

Sonya Bowen:

Okay, I'm going to give you a quick overview of the Medicare Health Outcome Survey. This is a HEDIS measure. There's a little bit of confusion. Some people don't understand that it is a HEDIS effectiveness of care measure that was implemented back in 1998 by CMS. In contrast to the structure and process of care measures that are reported directly by the plans, the Health Outcome Survey is a questionnaire that the information is collected directly from the beneficiary so it's a little bit different methodology.

This is a survey that's collected annually from 1,200 randomly selected beneficiaries from each eligible contract. As was said earlier, this is at the contract level. The only type of beneficiary that we exclude is ESRD patients, and this is when we do our baseline collection. We survey elderly and disabled adults in each plan.

This is a longitudinal health status measure where we collect a baseline measure, and then two years later, those beneficiaries who are still enrolled in the plan are re-measured. It's a self-administered mail survey with telephone follow-up for those who don't respond by mail. Also in contrast to the HEDIS process of care measures that measure more along the lines of direct care that are delivered by the health plans, the HOS is more of an overall performance measure of a health plan's ability to maintain or improve the quality of life and health of its Medicare patients. Together, all of these measures, HEDIS, HOS and CAPS, they really give CMS a more comprehensive picture of health plan quality and performance.

What HOS allows CMS and the health plans to do is to meet the MNA mandate for each Medicare Advantage Plan to collect, analyze and report health outcomes data as well as other indices of quality, so that's why we do it. As far as who must report HOS, the MA contracts for local and coordinated regional care plans must report, social HMOs must report and then the 1876 cost plans who have open enrollment must report. Then the private fee-for-service plans, because of legislative restrictions, we don't require them to report, but we do encourage them to report this as voluntary. Then, as far as contract effective date, those that were effective January 1 of the year preceding measurement are in the survey so, for this year, 2008, those who were effective on or before January 1, 2007 are in. It just so happens that we are starting survey implementation this week. pre-notification post cards are going out. Then last year we implemented an enrollment threshold of 500 for plans so that we have meaningful data at the end of two years.

I just wanted to highlight Special Needs Plans because we have changed reporting requirements this year for Special Needs Plans. Prior to this year, contracts that had exclusive SNP enrollment, they were exempt from HOS, and the only exception were the former long-term care demo plans which participate in the HOS-Modified, which I'll highlight in a minute. But what's new to this year is that if a contract otherwise meets the HOS requirements and they have one or more SNP benefit package, these types of contracts must participate in HOS now. I also wanted to note before this year, if a contract was majority institutional SNP, they were exempt, so everybody basically is in regardless of SNP type. They're in the HOS, and it's sampled and collected at the contract level like other MA contracts.

The overall goal of the HOS program has been pretty consistent since the beginning. Like Liz said, we focus on standardization because what's the most important is that the data that we collect is valid and reliable. That's pretty much the core of what we do so that this data can be used to promote performance assessment and managed care, to promote quality improvement and efforts and also beneficiary choice.

The fourth point, Outcomes Research, it's kind of been a natural outgrowth from the program to be able to advance the state of the science in outcomes research. So that wasn't a primary focus but it has become one. From all of the efforts from the various groups, the HOS program has been able to achieve national and international recognition as a collection of robust health outcomes measures from the patient perspective. That's something that's pretty impressive.

Just to mention the HOS-Modified: this is a shorter version of the HOS instrument, and it was implemented in 2005. We use this for certain specialized plans, PACE plans and then also former long-term demo plans which now have been phased into regular Medicare Advantage Plan. What this data does is it has allowed CMS to adjust payment for these frail populations. Just to note, the long-term care plans? They will be phased into regular HOS as of 2010.

I want to spend a couple minutes on this particular slide because it really helps to kind of explain the depth of the data that's available to CMS and to the plans and QIOs who want to know how to use this data. The primary measure of the Health Outcome Survey is the physical health status. I'll kind of go down the left and then swing around. The physical health status is a summary measure, and the mental health status is a summary measure. Those are the two primary outcome measures that come from a core 12-item health survey. Then we ask about 14 health problems that are common and relevant to the Medicare population. This would include things like hypertension, a variety of heart conditions, stroke, pulmonary conditions, arthritis, diabetes, cancer, so it really is a lot of good information. Then we also ask about a variety of clinical symptoms, like chest pain, arthritis pain, low-back pain, sciatica, shortness of breath, neuropathy, to kind of give everyone an idea of what the patients look like in your plan. We also ask about self-reported difficulty in six daily tasks including bathing, dressing, eating, walking, and toileting. Not uncommon to this population, HOS data shows us that walking is the greatest report difficulty in our data. Recently we added a measure for height and weight in 2006, and this allows us to calculate BMI, which gives us important information about obesity as well as issues like underweight.

There's also a depression indicator in addition to the mental health status component which is very helpful information. We ask about smoking status. Also embedded within the HOS there are four HEDIS process-of-care measures that were added recently, and I'll go into a little bit more detail in a minute.

Then a couple of years ago, a few years ago in 2003, we added three questions called Healthy Days, which comes from CDC's Behavioral Risk Factor Surveillance System. They ask the number of days within the past 30 days that a person has had poor physical health, poor mental health, or difficulties in activities because of physical or mental health problems. This allows us to link with CDC data, which collects at National level, but they also have information on the

elderly population so that we can directly compare our population to the National level. This is a really important link data-wise. Then various demographic information we also collect.

The HEDIS measures that have been added within the last three or four years, we ask about management of urinary incontinence in older adults, and that asks whether a person's doctor is discussing urinary incontinence in those who are having leakage problem if they're receiving treatment. The physical activity in older adults that asks about whether a doctor's advising about physical activity, and then the fall-risk management measure asks whether a doctor's discussing managing fall risk. Then, lastly, osteoporosis testing in older women asks whether women over 65 have ever had a bone density test. Having these kind of measures in HOS allows plans to link some process-of-care measures with outcomes measures, as well.

Specifically what CMS looks at as far as performance measurement, the primary outcome measure is, we look at percentage of physical and mental health that's improved over the last two year, that's remained the same over the last two years, and which has declined over the last two years. So this is looking at the two-year period between baseline and follow-up. For each health plan, the patient outcome results are aggregated up across respondents for each health plan. Then the plan level results are computed using a rigorous set of case-mix and risk-adjustment variables so that we can adjust for expected differences based on co-morbid disease and socio-demographic conditions. Then the way we present this information at the two-year results is the percentage of beneficiaries who are better, same or worse than expected as I went over earlier.

To quickly go through the last slides, how does CMS use this data? We monitor health plan performance, which has been talked about extensively. HOS is one component of the Performance Assessment System. We also use this information to reward top-performing plans with regulatory relief, which equates to audit exemptions, and then we also use the data through HOS-M to construct a frailty adjustment. Lastly, this data is important in informing agency programs and priorities, for example, health care disparities, disease management, for example.

Then how do plans and QIOs use these results? The data really can be used – it's a great opportunity to identify opportunities to improve care and we provide a variety of tools and resources that plans and QIOs can use. We provide beneficiary-level data and data users guides. Every year we disseminate baseline profile reports and two-year performance measurement reports to help plans get a snapshot of what their plans look like, how they might be able to drill-down and use the resources that are available to target improved care. We also provide technical support. We also have a variety of best practice and applied research results that we share publicly to help plans.

These last couple of slides are just to basically give you an idea of how we operationalize the survey. It's really two phases, annual survey administration, that's kind of Phase One, and that would be the data collection piece, which we're currently doing in 2008. Right now where we are in the timeline is fielding the baseline survey April through June. The other piece is HOS data reporting, which is Phase Two. Where we are in that now is we're working with the data we collected last year in 2007 to create the data reports and the data sets that I was just talking about. This kind of gives you an idea of the flow of when we collect the data and then report it back to everyone.

If there are any questions that we don't have time to answer during the question and answer period, please feel free to contact us. This last slide is some resources. [HOS@CMS.HHS.gov](mailto:HOS@CMS.HHS.gov), that's for any program or policy questions, and you can also direct them to me as well. Then we have some other technical resources available.

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