0)	40.6 (11.9)
3 IADL Impairments	19.5 ( 5.2)	26.6 ( 8.8)	29.0 (21.7)	38.2 (11.7)

† If no beneficiaries reported for a category, the result is *not applicable* (NA). If only one member reported in a category, the standard deviation (SD) was *not calculated* (NC).

\* Respondents who indicated “I don’t do this activity” to IADL questions were removed from the denominator.

## Healthy Days

### *Definition of Measure*

- Physically unhealthy days is a self-reported measure of the number of days during the past 30 days when physical health was not good. The measure is found in Question 12 of the 2015 HOS 3.0.
- Mentally unhealthy days is a self-reported measure of the number of days during the past 30 days when mental health was not good. The measure is found in Question 13 of the 2015 HOS.
- Days with activity limitations is a self-reported measure of the number of days during the past 30 days when poor physical or mental health kept the beneficiary from usual activities. The measure is found in Question 14 of the 2015 HOS.

Healthy Days Measures provide key information about the functional status of vulnerable sub-populations, and are used to assess the HRQOL<sup>37</sup> across the U.S. As sentinel indicators of present and future disease and injury risk, MAOs can use Healthy Days Measures to identify vulnerable sub-populations for effective preventative care and disease management. According to the CDC, “In recent years, several organizations have found these Healthy Days Measures useful at the national, state, and community levels for (1) identifying health disparities, (2) tracking population trends, and (3) building broad coalitions around a measure of population health compatible with the World Health Organization’s definition of health.”<sup>38</sup>

### *How Is Your MAO Doing?*

Table 21 provides the frequency distributions of Healthy Days Measures for your MAO and HOS Total respondent sample.

**Table 21: 2013-2015 Cohort 16 Performance Measurement Distribution of Healthy Days Measures for MAO HXXXXA and HOS Total at Baseline and Follow Up**

Healthy Days Measures	MAO HXXXXA		HOS Total	
	Baseline	Follow Up	Baseline	Follow Up
<b>Physically Unhealthy Days</b>	(N=162)	(N=155)	(N=89,172)	(N=86,893)
None	58.6%	59.4%	60.2%	55.4%
1-13	29.6%	21.9%	23.7%	25.7%
14-30	11.7%	18.7%	16.1%	18.9%
<b>Mentally Unhealthy Days</b>	(N=164)	(N=159)	(N=89,628)	(N=87,158)
None	78.0%	67.3%	72.3%	69.9%
1-13	15.2%	22.0%	18.8%	20.3%
14-30	6.7%	10.7%	8.9%	9.8%
<b>Days with Activity Limitations</b>	(N=160)	(N=163)	(N=89,542)	(N=87,625)
None	76.3%	73.0%	75.5%	71.7%
1-13	15.0%	15.3%	13.9%	15.7%
14-30	8.8%	11.7%	10.6%	12.5%



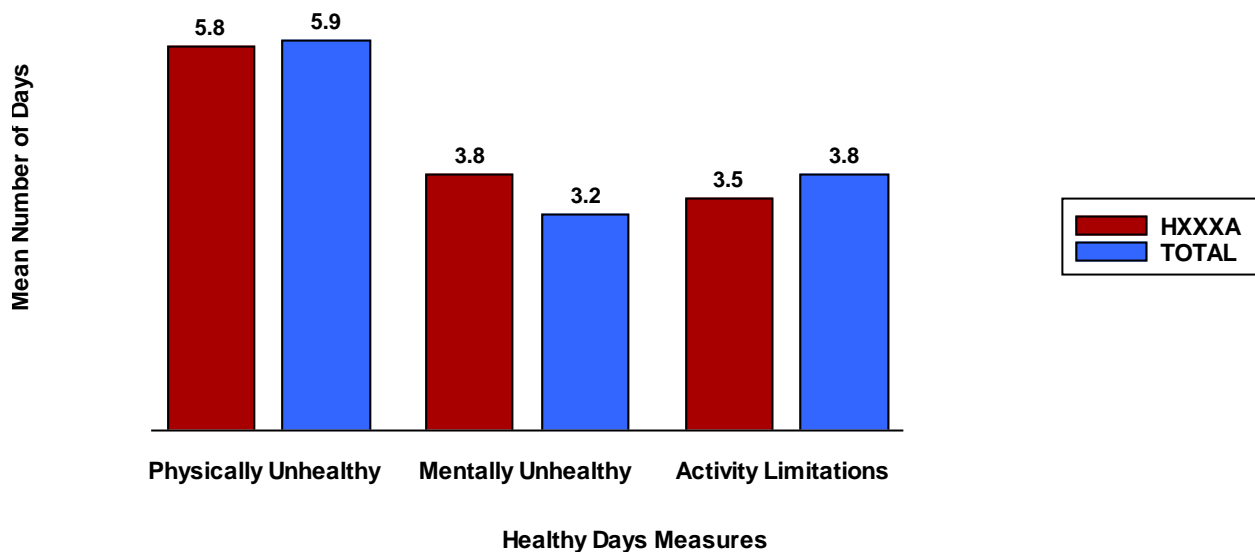
Table 22 presents the mean unadjusted MCS scores at baseline and follow up for your MAO and the HOS Total respondent sample by the number of mentally unhealthy days at follow up.

**Table 22: 2013-2015 Cohort 16 Performance Measurement Mean Unadjusted MCS Scores at Baseline and Follow Up by Number of Mentally Unhealthy Days at Follow Up for MAO HXXXXA and HOS Total**

Mentally Unhealthy Days	MAO HXXXXA		HOS Total	
	Baseline MCS Mean (SD)	Follow Up MCS Mean (SD)	Baseline MCS Mean (SD)	Follow Up MCS Mean (SD)
None	56.8 ( 7.6)	58.0 ( 6.5)	55.9 ( 8.2)	58.1 ( 6.6)
1-13 Days	51.8 ( 8.4)	50.5 ( 8.4)	49.1 ( 9.8)	49.1 ( 8.4)
14-30 Days	42.2 (10.0)	35.6 (14.0)	41.6 (12.4)	36.8 (11.1)

Figure 3 presents the results of the Healthy Days Measures as the mean number of unhealthy days in the previous 30 days for each of the three measures that were reported by beneficiaries at follow up for your MAO and the HOS Total respondent sample.

**Figure 3: 2013 Cohort 16 Performance Measurement Mean Number of Unhealthy Days for the Healthy Days Measures for MAO HXXXXA and HOS Total at Follow Up**



## Body Mass Index

### Definition of Measure

- Self-reported height and weight values are used to calculate BMI,<sup>H</sup> a measure that correlates with the amount of body fat in adult men and women. BMI is derived from the open-ended responses in Questions 55 and 56 in the 2015 HOS 3.0.

A BMI of 30 or higher is considered obese and increases risk for several chronic conditions including: hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, and some cancers.<sup>39</sup> Being overweight (BMI 25-29.9) or obese has also been shown to accelerate the aging process.<sup>40</sup> Since 1960, the prevalence of obesity in adults (age 18 or over) in the United States has nearly tripled, from 13% during 1960-1962 to 36% during 2009-2010.<sup>41</sup> The prevalence of obesity among older adults has risen significantly over the past 20 years.<sup>42</sup> A BMI under 20 is considered underweight. Rapid weight loss often indicates an underlying disease and can accelerate the natural loss of muscle mass, which occurs with the aging process.<sup>43</sup>

A study using the HOS 2006-2008 Cohort 9 Merged Baseline and Follow Up data found that in beneficiaries age 65 or older,<sup>44</sup> most of the reported health conditions were significantly more prevalent among obese than normal weight beneficiaries, in particular, high blood pressure (75.8% of obese vs. 53.9% of normal weight), diabetes (34.8% vs. 12.7%), and arthritis of the hip or knee (55.3% vs. 31.3%). Exceptions were osteoporosis and stroke. Osteoporosis was significantly less prevalent among the obese (16.1% vs. 26.9%). The prevalence of stroke increased only slightly with BMI (7.9% vs. 7.3%). The results also indicated that obese beneficiaries had substantially greater limitations with ADLs than normal weight beneficiaries.<sup>44</sup>

### How Is Your MAO Doing?

Table 23 shows the distribution of BMI categories including underweight (BMI less than 20), normal weight (BMI of 20-24.99), overweight (BMI of 25-29.99), and obese (BMI of 30 or more) for MAO HXXXXA and the HOS Total respondent sample.

**Table 23: 2013-2015 Cohort 16 Performance Measurement Distribution of BMI Categories for MAO HXXXXA and HOS Total at Baseline and Follow Up**

BMI Category	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
Underweight (<20)	10 ( 6.1%)	6 ( 3.8%)	3,797 ( 4.3%)	4,190 ( 5.0%)
Normal (20-24.99)	37 (22.7%)	34 (21.7%)	24,363 (27.3%)	23,283 (27.8%)
Overweight (25-29.99)	65 (39.9%)	64 (40.8%)	34,523 (38.7%)	31,545 (37.7%)
Obese (30-34.99)	26 (16.0%)	32 (20.4%)	16,947 (19.0%)	15,765 (18.8%)
Morbid Obesity (≥35)	25 (15.3%)	21 (13.4%)	9,473 (10.6%)	8,941 (10.7%)

<sup>H</sup> BMI is calculated as:  $BMI = [\text{weight in pounds} / (\text{height in inches})^2] \times 703$ , which uses the height and weight to produce the standard measure of  $\text{kg}/\text{m}^2$  units.

## Sleep

### Definition of Measure

- Sleep duration is a self-reported measure of the average number of hours of actual sleep at night during the past month. The measure is found in Question 53 of the 2015 HOS 3.0.
- Sleep quality is a self-reported measure that rates the overall sleep quality during the past month. The measure is found in Question 54 of the 2015 HOS.

Two new sleep questions in the 2015 HOS 3.0 were drawn from the Pittsburgh Sleep Quality Index (PSQI). The questions focus on “habitual” (i.e., past month) sleep duration and quality, rather than past week measures, in order to capture more chronic sleep disturbances. The PSQI has a high test-retest reliability and good validity in patients with insomnia.<sup>45</sup>

Over half of older adults suffer from symptoms of insomnia, a common problem related to aging.<sup>46</sup> Sleep disorders in the elderly can be caused by a number of factors, including medication, diseases, poor sleeping habits, and age-related changes in circadian sleep/wake regulation. There is substantial evidence linking insufficient sleep duration and poor sleep quality to mental and physical health morbidity and mortality.<sup>47</sup> Various epidemiologic findings associate sleep duration with obesity, diabetes, impaired glucose tolerance, hypertension, and mortality. People who report fair or poor health are less likely to overestimate sleep hours and report shorter sleep hours on average than those with better self-rated health.<sup>48</sup> These observations provide a basis for future studies on weight control interventions and maintenance of daily routines in sleep habits to increase the quantity and quality of sleep.

### How Is Your MAO Doing?

Table 24 provides frequency distributions of sleep duration (less than 5, 5–6, 7–8, and 9 or more hours) and sleep quality (Very good, Fairly good, Fairly bad, and Very bad) for MAO HXXXXA and the HOS Total at Follow Up.

**Table 24: 2015 Cohort 16 Distributions of Sleep Duration and Quality for MAO HXXXXA and HOS Total at Follow Up**

Sleep Questions	MAO HXXXXA		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
<b>Hours of actual sleep</b>				
Less than 5 hours	NA	8 ( 4.9%)	NA	6,010 ( 6.8%)
5-6 hours	NA	61 (37.2%)	NA	32,926 (37.2%)
7-8 hours	NA	88 (53.7%)	NA	44,211 (49.9%)
9 or more hours	NA	7 ( 4.3%)	NA	5,409 ( 6.1%)
<b>Overall sleep quality</b>				
Very Good	NA	34 (20.7%)	NA	23,187 (26.1%)
Fairly Good	NA	111 (67.7%)	NA	53,365 (60.0%)
Fairly Bad	NA	14 ( 8.5%)	NA	10,326 (11.6%)
Very Bad	NA	5 ( 3.0%)	NA	2,047 ( 2.3%)

## Health Status by Baseline Demographic Groups for MAO HXXXXA

Evidence from recent studies suggests the presence of variations in health among Medicare eligible beneficiaries by age, racial, and socioeconomic groups.<sup>49,50,51,52</sup> The following tables show differences in health status by demographic categories and illustrate changes from baseline to follow up measurement. You may compare disparities within your MAO across these demographic categories. For the following tables, groups within your MAO are defined by the sub-categories for a demographic characteristic (e.g., the 65-69 age group or White race).

**Table 25: 2013-2015 Cohort 16 Performance Measurement Distribution of Mean Unadjusted PCS and MCS Scores\* at Baseline and Follow Up by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Unadjusted PCS		Unadjusted MCS	
	Baseline Mean (SD)	Follow Up Mean (SD)	Baseline Mean (SD)	Follow Up Mean (SD)
<b>MAO HXXXXA Total</b>	41.2 (11.4)	39.3 (11.7)	54.0 (9.5)	53.9 (10.5)
<b>Age</b>				
65-69	43.8 (11.5)	42.3 (10.3)	55.9 (7.5)	54.5 (8.4)
70-74	41.7 (10.6)	40.0 (11.9)	54.1 (10.0)	54.7 (10.2)
75-79	40.5 (9.6)	37.3 (11.5)	52.4 (11.2)	53.2 (14.0)
80-84	41.4 (11.5)	39.5 (10.9)	53.6 (9.4)	54.3 (8.4)
85+	34.0 (12.7)	32.5 (13.5)	51.2 (10.5)	51.0 (14.3)
<b>Gender</b>				
Male	40.8 (11.7)	38.3 (12.2)	53.4 (10.6)	55.5 (9.4)
Female	41.4 (11.3)	40.0 (11.3)	54.3 (8.7)	52.9 (11.1)
<b>Race</b>				
White	41.0 (11.4)	39.2 (11.7)	54.0 (9.7)	54.2 (10.6)
Black	44.1 (10.8)	38.0 (11.1)	53.1 (8.7)	50.0 (10.4)
Other/Unknown	41.8 (12.6)	42.5 (12.1)	55.3 (6.2)	53.1 (9.2)
<b>Marital Status</b>				
Married	41.8 (10.8)	40.3 (11.4)	55.5 (8.7)	55.4 (8.9)
Widowed	37.3 (11.4)	35.4 (12.6)	51.9 (10.6)	50.8 (12.9)
Divorced or Separated	42.7 (12.8)	39.7 (9.7)	50.1 (10.5)	52.5 (13.0)
Never Married	46.7 (11.8)	43.8 (12.1)	57.1 (5.1)	56.9 (6.0)
<b>Education</b>				
Did Not Graduate HS	33.8 (11.2)	33.6 (13.1)	48.8 (12.0)	47.6 (11.8)
High School Graduate	42.1 (11.2)	39.8 (11.7)	55.4 (8.5)	54.5 (11.4)
Some College	43.1 (11.2)	39.7 (10.7)	54.2 (8.4)	55.1 (8.7)
4 Year Degree or Beyond	43.8 (10.0)	42.4 (10.1)	56.6 (8.3)	57.6 (7.7)
<b>Annual Household Income</b>				
Less than \$10,000	41.6 (12.3)	38.8 (12.4)	48.3 (9.7)	50.8 (9.1)
\$10,000-\$19,999	34.7 (11.8)	33.8 (11.6)	51.0 (9.8)	49.2 (13.3)
\$20,000-\$29,999	41.6 (11.2)	40.5 (11.3)	55.3 (9.0)	57.0 (6.8)
\$30,000-\$49,999	41.2 (11.1)	39.9 (12.0)	55.0 (9.6)	54.0 (10.1)
\$50,000 or More	44.5 (8.7)	43.3 (9.4)	57.8 (6.7)	58.5 (6.9)
Don't Know	39.4 (14.0)	33.0 (11.9)	50.9 (11.1)	50.1 (14.7)
<b>Medicaid Status</b>				
Medicaid	33.0 (12.3)	34.2 (11.9)	50.5 (10.1)	47.6 (13.4)
Non-Medicaid	42.2 (10.9)	40.0 (11.5)	54.4 (9.3)	54.8 (9.9)

\* Mean unadjusted PCS and MCS scores are the raw scores used to determine the final adjusted change scores in the "Cohort 16 Performance Measurement Results" section. Beneficiaries are displayed according to their baseline demographic group.

**Table 26: 2013-2015 Cohort 16 Performance Measurement Distribution of Self-Rated General Health Status, and Physical and Mental Health Status Compared to One Year Ago at Baseline and Follow Up by Baseline Demographic Group for MAO HXXXA**

Baseline Demographic	General Health Status Poor or Fair		Comparative Health-Physical Slightly Worse or Much Worse		Comparative Health-Mental Slightly Worse or Much Worse	
	Baseline N (%)	Follow Up* N (%)	Baseline N (%)	Follow Up* N (%)	Baseline N (%)	Follow Up* N (%)
<b>MAO HXXXA Total</b>	35 (21.0%)	37 (22.4%)	34 (20.7%)	47 (29.4%)	13 ( 8.0%)	18 (11.5%)
<b>Age</b>						
65-69	7 (14.6%)	10 (20.8%)	6 (13.0%)	9 (19.1%)	1 ( 2.1%)	3 ( 6.4%)
70-74	12 (26.1%)	12 (26.7%)	8 (17.4%)	12 (27.9%)	7 (15.6%)	5 (11.6%)
75-79	7 (31.8%)	5 (22.7%)	5 (23.8%)	6 (28.6%)	3 (14.3%)	2 ( 9.5%)
80-84	3 ( 9.7%)	5 (16.1%)	8 (25.8%)	11 (37.9%)	1 ( 3.3%)	4 (14.8%)
85+	6 (30.0%)	5 (26.3%)	7 (35.0%)	9 (45.0%)	1 ( 5.0%)	4 (21.1%)
<b>Gender</b>						
Male	17 (25.8%)	23 (34.8%)	18 (27.7%)	20 (31.7%)	7 (10.6%)	9 (14.5%)
Female	18 (17.8%)	14 (14.1%)	16 (16.2%)	27 (27.8%)	6 ( 6.2%)	9 ( 9.5%)
<b>Race</b>						
White	31 (20.5%)	32 (21.5%)	33 (22.0%)	43 (29.9%)	12 ( 8.2%)	18 (12.7%)
Black	2 (22.2%)	3 (33.3%)	0 ( 0.0%)	2 (22.2%)	0 ( 0.0%)	0 ( 0.0%)
Other/Unknown	2 (28.6%)	2 (28.6%)	1 (14.3%)	2 (28.6%)	1 (14.3%)	0 ( 0.0%)
<b>Marital Status</b>						
Married	19 (19.4%)	21 (21.6%)	20 (20.4%)	25 (26.6%)	7 ( 7.3%)	11 (11.7%)
Widowed	10 (24.4%)	12 (30.0%)	11 (27.5%)	16 (40.0%)	3 ( 7.3%)	5 (13.5%)
Divorced or Separated	6 (31.6%)	3 (15.8%)	3 (16.7%)	5 (27.8%)	3 (16.7%)	2 (11.1%)
Never Married	0 ( 0.0%)	1 (16.7%)	0 ( 0.0%)	1 (20.0%)	0 ( 0.0%)	0 ( 0.0%)
<b>Education</b>						
Did Not Graduate HS	18 (56.3%)	14 (45.2%)	11 (36.7%)	11 (36.7%)	5 (16.1%)	5 (16.7%)
High School Graduate	11 (19.0%)	14 (24.6%)	9 (15.5%)	14 (24.6%)	3 ( 5.3%)	8 (14.3%)
Some College	3 ( 7.7%)	6 (15.4%)	5 (13.2%)	13 (35.1%)	3 ( 8.1%)	4 (11.1%)
4 Year Degree or Beyond	3 ( 8.8%)	3 ( 8.8%)	8 (23.5%)	9 (28.1%)	2 ( 5.9%)	1 ( 3.2%)
<b>Annual Household Income</b>						
Less than \$10,000	8 (44.4%)	6 (33.3%)	4 (22.2%)	4 (26.7%)	3 (17.6%)	2 (13.3%)
\$10,000-\$19,999	9 (39.1%)	9 (40.9%)	7 (30.4%)	9 (40.9%)	2 ( 9.1%)	4 (19.0%)
\$20,000-\$29,999	6 (19.4%)	5 (16.1%)	4 (13.8%)	6 (19.4%)	1 ( 3.2%)	2 ( 6.5%)
\$30,000-\$49,999	4 (13.8%)	6 (20.7%)	9 (31.0%)	8 (27.6%)	2 ( 7.1%)	3 (11.1%)
\$50,000 or More	1 ( 2.9%)	2 ( 5.9%)	4 (12.1%)	8 (25.0%)	2 ( 6.1%)	1 ( 3.1%)
Don't Know	7 (41.2%)	8 (50.0%)	2 (11.8%)	7 (41.2%)	2 (11.8%)	3 (17.6%)
<b>Medicaid Status</b>						
Medicaid	10 (52.6%)	9 (50.0%)	8 (44.4%)	7 (41.2%)	5 (27.8%)	4 (22.2%)
Non-Medicaid	25 (16.9%)	28 (19.0%)	26 (17.8%)	40 (28.0%)	8 ( 5.5%)	14 (10.1%)

\* Percentages for demographic groups in the follow up columns highlighted in red are greater by ten percentage points or more compared to the baseline columns. Estimates highlighted in red indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

**Table 27: 2013-2015 Cohort 16 Performance Measurement Distribution of Positive Depression Screens at Baseline and Follow Up by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Positive Depression Screen	
	Baseline N (%)	Follow Up* N (%)
<b>MAO HXXXXA Total</b>	11 ( 6.9%)	16 (10.3%)
<b>Age</b>		
65-69	2 ( 4.3%)	2 ( 4.3%)
70-74	6 (13.3%)	7 (17.1%)
75-79	1 ( 4.8%)	1 ( 5.3%)
80-84	0 ( 0.0%)	1 ( 3.3%)
85+	2 (10.5%)	5 (26.3%)
<b>Gender</b>		
Male	5 ( 8.1%)	6 (10.2%)
Female	6 ( 6.1%)	10 (10.3%)
<b>Race</b>		
White	10 ( 6.9%)	15 (10.6%)
Black	1 (12.5%)	0 ( 0.0%)
Other/Unknown	0 ( 0.0%)	1 (14.3%)
<b>Marital Status</b>		
Married	4 ( 4.3%)	7 ( 7.7%)
Widowed	6 (15.0%)	4 (10.3%)
Divorced or Separated	1 ( 5.9%)	5 (27.8%)
Never Married	0 ( 0.0%)	0 ( 0.0%)
<b>Education</b>		
Did Not Graduate HS	5 (17.9%)	7 (25.0%)
High School Graduate	6 (10.5%)	6 (10.9%)
Some College	0 ( 0.0%)	3 ( 8.1%)
4 Year Degree or Beyond	0 ( 0.0%)	0 ( 0.0%)
<b>Annual Household Income</b>		
Less than \$10,000	4 (23.5%)	3 (18.8%)
\$10,000-\$19,999	1 ( 4.5%)	4 (19.0%)
\$20,000-\$29,999	1 ( 3.7%)	1 ( 3.4%)
\$30,000-\$49,999	2 ( 6.9%)	2 ( 6.9%)
\$50,000 or More	0 ( 0.0%)	0 ( 0.0%)
Don't Know	3 (18.8%)	5 (35.7%)
<b>Medicaid Status</b>		
Medicaid	4 (23.5%)	6 (37.5%)
Non-Medicaid	7 ( 4.9%)	10 ( 7.1%)

\* Percentages for demographic groups in the follow up column highlighted in **red** are greater by ten percentage points or more compared to the baseline column. Estimates highlighted in **red** indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

**Table 28: 2013-2015 Cohort 16 Performance Measurement Distribution of Multiple Chronic Conditions<sup>s</sup> at Baseline and Follow Up by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Multiple Chronic Medical Conditions <sup>s</sup>	
	Baseline	Follow Up*
	N (%)	N (%)
<b>MAO HXXXXA Total</b>	128 (76.6%)	131 (80.9%)
<b>Age</b>		
65-69	32 (66.7%)	35 (74.5%)
70-74	37 (80.4%)	36 (81.8%)
75-79	19 (86.4%)	19 (90.5%)
80-84	23 (74.2%)	25 (83.3%)
85+	17 (85.0%)	16 (80.0%)
<b>Gender</b>		
Male	48 (72.7%)	51 (79.7%)
Female	80 (79.2%)	80 (81.6%)
<b>Race</b>		
White	115 (76.2%)	116 (78.9%)
Black	7 (77.8%)	8 (100%)
Other/Unknown	6 (85.7%)	7 (100%)
<b>Marital Status</b>		
Married	74 (75.5%)	76 (79.2%)
Widowed	36 (87.8%)	35 (87.5%)
Divorced or Separated	13 (68.4%)	14 (77.8%)
Never Married	3 (50.0%)	3 (60.0%)
<b>Education</b>		
Did Not Graduate HS	29 (90.6%)	28 (93.3%)
High School Graduate	44 (75.9%)	44 (78.6%)
Some College	27 (69.2%)	33 (84.6%)
4 Year Degree or Beyond	25 (73.5%)	23 (69.7%)
<b>Annual Household Income</b>		
Less than \$10,000	12 (66.7%)	12 (70.6%)
\$10,000-\$19,999	22 (95.7%)	21 (91.3%)
\$20,000-\$29,999	26 (83.9%)	28 (93.3%)
\$30,000-\$49,999	20 (69.0%)	20 (69.0%)
\$50,000 or More	23 (67.6%)	25 (73.5%)
Don't Know	13 (76.5%)	14 (93.3%)
<b>Medicaid Status</b>		
Medicaid	17 (89.5%)	16 (94.1%)
Non-Medicaid	111 (75.0%)	115 (79.3%)

\* Percentages for demographic groups in the follow up column highlighted in **red** are greater by ten percentage points or more compared to the baseline column. Estimates highlighted in **red** indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

<sup>s</sup> Multiple chronic medical conditions are defined as having two or more conditions (maximum of 15).



**Table 29: 2013-2015 Cohort 16 Performance Measurement Distribution of Multiple ADL Impairments<sup>s</sup> at Baseline and Follow Up by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Multiple ADL Impairments <sup>s</sup>	
	Baseline N (%)	Follow Up* N (%)
<b>MAO HXXXXA Total</b>	29 (17.4%)	33 (20.4%)
<b>Age</b>		
65-69	6 (12.5%)	2 ( 4.3%)
70-74	4 ( 8.7%)	6 (13.6%)
75-79	6 (27.3%)	6 (27.3%)
80-84	6 (19.4%)	7 (24.1%)
85+	7 (35.0%)	12 ( <b>60.0%</b> )
<b>Gender</b>		
Male	14 (21.2%)	16 (25.0%)
Female	15 (14.9%)	17 (17.3%)
<b>Race</b>		
White	28 (18.5%)	32 (21.9%)
Black	0 ( 0.0%)	1 (11.1%)
Other/Unknown	1 (14.3%)	0 ( 0.0%)
<b>Marital Status</b>		
Married	16 (16.3%)	14 (14.7%)
Widowed	9 (22.0%)	16 ( <b>40.0%</b> )
Divorced or Separated	4 (21.1%)	3 (15.8%)
Never Married	0 ( 0.0%)	0 ( 0.0%)
<b>Education</b>		
Did Not Graduate HS	11 (34.4%)	12 (38.7%)
High School Graduate	5 ( 8.6%)	8 (13.8%)
Some College	7 (17.9%)	8 (21.6%)
4 Year Degree or Beyond	5 (14.7%)	5 (15.6%)
<b>Annual Household Income</b>		
Less than \$10,000	4 (22.2%)	4 (25.0%)
\$10,000-\$19,999	6 (26.1%)	9 ( <b>39.1%</b> )
\$20,000-\$29,999	5 (16.1%)	4 (12.9%)
\$30,000-\$49,999	4 (13.8%)	4 (13.8%)
\$50,000 or More	2 ( 5.9%)	4 (12.5%)
Don't Know	4 (23.5%)	4 (23.5%)
<b>Medicaid Status</b>		
Medicaid	7 (36.8%)	6 (33.3%)
Non-Medicaid	22 (14.9%)	27 (18.8%)

\* Percentages for demographic groups in the follow up column highlighted in **red** are greater by ten percentage points or more compared to the baseline column. Estimates highlighted in **red** indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

<sup>s</sup> Multiple ADL impairments are defined as having two or more impairments.



**Table 30: 2013-2015 Cohort 16 Performance Measurement Mean Number of Unhealthy Physical, Mental, and Activity Limitation Days by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Physically Unhealthy Number of Days		Mentally Unhealthy Number of Days		Activity Limitations Number of Days	
	Baseline Mean (SD)	Follow Up* Mean (SD)	Baseline Mean (SD)	Follow Up* Mean (SD)	Baseline Mean (SD)	Follow Up* Mean (SD)
<b>MAO HXXXXA Total</b>	4.4 (8.5)	5.8 (9.9)	2.2 (6.3)	3.8 (8.1)	2.9 (7.4)	3.5 (7.9)
<b>Age</b>						
65-69	4.2 (8.5)	3.8 (7.6)	2.1 (5.8)	3.6 (7.6)	3.2 (7.9)	2.5 (6.0)
70-74	3.4 (8.1)	4.9 (9.9)	2.6 (7.1)	4.8 (9.9)	3.1 (8.2)	4.5 (9.9)
75-79	3.9 (8.0)	4.6 (9.0)	3.3 (8.7)	2.2 (6.8)	2.4 (4.8)	3.2 (7.3)
80-84	5.1 (9.0)	5.4 (9.7)	0.3 (1.1)	1.9 (3.6)	2.2 (7.0)	2.5 (6.4)
85+	6.7 (9.4)	14.6 (12.8)	3.3 (7.2)	6.9 (10.0)	3.0 (7.9)	5.6 (10.0)
<b>Gender</b>						
Male	5.1 (10.0)	6.8 (11.1)	1.8 (5.8)	3.6 (8.3)	3.6 (8.6)	4.1 (8.5)
Female	3.9 (7.3)	5.1 (9.0)	2.5 (6.6)	4.0 (8.0)	2.4 (6.6)	3.1 (7.6)
<b>Race</b>						
White	4.5 (8.6)	6.2 (10.2)	2.3 (6.5)	3.8 (8.0)	2.9 (7.4)	3.8 (8.3)
Black	1.4 (3.4)	3.4 (5.8)	1.9 (5.0)	5.8 (11.2)	1.7 (5.0)	1.1 (3.3)
Other/Unknown	5.0 (11.2)	0.4 (1.1)	0.0 (0.0)	2.0 (3.8)	4.3 (11.3)	0.4 (1.1)
<b>Marital Status</b>						
Married	3.6 (7.7)	5.1 (10.0)	1.3 (4.4)	3.4 (7.5)	2.6 (6.9)	3.6 (8.2)
Widowed	6.8 (10.2)	8.9 (11.1)	3.5 (8.3)	5.6 (9.8)	3.8 (9.1)	4.0 (8.3)
Divorced or Separated	4.9 (9.4)	4.2 (7.8)	4.6 (9.4)	3.8 (8.4)	3.1 (7.4)	3.3 (8.0)
Never Married	1.2 (1.8)	3.2 (4.6)	0.3 (0.8)	0.8 (1.8)	0.0 (0.0)	0.5 (1.2)
<b>Education</b>						
Did Not Graduate HS	7.5 (11.7)	8.8 (12.4)	5.6 (11.1)	6.7 (11.2)	6.9 (11.3)	5.6 (10.4)
High School Graduate	4.1 (8.1)	6.0 (10.4)	1.4 (5.1)	4.1 (8.4)	1.8 (6.0)	3.5 (8.4)
Some College	3.2 (6.2)	5.0 (8.9)	1.9 (4.1)	3.7 (6.3)	2.0 (5.3)	3.6 (7.8)
4 Year Degree or Beyond	3.7 (7.9)	3.8 (7.3)	0.9 (2.4)	1.4 (5.3)	2.2 (6.6)	1.9 (4.4)
<b>Annual Household Income</b>						
Less than \$10,000	4.1 (8.5)	7.8 (11.7)	5.4 (10.5)	7.9 (11.8)	5.4 (10.2)	5.4 (11.7)
\$10,000-\$19,999	10.2 (10.9)	10.3 (11.6)	3.8 (8.8)	6.1 (9.4)	2.2 (7.0)	6.0 (9.2)
\$20,000-\$29,999	3.2 (7.6)	2.5 (6.0)	1.4 (3.7)	1.5 (2.7)	2.1 (6.5)	0.8 (2.0)
\$30,000-\$49,999	4.2 (9.3)	7.5 (11.8)	2.2 (6.6)	3.8 (6.6)	3.6 (8.5)	5.4 (10.0)
\$50,000 or More	2.0 (3.6)	3.7 (8.1)	0.8 (2.4)	1.3 (5.3)	0.9 (1.8)	1.9 (6.1)
Don't Know	4.3 (8.9)	5.2 (10.1)	2.6 (7.4)	7.9 (13.2)	4.3 (8.7)	4.1 (9.2)
<b>Medicaid Status</b>						
Medicaid	8.1 (11.8)	9.2 (12.2)	4.9 (10.0)	7.8 (11.7)	6.1 (11.7)	6.4 (10.9)
Non-Medicaid	3.9 (7.9)	5.3 (9.5)	1.9 (5.7)	3.3 (7.4)	2.5 (6.7)	3.2 (7.5)

\* Means for demographic groups in the follow up columns highlighted in red are greater by ten percent or more compared to the baseline columns. Estimates highlighted in red indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

**Table 31: 2013-2015 Cohort 16 Performance Measurement Distribution of BMI Categories by Baseline Demographic Group for MAO HXXXXA**

Baseline Demographic	Underweight (<20 BMI)		Obese (≥30 BMI)	
	Baseline N (%)	Follow Up* N (%)	Baseline N (%)	Follow Up* N (%)
<b>MAO HXXXXA Total</b>	10 ( 6.1%)	6 ( 3.8%)	51 (31.3%)	53 (33.8%)
<b>Age</b>				
65-69	1 ( 2.1%)	1 ( 2.1%)	20 (42.6%)	20 (41.7%)
70-74	2 ( 4.4%)	1 ( 2.4%)	15 (33.3%)	15 (35.7%)
75-79	1 ( 4.8%)	0 ( 0.0%)	8 (38.1%)	9 (47.4%)
80-84	2 ( 6.5%)	2 ( 6.9%)	6 (19.4%)	7 (24.1%)
85+	4 (21.1%)	2 (10.5%)	2 (10.5%)	2 (10.5%)
<b>Gender</b>				
Male	2 ( 3.1%)	1 ( 1.6%)	18 (28.1%)	18 (29.0%)
Female	8 ( 8.1%)	5 ( 5.3%)	33 (33.3%)	35 (36.8%)
<b>Race</b>				
White	9 ( 6.1%)	5 ( 3.5%)	41 (27.9%)	44 (31.2%)
Black	0 ( 0.0%)	0 ( 0.0%)	7 (77.8%)	6 (66.7%)
Other/Unknown	1 (14.3%)	1 (14.3%)	3 (42.9%)	3 (42.9%)
<b>Marital Status</b>				
Married	6 ( 6.3%)	4 ( 4.3%)	28 (29.5%)	29 (31.5%)
Widowed	4 (10.0%)	2 ( 5.3%)	9 (22.5%)	12 (31.6%)
Divorced or Separated	0 ( 0.0%)	0 ( 0.0%)	10 (52.6%)	8 (44.4%)
Never Married	0 ( 0.0%)	0 ( 0.0%)	2 (33.3%)	2 (33.3%)
<b>Education</b>				
Did Not Graduate HS	2 ( 6.5%)	1 ( 3.3%)	9 (29.0%)	8 (26.7%)
High School Graduate	3 ( 5.2%)	3 ( 5.5%)	20 (34.5%)	21 (38.2%)
Some College	1 ( 2.7%)	1 ( 2.7%)	13 (35.1%)	12 (32.4%)
4 Year Degree or Beyond	4 (11.8%)	1 ( 3.2%)	7 (20.6%)	9 (29.0%)
<b>Annual Household Income</b>				
Less than \$10,000	1 ( 5.9%)	0 ( 0.0%)	7 (41.2%)	7 (41.2%)
\$10,000-\$19,999	2 ( 8.7%)	2 (10.5%)	8 (34.8%)	6 (31.6%)
\$20,000-\$29,999	0 ( 0.0%)	1 ( 3.2%)	10 (34.5%)	13 (41.9%)
\$30,000-\$49,999	4 (14.3%)	2 ( 6.9%)	9 (32.1%)	8 (27.6%)
\$50,000 or More	2 ( 5.9%)	0 ( 0.0%)	10 (29.4%)	10 (31.3%)
Don't Know	0 ( 0.0%)	0 ( 0.0%)	5 (29.4%)	5 (31.3%)
<b>Medicaid Status</b>				
Medicaid	1 ( 5.6%)	0 ( 0.0%)	7 (38.9%)	7 (43.8%)
Non-Medicaid	9 ( 6.2%)	6 ( 4.3%)	44 (30.3%)	46 (32.6%)

\* Percentages for demographic groups in the follow up columns highlighted in red are greater by ten percentage points or more compared to the baseline columns. Estimates highlighted in red indicate groups that were worse off at follow up compared to baseline. Beneficiaries are displayed according to their baseline demographic group.

## Appendix 1

### Program Background

This section introduces the Medicare HOS, survey administration, and the calculation of outcomes for the performance measurement. A complete description of the HOS program, the program timeline, the HOS 2.5 instrument, the HOS 3.0 instrument, previous survey results, and supporting documents are available on the HOS website at [www.HOSonline.org](http://www.HOSonline.org).

CMS is committed to monitoring the quality of care provided by MAOs. The HOS results continue to be an important part of the CMS quality improvement activities, ensuring that medical care paid for under the Medicare program meets professionally recognized standards of health care and leads to desired health outcomes. Section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates collecting, analyzing, and reporting health outcomes information. This legislation also specifies that data collected on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration must use the same types of data that were collected prior to November 1, 2003. Collected since 1998, the HOS is the first patient-reported outcomes measure in Medicare managed care, and therefore remains a critical part of assessing MAO quality performance.

The goal of the Medicare HOS program is to gather valid and reliable clinically meaningful data for uses such as: targeting quality improvement activities and resources; monitoring health plan performance; rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement. This Performance Measurement Report is part of a larger CMS effort to increase the health care industry's capacity to improve the health status of its Medicare population. The results are intended to help MAOs identify areas for potential improvement. The HOS Performance Measurement Report is made available to all participating MAOs after each annual follow up cohort data collection is completed.

### 2013-2015 Medicare Advantage Organization Participation

MAOs with Medicare contracts in effect on or before January 1, 2012, and with a minimum enrollment of 500 beneficiaries were required to report the Baseline HOS in 2013:

- All coordinated care plans, including local and regional preferred provider organizations (RPPO), health maintenance organizations (HMO), and contracts with Special Needs Plan (SNP) benefit packages
- Continuing §1876 cost contracts with open enrollment
- Private Fee-for-Service (PFFS) plans
- Medical savings accounts
- Employer group/union direct-only PFFS contracts

MAOs that administered the HOS Baseline Survey in 2013 were required to administer the HOS Follow-Up Survey in 2015.

All Program of All-Inclusive Care for the Elderly (PACE) plans with Medicare contracts in effect on or before January 1, 2014, were required by CMS to administer the HOS-Modified (HOS-M) in 2015.

MAOs sponsoring Fully Integrated Dual Eligible (FIDE) SNPs within Medicare contracts in effect on or before January 1, 2012, and with a minimum enrollment of 30 beneficiaries could elect to report the 2013 HOS at the FIDE SNP level to determine eligibility for a frailty adjustment payment, similar to those payments provided to PACE programs that use HOS-M data. Voluntary reporting is in addition to standard HOS requirements for quality reporting at the contract level. Refer to the list of participating MAO contracts available in the “Survey Results” section on the “Survey” page of the HOS website ([www.HOSonline.org](http://www.HOSonline.org)).

### Cohort 16 Baseline Sampling

For MAOs participating in the *2013 Cohort 16 Baseline* survey, CMS identified beneficiaries who were eligible for sampling by the following criteria:

- MAOs with fewer than 500 beneficiaries were not required to report HOS.
- For MAOs with populations of 500 to 1,200 beneficiaries, all eligible beneficiaries were included in the sample.
- For MAOs with Medicare populations of more than 1,200 and less than 3,000 beneficiaries, a simple random sample of 1,200 beneficiaries was selected.
- In MAOs with 3,000 or more beneficiaries, beneficiaries who responded to the previous year’s baseline survey were excluded from the random sample of 1,200 for the current year.
- Beneficiaries were defined as eligible if they were 18 years or older on the date the sample was drawn. The six months enrollment requirement was waived beginning in 2009, and beneficiaries with End Stage Renal Disease (ESRD) were no longer excluded from the sampling beginning in 2010.

### Cohort 16 Follow Up Sampling

For MAOs participating in the *2015 Cohort 16 Follow Up* survey, CMS identified beneficiaries from the *2013 Cohort 16 Baseline* sample who were eligible for remeasurement by the following criteria:

- Beneficiaries were eligible for remeasurement if they had sufficient data to derive PCS or MCS scores at baseline.
- Beneficiaries were excluded from follow up if they disenrolled from their MAO or died after the baseline survey. Although deceased beneficiaries were excluded from the sample, CMS includes deceased baseline respondents when calculating the HOS performance measurement results.<sup>6</sup>

### Survey Administration

- MAOs contracted with a CMS approved survey vendor to administer the surveys following the protocols specified in the HEDIS 2013 and 2015, Volume 6, Specifications for the Medicare Health Outcomes Survey Manuals. The manuals detailed the methods for mail, telephone, and mixed methods of data collection.
- The mail component of the surveys used prenotification postcards (in 2013) and letters (in 2015), a standardized questionnaire, survey letters, and reminder/thank you postcards. Sample respondents completed the HOS in English, Spanish, or Chinese language versions of the mail survey.

- Survey vendors attempted telephone follow up in English or Spanish (with at least six attempts) in those instances when beneficiaries failed to respond after the second mail survey or returned an incomplete mail survey in order to obtain responses for missing items. A standardized version of an Electronic Telephone Interviewing System script was used to collect telephone interview data for the survey.
- Survey vendors performed initial data cleaning and follow up with survey respondents, as necessary.

Additional information about *Cohort 16* sampling and survey administration can be found in the NCQA HEDIS 2013 and 2015 Volume 6 manuals.<sup>6,7</sup>

## HOS Data Collection Tools

The core HOS health status items were collected with the same instrument for the *2013 Cohort 16 Baseline* and *2015 Cohort 16 Follow Up*. Since 2006, the HOS has incorporated the Veterans RAND 12-Item Health Survey (VR-12).

### Medicare HOS 2.5 and 3.0 Instruments

In 2013, CMS implemented the Medicare HOS 2.5 for MAOs. The HOS 2.5 evaluates the HRQOL of MA beneficiaries by measuring their physical and mental health status using the VR-12.<sup>53</sup> The HOS contains questions about socio-demographics, ADLs, IADLs, chronic medical conditions, self-rated health, number of unhealthy days in the past 30 days, depression risk, cognitive functioning, memory, pain, living arrangements, and self-reported height and weight used for calculation of BMI. Four HEDIS Effectiveness of Care measures are included to evaluate management of urinary incontinence, physical activity, osteoporosis testing, and fall risk management. Questions regarding race, ethnicity, sex, primary language, and disability status comply with standards established by the Affordable Care Act §4302. In 2014, the HOS 2.5 was further modified by revising eight questions and removing six questions. All versions of the HOS instruments listed by year are available on the “Survey” page of the HOS website ([www.HOSonline.org](http://www.HOSonline.org)).

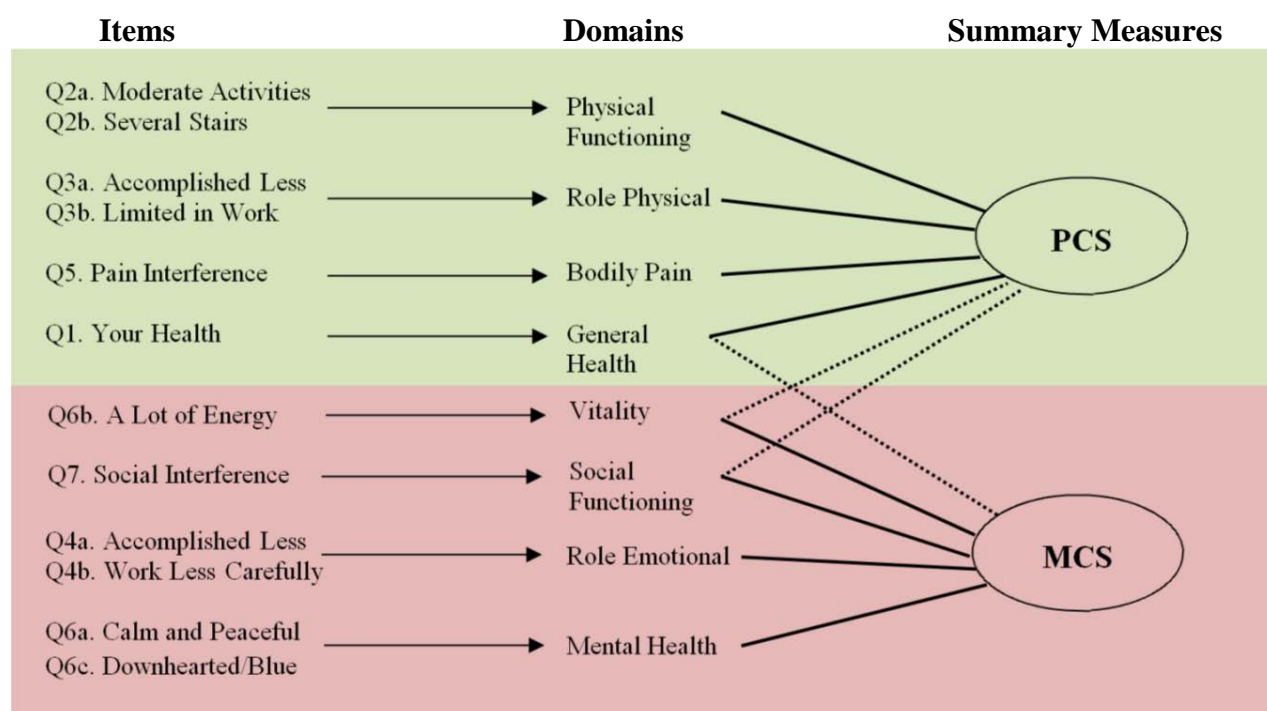
In 2015, CMS implemented the Medicare HOS 3.0. In a formatting change from previous versions of the HOS, the new survey uses a two column layout for each page. Other modifications in the HOS 3.0 as compared with the HOS 2.5 include changes to questions about the leakage of urine, osteoporosis testing in older women, sleep duration and quality, and primary language spoken in the home.

The VR-12 was derived from the Veterans RAND 36-Item Health Survey (VR-36).<sup>54,55,56</sup> The VR-12 is a generic, multipurpose health survey, which consists of the 12 most important items from the VR-36 for construction of the physical and mental health summary scores (Q1-Q7) and two items that assess change in physical and emotional health compared with one year ago (Q8 and Q9) that are not used in the calculation of the summary scores. The shorter instrument was adopted to reduce response burden and survey costs, while maintaining comparability of HOS results over time. The body of literature supports the shorter survey as a reliable and valid substitute for the 36-item health survey. Conversion formulas have been developed and validated to relate the VR-12 with the earlier 36-item survey that allow reliable comparisons of HOS 1.0 results with results from HOS 2.0 and later versions.<sup>57</sup>

In comparison with the earlier 36-item survey, two modifications were made in the VR-12. The first modification was an increase in the number of response choices for the items used for role limitations due to physical problems (Q3a and Q3b) and role limitations due to emotional problems (Q4a and Q4b) from a two-point choice of “Yes” or “No” to a five-point Likert scale (“No, none of the time,” “Yes, a little of the time,” “Yes, some of the time,” “Yes, most of the time,” and “Yes, all of the time”). The role-physical questions assess whether respondents’ physical health limits them in the kind of work or other usual activities they perform, while the role-emotional questions assess whether emotional problems have caused respondents to accomplish less in their work or other usual activities. The second modification was that two questions were used to assess health change, one focusing on physical health (Q8) and one on emotional problems (Q9), in contrast to the one general change item in the 36-item survey.<sup>58,59</sup>

The VR-12 measures the same eight health domains as the 36-item health survey: 1) Physical Functioning, 2) Role-Physical, 3) Role-Emotional, 4) Bodily Pain, 5) Social Functioning, 6) Mental Health, 7) Vitality, and 8) General Health. Each domain aggregates one or two items and all eight domains are used to calculate the two summary measures, as illustrated in the VR-12 mapping model that follows in Figure 4.

**Figure 4: Mapping of HOS VR-12 to 8 Health Domains and 2 Summary Measures**



Note: Domains contributing the most to each summary measure are indicated by a solid line. Domains contributing to a lesser degree are indicated by a broken line; however, all domains contribute to some extent to the scoring of both summary measures (PCS and MCS).

### Physical and Mental Component Summary Scores

The PCS and MCS scores were calculated from the VR-12 using the Modified Regression Estimate (MRE) for scoring and imputation of missing data.<sup>53</sup> For those beneficiaries with complete responses across the VR-12, the following steps<sup>60</sup> were taken to calculate the scores:



- Step One: New variables were created for each response level choice with one level omitted. Using the 59 total response categories across the VR-12 questions, 47 indicator variables were created.
- Step Two: Aggregate PCS and MCS scores were created separately from a regression equation that weighted each of the 47 indicator variables. The weights were derived from the Veterans SF-36 PCS and MCS Scales using the 1999 Large Health Survey of Veteran Enrollees.<sup>61</sup>
- Step Three: A constant was added to each of the estimates obtained from Step Two. The scores were then standardized using normative values from a 1990 U.S. general population. Therefore a mean score of 50 represents the national average, a 10-point difference above and below the mean score is one standard deviation, and with few exceptions, the scores have a range of 0 through 100 (higher being better).

PCS and MCS scores were imputed using the MRE when beneficiary data was missing across the VR-12 items. Using the MRE algorithm, PCS and MCS scores can be calculated in as many as 90% of the cases in which one or more VR-12 responses are missing.<sup>62</sup> Depending on the pattern of missing item responses for a beneficiary, a different set of regression weights was required to compute that individual's PCS and/or MCS scores.<sup>60</sup> For each combination of missing data, the beneficiaries' data were merged with the stored regression weights and the PCS or MCS scores were computed and then standardized using the normative values from MRE Step Three.

Beneficiary PCS and MCS results were mode adjusted for the impact of telephone administration compared with the reference mode of mail administration. Comparisons across the VR-12 of matched HOS and Veterans Administration surveys for the same respondents showed that PCS and MCS scores were, on average, 1.9 and 4.5 points greater respectively for telephone compared with mail administered surveys.<sup>63</sup> Therefore, for telephone surveys, 1.9 points were subtracted from the PCS score and 4.5 points were subtracted from the MCS score.

For the physical health summary measure, very high scores indicate no physical limitations, disabilities, or decline in well-being; high energy level; and a rating of health as "excellent." For the mental health summary measure, very high scores indicate frequent positive affect, absence of psychological distress, and no limitations in usual social and role activities due to emotional problems.

## **Data Evaluation and Processing**

The entire HOS data file was reviewed to verify the presence of unique beneficiaries. Additional reviews of the data are performed using the complete HOS data file as well as subsets of the data (e.g., mode of administration and vendor).

- Data consistency checks are performed to identify:
  - Out of range dates and response values
  - Duplicate Beneficiary Link Keys, Health Insurance Claim (HIC) numbers and Social Security Numbers (SSN)
  - Data shifts in value assignment
  - Differences in percentage distributions of survey response values and inconsistent data distributions among vendors
  - Discrepancies in the percent complete and survey disposition codes

- Inconsistent assignment of survey variables (such as survey disposition, round number, and survey language)
- Response consistency checks between related items are performed to validate the integrity of the data.
- Date variables are converted to a SAS<sup>®1</sup> date format to facilitate the calculation of duration of enrollment and age, which are then stored in the data file.
- For the performance measurement, baseline and follow up data are evaluated and merged, and additional variables are calculated or obtained from other CMS data sources.

## Calculation of Outcomes

The *2013-2015 Cohort 16 Performance Measurement Report* incorporates results from the 2013 HOS 2.5 for the baseline and the 2015 HOS 3.0 for the follow up survey administrations. The outcomes of the performance measurement analysis were death, change in physical health as measured by the PCS score, and change in mental health as measured by the MCS score. For the HOS results, death and PCS outcomes were combined into one overall measure of change in physical health. Thus, there are two primary outcomes: (1) Alive and PCS better or same (vs. PCS worse or death), and (2) MCS better or same (vs. MCS worse). These outcomes are designated as the primary outcomes of interest since health maintenance, rather than improvement, is a realistic clinical goal for many seniors.

Multivariate logistic regression models were used for case-mix adjustment, and to calculate expected outcomes for each beneficiary. Case-mix adjustments were used so that all MAOs were as comparable as possible in terms of socio-demographic characteristics (age, gender, race, etc.), chronic conditions, baseline health status, and other design variables. All beneficiaries who completed the HOS at baseline and had a baseline PCS or MCS score were included in the analysis of death outcomes. Beneficiaries age 65 or older who completed the HOS at baseline and follow up, and for whom PCS and MCS scores could be computed at both time points, were included in the analysis of PCS and MCS outcomes.

For expected outcomes, the probability of being better or worse was calculated using statistical models that take into account the demographic and socioeconomic variables and other covariates. The expected outcomes were death, “PCS better or same,” and “MCS better or same.” For calculating expected outcomes, separate case-mix models were warranted for death, PCS scores, and MCS scores.

A series of 12 different models (six death models, three PCS models and three MCS models) were applied, since not all beneficiaries had data for all of the independent variables that could be used to calculate an expected score. In other words, each expected outcome for a beneficiary was based on those variables for which the beneficiary had data. For example, if a beneficiary had all of the required independent variables for Model A (the model containing the highest number of independent variables), then their expected score was calculated using that model. If not, then Model B (the model containing the second highest number of independent variables) was used if all of the required independent variables for this model were available, and so on. One model was used to calculate an expected outcome for each beneficiary.

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<sup>1</sup> SAS<sup>®</sup> is a registered trademark of SAS Institute Inc., Cary, NC.



## Death Models

Models used to predict the probability of death for each beneficiary included variables to control for baseline differences in demographic and socioeconomic characteristics, chronic medical conditions, and functional status. Demographic and socioeconomic variables included age, gender, race, education, marital status, annual household income, home ownership, Medicaid status, and eligibility for Supplemental Security Income (SSI). Chronic medical conditions were measured with a checklist of 14 conditions and four indicators of current cancer treatment. Conditions were grouped into four categories that were strong, moderate, weak, and negative predictors of death, for models in which the individual chronic medical condition data were incomplete. Additional variables considered for the models included the baseline item about general health compared to others, the six ADL items, the individual VR-12 response items, and the baseline PCS and MCS scores. For example, functional status was measured using a combined VR-12 physical functioning/ADL scale, the individual VR-12 response items, and the baseline item about general health compared to others. Baseline PCS and MCS were used when VR-12 response items were incomplete (see Table A1 in this Appendix for detailed information about covariates used in each of the six death models).

## PCS and MCS Models

Models used to predict expected change in PCS and MCS scores (e.g., PCS better or same) used a set of exogenous demographic and socioeconomic variables at baseline, such as age, gender, race, education, marital status, annual household income, home ownership, Medicaid status, and SSI (see Table A2 in this Appendix for detailed information about the three PCS models and three MCS models). Because each beneficiary served as his or her own control for the PCS and MCS analysis, substantial case-mix was already reflected in the baseline PCS or MCS scores. Sensitivity analyses determined that further adjustment for chronic medical conditions at baseline was not warranted, because errors in disease reporting were correlated with functioning.

## Calculation of MAO-Level Results

Calculation of the overall MAO-level results was completed by creating an actual death indicator for each beneficiary in an MAO who died during the two-year follow up. The actual physical and mental health indicators were also created for whether the PCS score and MCS score were better, the same, or worse at the two-year follow up. The PCS score is considered to be the same if it changed by less than 5.66 points (plus or minus) between baseline and follow up survey administrations. A change greater than 5.66 points (plus or minus) is outside of the 95% confidence interval for an individual beneficiary, as estimated from the standard deviation and reliability of the PCS score. The MCS score is considered to be the same if it changed by less than 6.72 points (plus or minus).

An expected death rate, an expected PCS better or same rate, and an expected MCS better or same rate were calculated for each beneficiary within an MAO using regression models for the case-mix adjustment. Data for all beneficiaries within an MAO were summarized, and included the mean expected death rate, the mean expected PCS score better or same, and the mean expected MCS score better or same rates. The mean actual death rate, and the mean actual PCS score better or same, and the mean actual MCS score better or same rates were then calculated. Expected outcomes for “PCS better” and “MCS better” were also needed to calculate the percentage of beneficiaries who were better, the same, or worse on each measure. The percentage of beneficiaries who were worse at follow up is calculated as 1 minus the percentage

who were better or the same. The differences between actual and expected results were calculated by combining the national results and the MAO deviation score.

To summarize data for the outcome “Alive and PCS better or same” for all beneficiaries within an MAO, the mean expected death rate ( $E_d$ ) was calculated for all beneficiaries in the MAO, along with the mean expected “PCS better or same” rate ( $E_{psb}$ ). The expected “Alive and PCS better or same” for the MAO is  $(1-E_d)*E_{psb}$ . For the same beneficiaries within the MAO, the mean actual death rate ( $A_d$ ) and mean actual “PCS better or same” rate ( $A_{psb}$ ) were calculated across all beneficiaries. The actual “Alive and PCS better or same” rate for the MAO is  $[(1-A_d)*A_{psb}]$ . The difference between actual and expected results indicates the percentage points by which the MAO’s actual “Alive and PCS better or same” rate was higher (for a positive difference) or lower (for a negative difference) than expected results. A  $t$  statistic, expressing the significance of the MAO differences from the average national results, was calculated by dividing the MAO deviation by the standard error. A  $t$  statistic plus or minus 2.0 or larger was considered significant, as long as an overall  $F$  test indicated that the MAOs differed on the outcome of interest (discussed below). An adjusted MAO percentage of “Alive and PCS better or same” also was calculated by combining the overall (national) results and the MAO deviation score, using a logit transformation. Similar logic was used to calculate MAO level data for “Alive and PCS better,” “MCS better or same,” and “MCS better.”

#### Tests of Significance for MAO-Level Differences

For physical health (mortality and PCS) over the two-year follow up period, overall  $F$  tests are conducted to determine if mortality, “PCS better or same” and “PCS better” are significantly different at the MAO level. If both “Death” and “PCS better or same,” which when combined are specified *a priori* as the primary physical health outcome of “Alive and PCS better or same,” differ significantly at the MAO level, an outlier analysis for PCS is warranted. The PCS outlier analysis is performed using a  $t$  test at the MAO level. MAOs with a  $t$  statistic  $\geq 2.0$  are designated as a better than expected outlier for the physical health measure, while MAOs with a  $t$  statistic  $\leq -2.0$  are identified as a worse than expected outlier, compared to the national average. If the  $F$  test for “Death” or “PCS better or same” is not significant, the  $t$  tests are not warranted and all MAOs are designated as the same, when compared to the national average. Note that the “Alive and PCS better or same” measure is the combined Physical Health Percent Better plus Same result in the Physical Health Results Table 7 in the “*Cohort 16 Performance Measurement Results*” section and is used as the Medicare Star Ratings measure for *Improving or Maintaining Physical Health*.

For the two-year follow up period for mental health (MCS), an overall  $F$  test is conducted to determine if “MCS better or same” and “MCS better” are significantly different at the MAO level. If “MCS better or same,” which is specified *a priori* as the primary mental health outcome, differs significantly at the MAO level, an outlier analysis for MCS is warranted. The MCS outlier analysis is also performed using a  $t$  test at the MAO level. MAOs with a  $t$  statistic  $\geq 2.0$  are designated as a better than expected outlier for the mental health measure, while MAOs with a  $t$  statistic  $\leq -2.0$  are identified as a worse than expected outlier, compared to the national average. If the  $F$  test for “MCS better or same” is not significant, the  $t$  tests are not warranted and all MAOs are designated as the same, when compared to the national average. Note that the “MCS better or same” measure is the combined Mental Health Percent Better plus Same result in the Mental Health Results Table 8 in the “*Cohort 16 Performance Measurement Results*” section and is used as the Medicare Star Ratings measure for *Improving or Maintaining Mental Health*.

**Table A1: Covariates Used in Estimation of Expected Mortality**

Death Model Covariates	Death Model					
	A	B	C	D	E	F
<b>Demographic and Socioeconomic Variables at Baseline</b>						
Age (linear), Age 75+, Age 85+	✓	✓	✓	✓	✓	✓
Gender	✓	✓	✓	✓	✓	✓
Age and Gender interaction	✓	✓	✓	✓	✓	✓
HOS Race/Ethnicity (Asian, Black/African-American, Hispanic, Native American, Pacific Islander, Multiracial)	✓	✓				
CMS Race/Ethnicity (Asian, Black/African-American, Hispanic, Native American, Other, Unknown)			✓	✓	✓	✓
Receive Medicaid or do not receive Medicaid	✓	✓	✓	✓	✓	✓
Eligible or not for Supplemental Security Income (SSI) due to disability	✓	✓	✓	✓	✓	✓
Home owner or non-home owner	✓	✓				
High school graduate or not high school graduate	✓	✓				
Married or not married (single, divorced, widowed, separated)	✓	✓				
Annual household income less than \$20,000 or annual household income of \$20,000 or greater	✓	✓				
<b>Chronic Medical Conditions at Baseline</b>						
Presence or absence of each of 14 chronic medical conditions: hypertension, myocardial infarction, angina/coronary artery disease, congestive heart failure, other heart conditions, stroke, pulmonary disease, gastrointestinal disorders, arthritis of hip or knee, arthritis of hand or wrist, sciatica, diabetes, depression, any cancer other than skin cancer	✓					
Treatment or non-treatment for 4 cancer types: colon/rectal, lung, breast, prostate	✓					
Mean number of conditions in 4 groups with varying relations to death:						
1. Strong relationship (congestive heart failure, any cancer, lung cancer)						
2. Moderate relationship (pulmonary disease, colon/rectal cancer, stroke, diabetes, other heart conditions)		✓	✓	✓		
3. Weak relationship (angina/coronary artery disease, breast cancer, myocardial infarction, depression)						
4. Negative relationship (gastrointestinal disorders, arthritis [both types], sciatica, hypertension, prostate cancer)						
<b>Baseline Functional Status</b>						
Physical Functioning/Activities of Daily Living Scale	✓	✓	✓			
General Health item (health is excellent, very good, good, fair, poor)	✓	✓	✓			
Physical Functioning item (limitations in moderate activities)	✓	✓	✓			
Physical Functioning item (limitations climbing several flights of stairs)	✓	✓	✓			
Role-Physical item (accomplished less than would like)	✓	✓	✓			
Role-Physical item (limited in the kind of work or other activities)	✓	✓	✓			
Role-Emotional item (accomplished less than would like)	✓	✓	✓			
Role-Emotional item (didn't do work or other activities as carefully)	✓	✓	✓			
Bodily Pain item (pain interfered with normal work)	✓	✓	✓			
Mental Health item (felt calm and peaceful)	✓	✓	✓			
Vitality item (had a lot of energy)	✓	✓	✓			
Mental Health item (felt downhearted and blue)	✓	✓	✓			
Social Functioning item (health interfered with social activities)	✓	✓	✓			
One-item measure of General Health compared to others	✓	✓	✓			
Baseline PCS and MCS				✓	✓	

**Table A2: Covariates Used in Estimation of Change in PCS and MCS Scores**

PCS/MCS Model Covariates at Baseline	PCS Model			MCS Model		
	A	B	C	A	B	C
Age (linear), Age 75+, Age 85+	✓	✓	✓	✓	✓	✓
Gender	✓	✓	✓	✓	✓	✓
Age and Gender interaction	✓	✓	✓	✓	✓	✓
HOS Race/Ethnicity (Asian, Black/African-American, Hispanic, Native American, Pacific Islander, Multiracial)	✓	✓	✓	✓	✓	✓
Receive Medicaid or do not receive Medicaid	✓	✓	✓	✓	✓	✓
Eligible or not for Supplemental Security Income (SSI) due to disability	✓	✓	✓	✓	✓	✓
Home owner or non-home owner	✓	✓	✓	✓	✓	✓
High school graduate or not high school graduate	✓	✓		✓	✓	
Married or not married (single, divorced, widowed, separated)	✓	✓	✓	✓	✓	✓
Annual household income less than \$20,000 or annual household income of \$20,000 or greater	✓			✓		

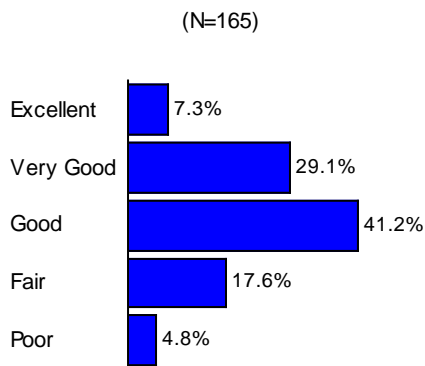
## Appendix 2

### 2015 Cohort 16 Follow Up Survey Field Frequencies for MAO HXXXXA

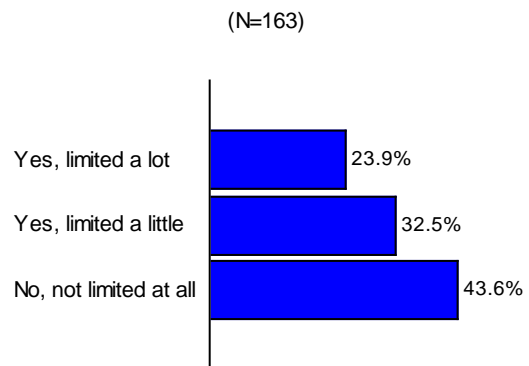
The frequency graphs on the following pages are available for most questions in the 2015 HOS 3.0 at follow up for your MAO's *Cohort 16 Performance Measurement* respondent sample, with the exception of demographic information in Q55 - Q68, which is provided in the Demographics and BMI tables in the "Performance Measurement Results" section.<sup>J</sup> Please note that the percentages in the graphs may not add to 100% due to rounding.

The response frequencies for questions used in the four HEDIS Effectiveness of Care measures (Q42-Q52) are displayed for the *2015 Cohort 16 Follow Up* fields only, and not the combination of the complete round of data (*2015 Cohort 18 Baseline* and *2015 Cohort 16 Follow Up* data), as reported in the "NCQA HEDIS Measures" section of the *2015 Cohort 18 Baseline Report*.

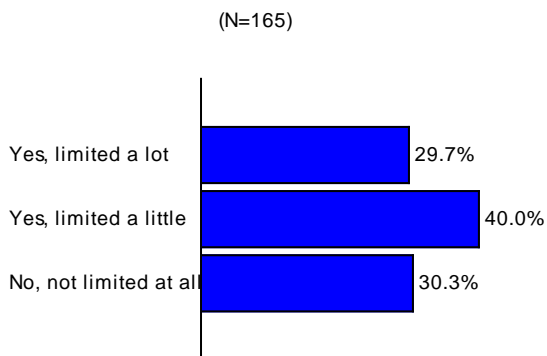
Q1. In general, would you say your health is:



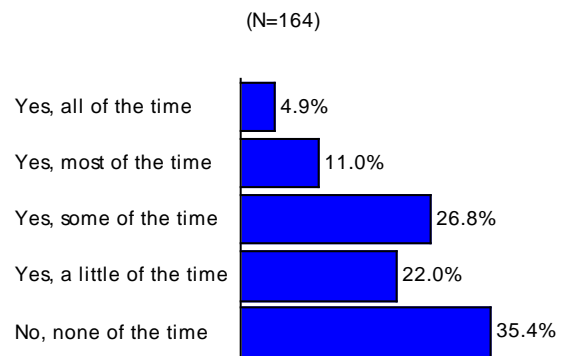
Q2a. Does your health now limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?



Q2b. Does your health now limit you in climbing several flights of stairs?

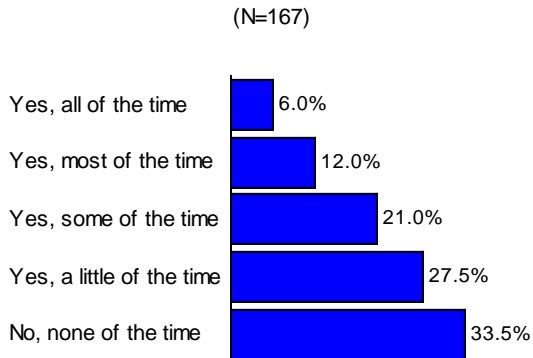


Q3a. During the past 4 weeks, have you accomplished less than you would like with your work or other regular daily activities as a result of your physical health?

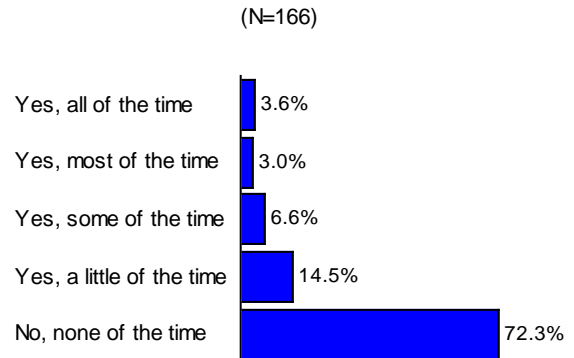


<sup>J</sup> The actual phrasing for the 2015 Medicare HOS 3.0 survey is available on the Health Outcomes Survey website at <http://www.hosonline.org/en/survey-instrument/>.

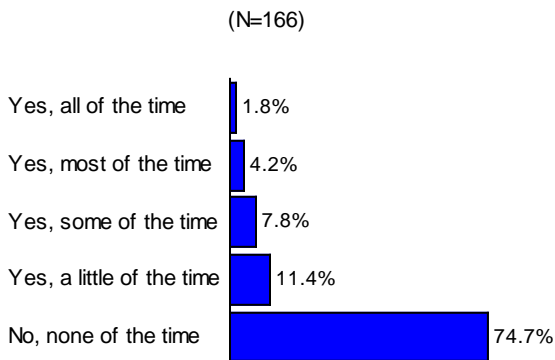
Q3b. During the past 4 weeks, were you limited in the kind of work or other activities as a result of your physical health?



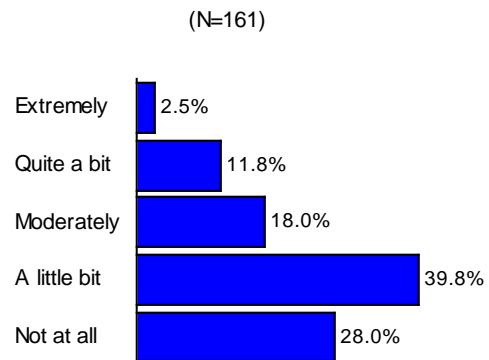
Q4a. During the past 4 weeks, have you accomplished less than you would like with your work or other regular daily activities as a result of any emotional problems?



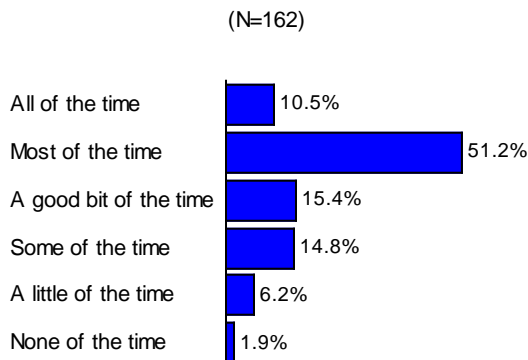
Q4b. During the past 4 weeks, did you not do work or other activities as carefully as usual as a result of any emotional problems?



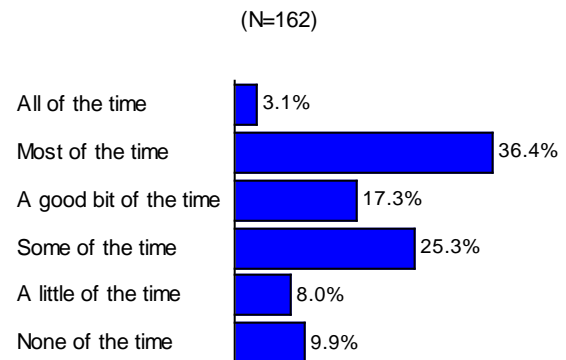
Q5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?



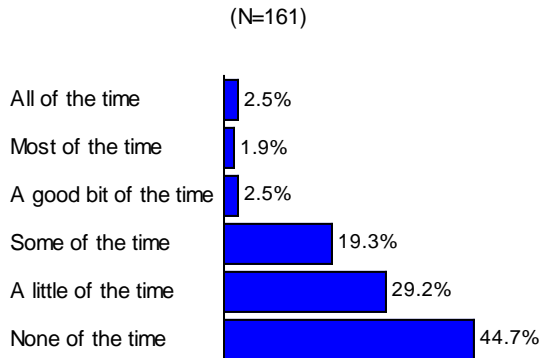
Q6a. How much of the time during the past 4 weeks: Have you felt calm and peaceful?



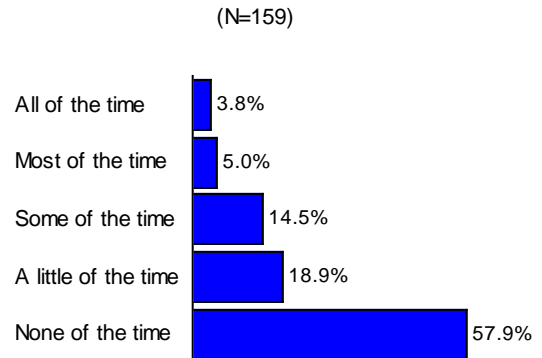
Q6b. How much of the time during the past 4 weeks: Did you have a lot of energy?



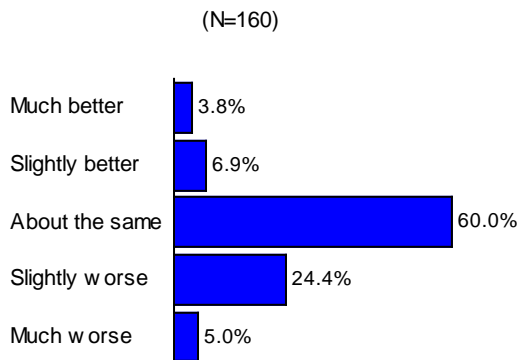
Q6c. How much of the time during the past 4 weeks: Have you felt downhearted and blue?



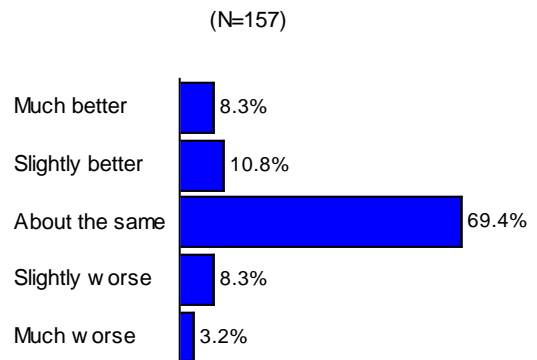
Q7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?



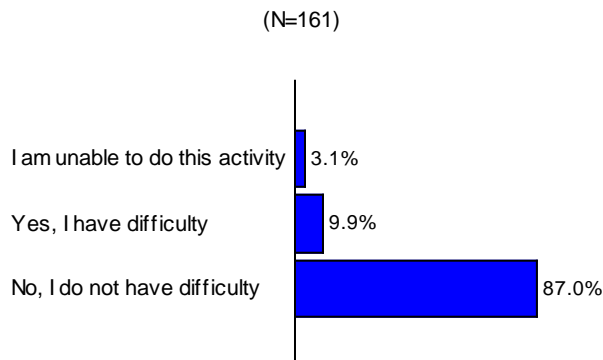
Q8. Compared to one year ago, how would you rate your physical health in general now?



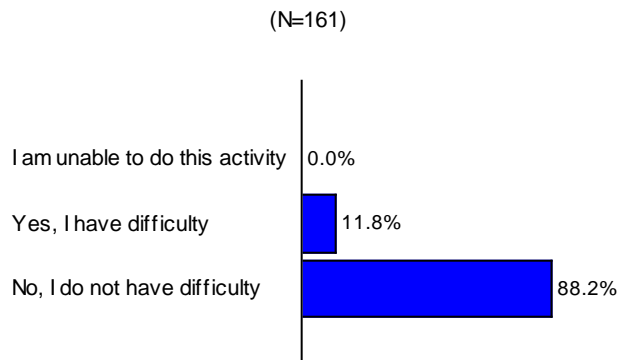
Q9. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) in general now?



Q10a. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Bathing?

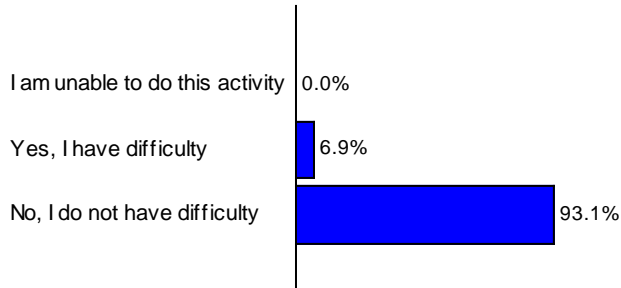


Q10b. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Dressing?



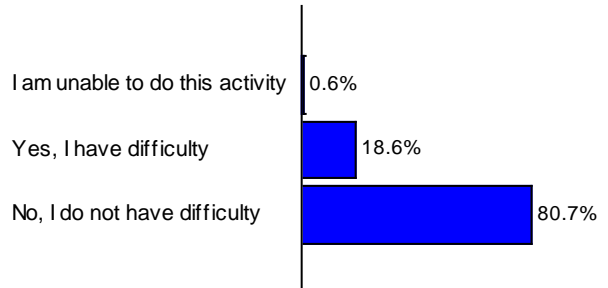
Q10c. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Eating?

(N=160)



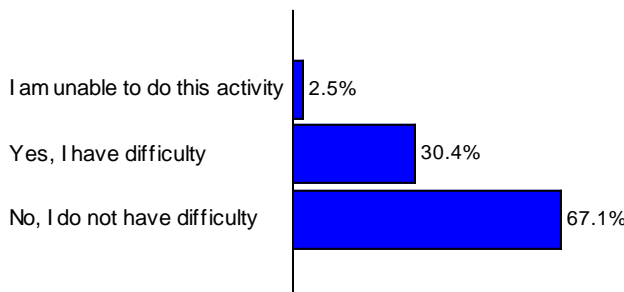
Q10d. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Getting in or out of chairs?

(N=161)



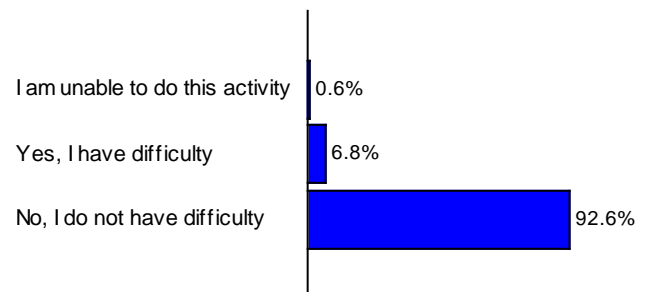
Q10e. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Walking?

(N=161)



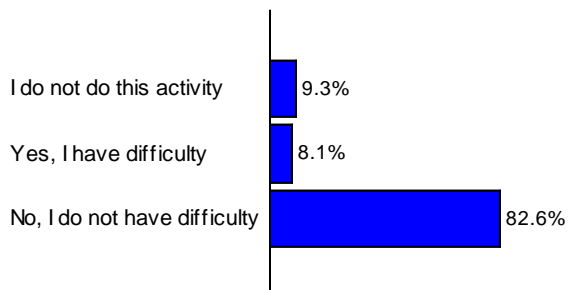
Q10f. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person: Using the toilet?

(N=162)



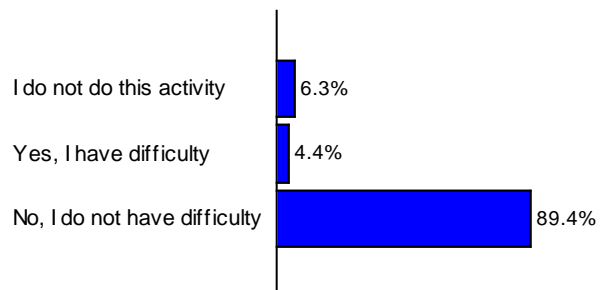
Q11a. Because of a health or physical problem, do you have any difficulty preparing meals?

(N=161)



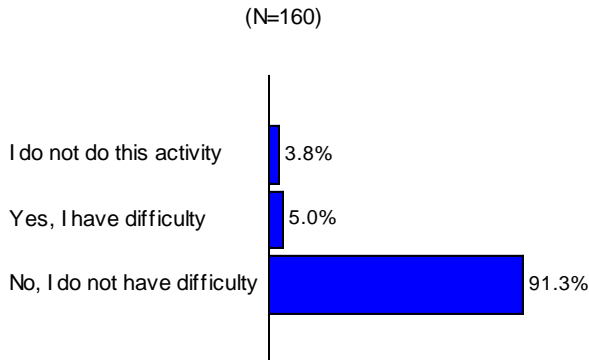
Q11b. Because of a health or physical problem, do you have any difficulty managing money?

(N=160)

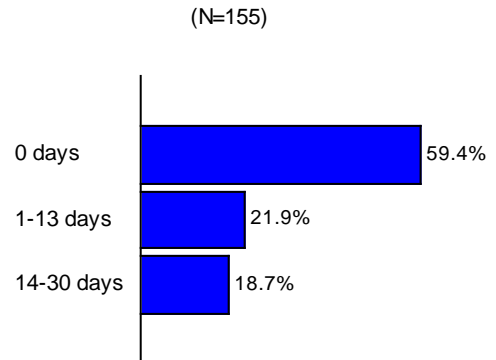




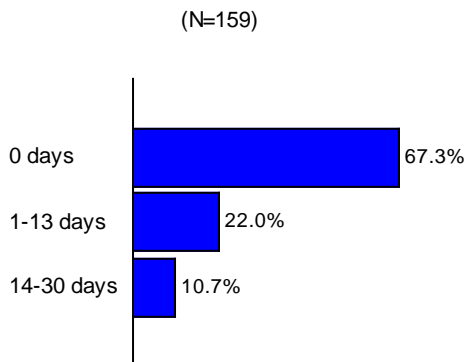
Q11c. Because of a health or physical problem, do you have any difficulty taking medication as prescribed?



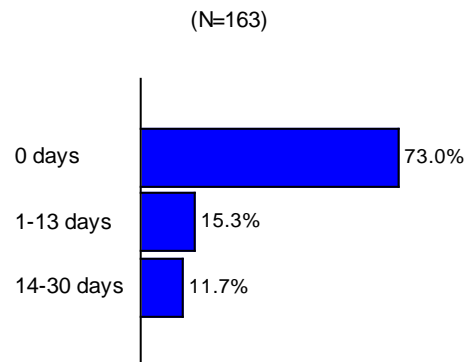
Q12. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



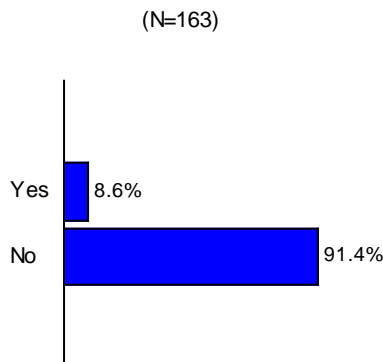
Q13. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?



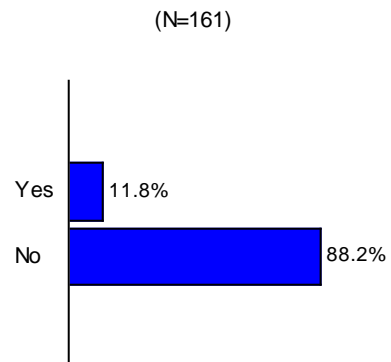
Q14. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?



Q15. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

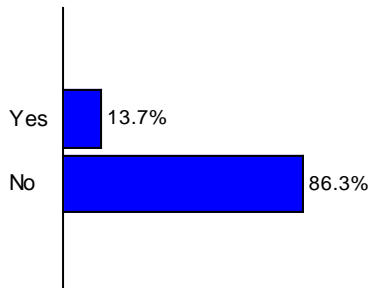


Q16. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?



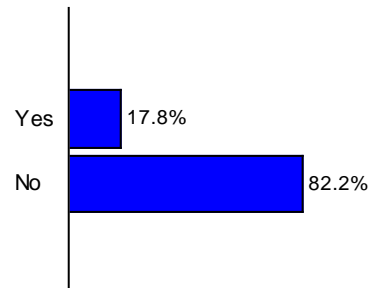
Q17. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

(N=161)



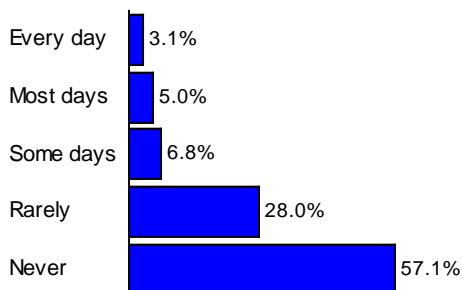
Q18. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

(N=163)



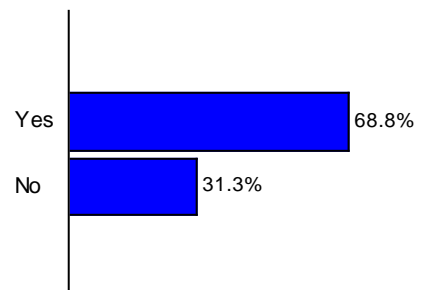
Q19. In the past month, how often did memory problems interfere with your daily activities?

(N=161)



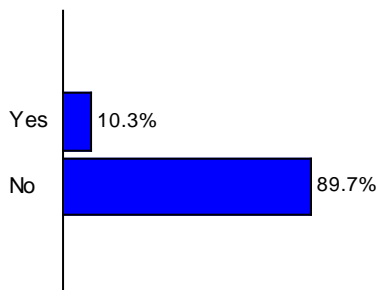
Q20. Has a doctor ever told you that you had: Hypertension or high blood pressure?

(N=160)



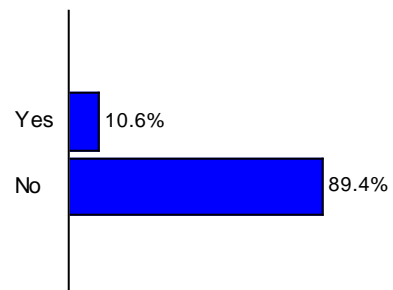
Q21. Has a doctor ever told you that you had: Angina pectoris or coronary artery disease?

(N=155)

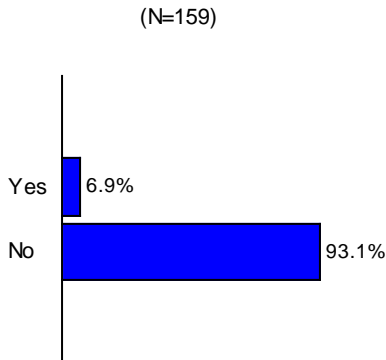


Q22. Has a doctor ever told you that you had: Congestive heart failure?

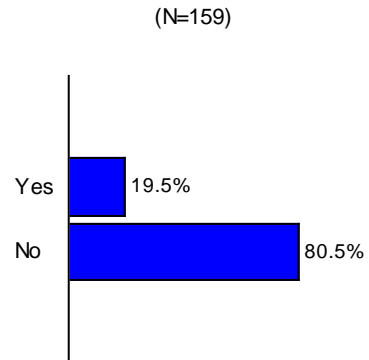
(N=161)



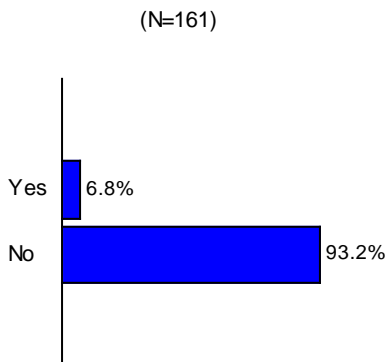
Q23. Has a doctor ever told you that you had:  
A myocardial infarction or heart attack?



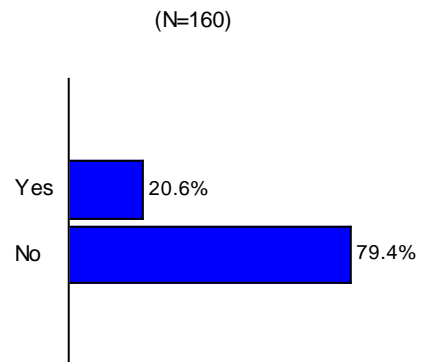
Q24. Has a doctor ever told you that you had:  
Other heart conditions, such as problems with heart  
valves or the rhythm of your heartbeat?



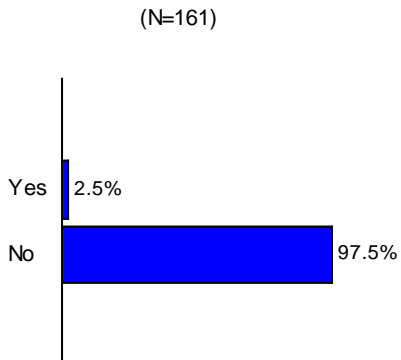
Q25. Has a doctor ever told you that you had:  
A stroke?



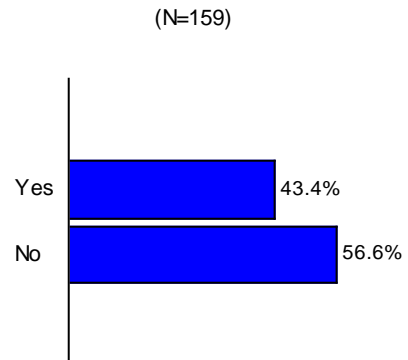
Q26. Has a doctor ever told you that you had:  
Emphysema, or asthma, or COPD (chronic obstructive  
pulmonary disease)?



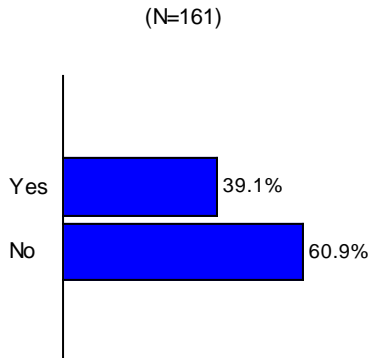
Q27. Has a doctor ever told you that you had:  
Crohn's disease, ulcerative colitis, or inflammatory  
bowel disease?



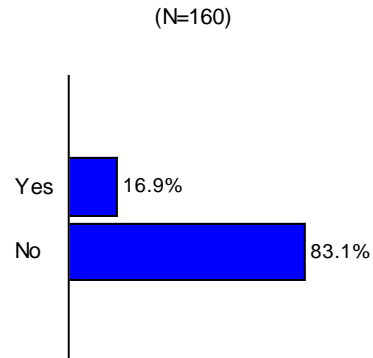
Q28. Has a doctor ever told you that you had:  
Arthritis of the hip or knee?



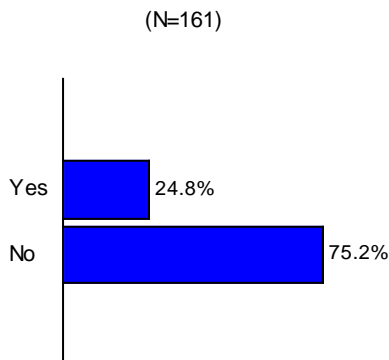
Q29. Has a doctor ever told you that you had:  
Arthritis of the hand or wrist?



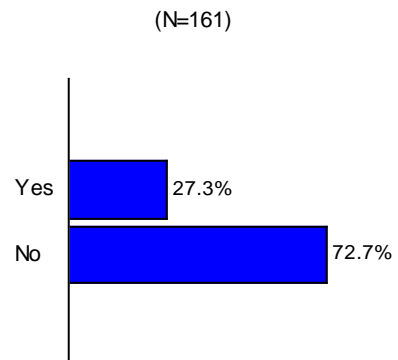
Q30. Has a doctor ever told you that you had:  
Osteoporosis, sometimes called thin or brittle bones?



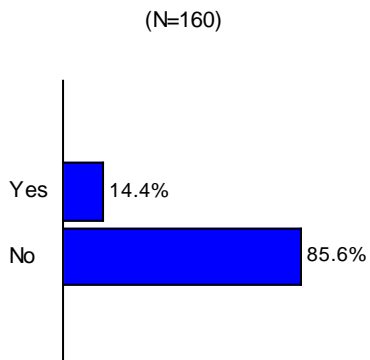
Q31. Has a doctor ever told you that you had:  
Sciatica (pain or numbness that travels down your leg  
to below your knee)?



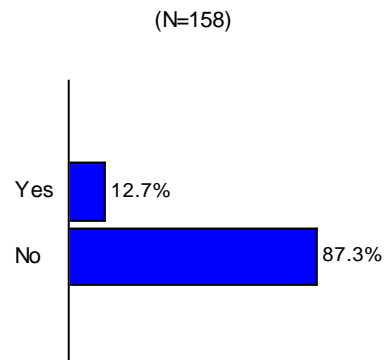
Q32. Has a doctor ever told you that you had:  
Diabetes, high blood sugar, or sugar in the urine?



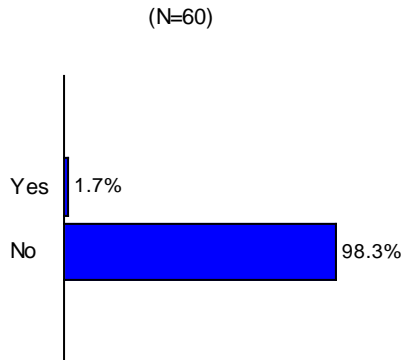
Q33. Has a doctor ever told you that you had:  
Depression?



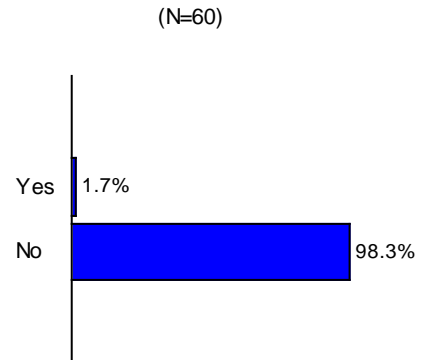
Q34. Has a doctor ever told you that you had:  
Any cancer (other than skin cancer)?



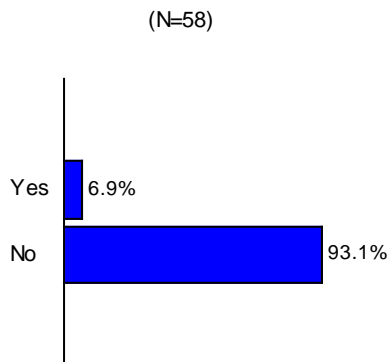
Q35a. Are you currently under treatment for:  
Colon or rectal cancer?



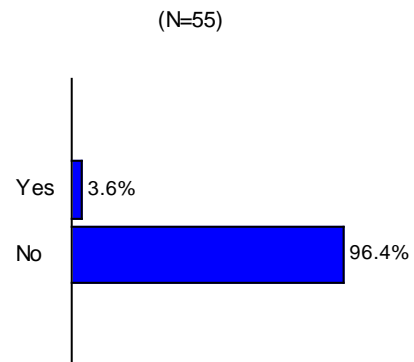
Q35b. Are you currently under treatment for:  
Lung cancer?



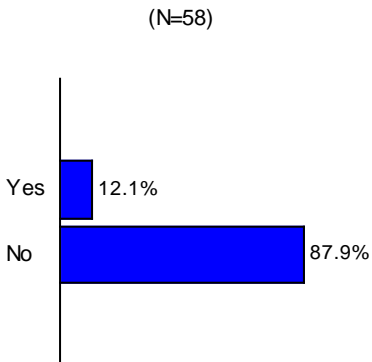
Q35c. Are you currently under treatment for:  
Breast cancer?



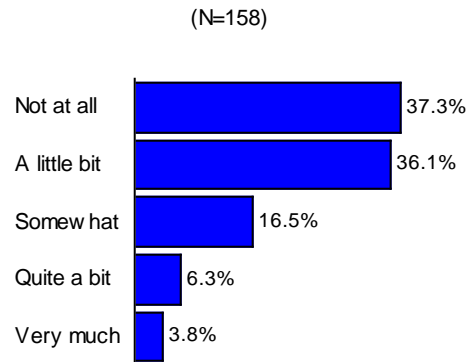
Q35d. Are you currently under treatment for:  
Prostate cancer?



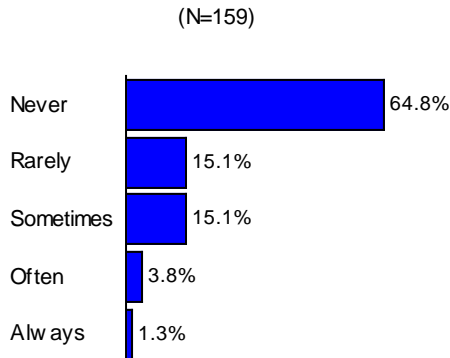
Q35e. Are you currently under treatment for: Other  
cancer (other than skin cancer)?



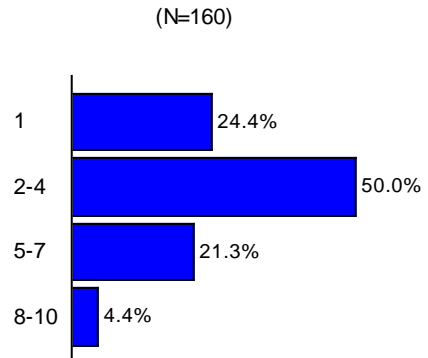
Q36. In the past 7 days, how much did pain interfere  
with your day to day activities?



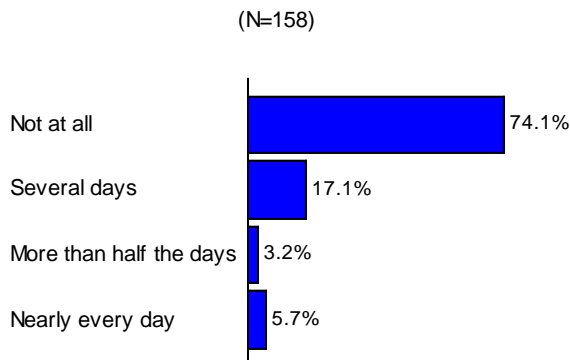
Q37. In the past 7 days, how often did pain keep you from socializing with others?



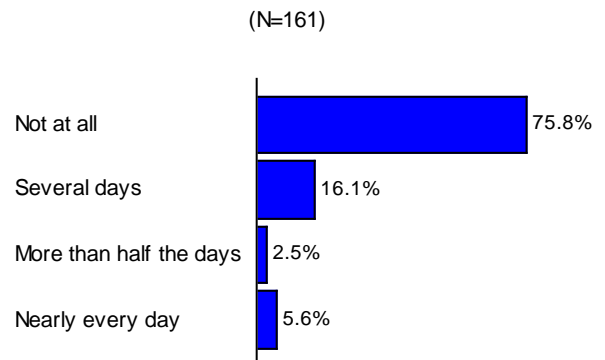
Q38. In the past 7 days, how would you rate your pain on average?



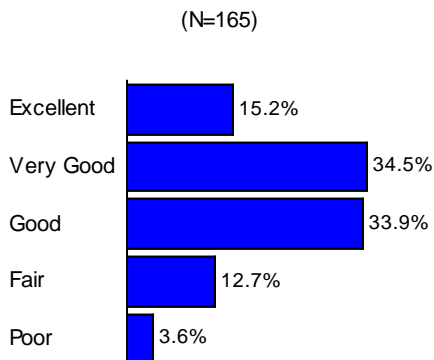
Q39a. Over the past 2 weeks, how often have you had little interest or pleasure in doing things?



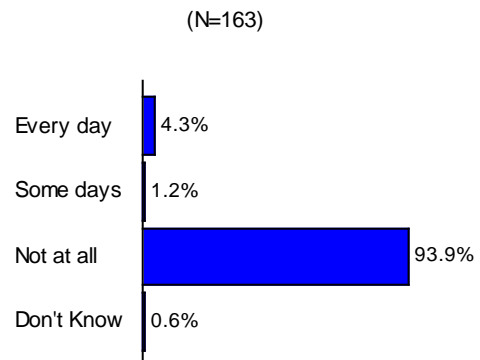
Q39b. Over the past 2 weeks, how often have you felt down, depressed or hopeless?



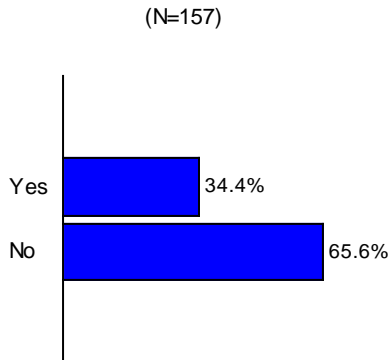
Q40. In general, compared to other people your age, would you say that your health is:



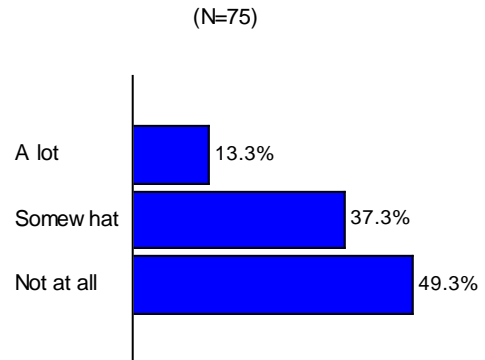
Q41. Do you now smoke every day, some days, or not at all?



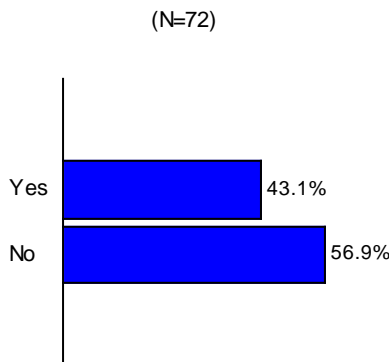
Q42. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?



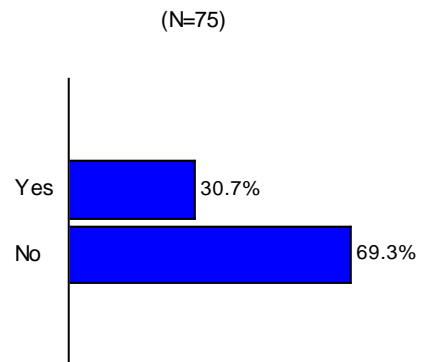
Q43. During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?



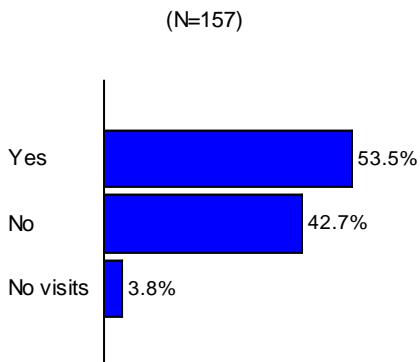
Q44. Have you ever talked with a doctor, nurse or other health care provider about leaking of urine?



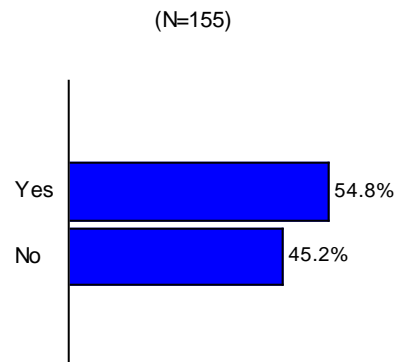
Q45. There are many ways to control or manage the leaking of urine, including bladder training, exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?



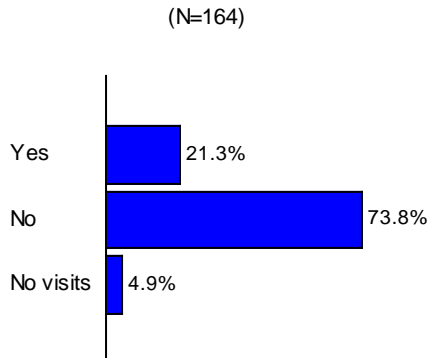
Q46. In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?



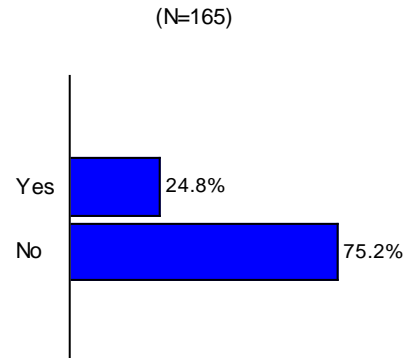
Q47. In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?



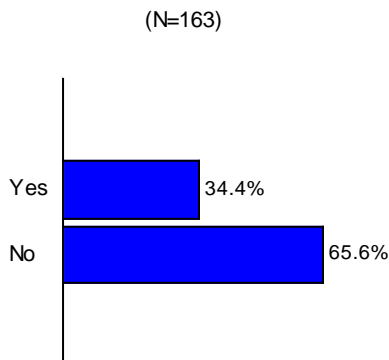
Q48. A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?



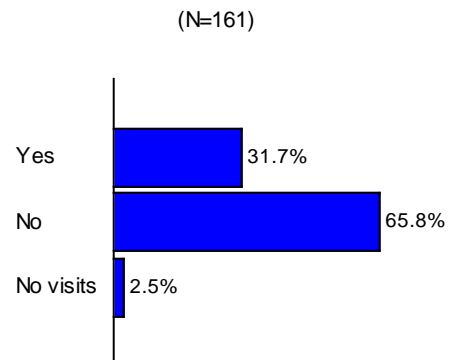
Q49. Did you fall in the past 12 months?



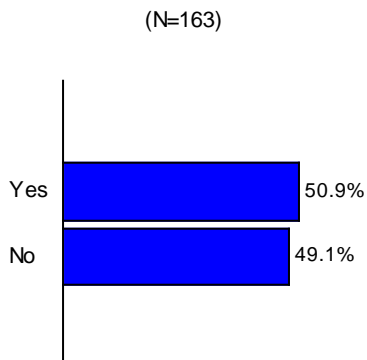
Q50. In the past 12 months, have you had a problem with balance or walking?



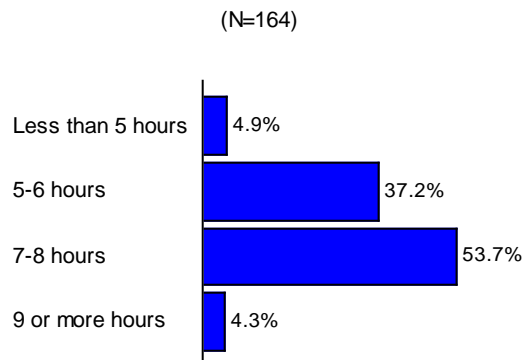
Q51. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?



Q52. Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'?

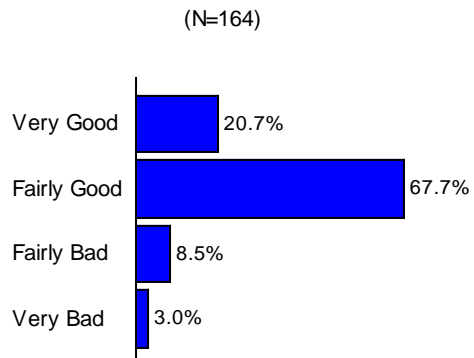


Q53. During the past month, on average, how many hours of actual sleep did you get at night?





Q54. During the past month, how would you rate your overall sleep quality?



## Appendix 3

### HOS Partners

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)**

**Address:**

7500 Security Boulevard  
Baltimore, MD 21244-1850

**HOS websites:**

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/index.html>

[www.HOSonline.org](http://www.HOSonline.org)

**HOS Email:**

[hos@cms.hhs.gov](mailto:hos@cms.hhs.gov)

The Health Outcomes Survey (HOS) Team at the Centers for Medicare & Medicaid Services (CMS) is responsible for leadership, oversight, coordination, and successful implementation of the national Medicare Health Outcomes Survey Program.

The HOS team directs and coordinates the work of various program partners. The survey implementation and operations contractors include the National Committee for Quality Assurance (NCQA), Research Triangle Institute (RTI) International, and the Center for the Assessment of Pharmaceutical Practices (CAPP), formerly Health Outcomes Technologies Program (HOT), of the Boston University School of Public Health. The data analysis, dissemination, education, and applied research contractor is Health Services Advisory Group (HSAG).

**CENTER FOR THE ASSESSMENT  
OF PHARMACEUTICAL  
PRACTICES (CAPP), FORMERLY  
HEALTH OUTCOMES  
TECHNOLOGIES PROGRAM  
(HOT)**

*Health Policy & Management  
Department, Boston University  
School of Public Health*

**Address:**

715 Albany Street (T-3W)  
Boston, MA. 02118

**Phone:** (617) 414-1418

**Fax:** (617) 638-5374

**CAPP website:**

<http://sph.bu.edu/Health-Policy-a-Management/center-for-the-assessment-of-pharmaceutical-practices-capp/menu-id-106.html>

**Survey website:**

<http://www.bu.edu/sph/research/research-landing-page/vr-36-vr-12-and-vr-6d/>

The Center for the Assessment of Pharmaceutical Practices (CAPP) at the Boston University (BU) School of Public Health was launched in 1998. The principal goals of CAPP are to advance the use of patient-centered assessments of health to improve health outcomes and to advance research efforts in the areas of health outcomes, cost-effectiveness analysis, technology assessment, disease management, pharmaceutical administration, and health care policy. CAPP has integrated patient-centered measures with extensive pharmaceutical and health services databases. CAPP has led several major projects in the VA involving the development of the Veterans RAND 36-Item Health Survey (VR-36), which is modified from the MOS SF-36 to provide greater precision and reliability than the original version. Well over 2 million administrations of the VR-36 have occurred in the VA since 1996. A shorter version of the VR-36, the Veterans RAND 12-Item Health Survey (VR-12), has also been developed by CAPP and administered to over 3.0 million users both inside and outside the VA. These assessments have contributed to the outcomes management system in the VA. The VR-12 is the principal outcome in HOS.

The work of the CAPP program is driven by an increased demand for new patient-based assessment tools and methodologies that can be used for clinical management and for monitoring the quality, efficiency, and effectiveness of patient care.

CAPP's staff have been engaged in several collaborative projects for the HOS, including comparisons of health outcomes between the HOS and the VA. The purpose of this study was to examine the differences in the outcomes of care for the HOS compared with the VA. Analyses included psychometric comparisons of a 36-item Health Survey between HOS and VA, and an examination of the differences of the disease burden of patients seen in the HOS systems of care compared with those veterans seen within the VA. A recent study examined the quality of care using medication data from the Medicare Part D data base merged with VR-12 outcomes from the HOS survey. The group has also developed imputation programs for the HOS to deal with missing values using the MOS SF-36 Version 1.0, the VR-36, and the VR-12, as well as risk adjustment models.

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Health Services Advisory Group, Inc. (HSAG) is a diversified, Arizona-based Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and External Quality Review Organization (EQRO). Established in 1979 by a group of medical professionals, HSAG served as the Arizona QIO since 1979. In 2003, HSAG acquired the Florida QIO (FMQAI) and in 2008, HSAG was selected as the QIO for California (HSAG in California). In 2014, HSAG was awarded the new QIN-QIO contract for the states of Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.

As a designated QIN-QIO, HSAG implements projects focused on improving the quality of healthcare services for Medicare beneficiaries. As an EQRO, HSAG is nationally recognized for its extensive experience with Medicaid programs and their populations.

HSAG is licensed by the National Committee for Quality Assurance (NCQA) to conduct HEDIS Compliance Audits™ and is an NCQA Certified HEDIS/CAHPS® Survey Vendor. Nationally accredited by the American Accreditation Healthcare Commission/URAC since 1993, HSAG also performs medical reviews for private and government clients.

HSAG has been CMS' data analysis, dissemination, education, and applied research contractor for the Medicare HOS program since 1998.

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The National Committee for Quality Assurance (NCQA) has served as the Centers for Medicare & Medicaid Services (CMS) contractor for implementing the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) Medicare Health Outcomes Survey (HOS) since the survey's inception in 1997. In this capacity, NCQA:

- Manages the data collection and transmittal of the HOS.
- Evaluates CMS-approved HOS survey vendors and conducts ongoing quality assurance of the survey process.
- Develops, evaluates, and refines quality measures for the HOS.
- Publishes the *HEDIS, Volume 6 Specifications for the Medicare Health Outcomes Survey*, which contains the technical specifications for the measure and survey protocol.
- Furnishes CMS, Medicare Advantage Organizations (MAOs), and interested parties with training, technical assistance, and materials related to the HOS measures.

NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA's website ([www.ncqa.org](http://www.ncqa.org)) contains information to help consumers, employers and others make more informed health care choices.

NCQA accredits and certifies a wide range of health care organizations, recognizes clinicians and clinician groups in key areas of performance and manages the evolution of HEDIS, the tool the nation's MAOs use to measure and report on their performance. There are more than 70 different measures in HEDIS, which provide purchasers and consumers with the information they need to reliably compare the performance of managed care plans.

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RTI International is an independent, nonprofit research institute based in Research Triangle Park, North Carolina. Established in 1958 as the Research Triangle Institute, RTI has a distinguished history of scientific achievement in the areas of health and pharmaceuticals, education and training, surveys and statistics, advanced technology, international development, economic and social policy, energy and the environment, and laboratory testing and chemical analysis. RTI's staff of more than 2,800 supports projects in more than 40 countries.

The organization was founded by a joint action of the University of North Carolina at Chapel Hill, Duke University, and North Carolina State University as the first scientific organization in the Research Triangle Park (RTP), North Carolina. RTI today comprises four research units, of which the largest encompasses statistics, health and social policy and survey research.

RTI staff have extraordinary depth of expertise in collecting, assessing, and reporting policy-oriented information and conducting health services research in many areas, including payment system design, risk adjustment, cost estimation and cost-effectiveness analysis, as well as state health care reform and Medicaid program evaluation. In addition, RTI possesses substantial capabilities in the analysis of large databases. Staff members are highly regarded in their respective areas of expertise and they have testified before the U.S. Congress, MedPAC (and its predecessor agencies ProPAC and PPRC), and various state commissions.

RTI's main campus is located on 180 acres in North Carolina's RTP. In addition, RTI maintains well-staffed research facilities at sites in Washington, DC; Rockville, Maryland; Waltham, Massachusetts; Chicago, Illinois; Atlanta, Georgia; and at numerous project locations in the United States and abroad.

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