30.2 - Medicare HOS Requirements

(Rev. 117, Issued: 08-08-14, Effective: 08-08-14, Implementation: 08-08-14)

HOS reporting requirements specify that MAOs with Medicare contracts in effect on or before January 1 of the preceding year report the Baseline HOS, provided they have a minimum enrollment of 500 members as of February 1 of the current year. In addition, all continuing MAOs that participated in the Baseline survey two years prior are required to administer a Follow-Up survey regardless of whether they meet the current year's enrollment threshold.

The following organizations with plan contracts in effect on or before January 1 of the previous year are included in the HOS:

- All coordinated care contracts, including PFFS and MSA contracts;
- Section 1876 cost contracts even if they are closed for enrollment;
- Employer/union only direct PFFS contracts.

Additionally, MAOs sponsoring fully integrated dual eligible (FIDE) SNPs may elect to report HOS at the FIDE SNP level to determine eligibility for a frailty adjustment payment under the Affordable Care Act, similar to those payments provided to PACE programs. Voluntary reporting will be in addition to the standard HOS requirements for quality reporting at the contract level.

The Veterans RAND 12-Item Health Survey (VR-12), supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS® functional status measure, HOS. This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, the results are primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that MAOs are currently using for clinical quality improvement. Each year a baseline cohort will be drawn and 1,200 beneficiaries per reporting unit (i.e., contract) will be surveyed. If the contract-market has fewer than 1,200 eligible members, all will be surveyed.

Additionally, each year the cohort measured two years previously at baseline will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well-being of each respondent. Depending on the amount of expected change, the respondent's physical and mental health status will be categorized as better, the same or worse than expected over the two-year period. Members who are deceased at follow-up are included in the "worse" physical outcome category. Beneficiary level results are aggregated to derive the MAO, state, and HOS national percent better, same, and worse than expected values.

To expedite the survey process, MAOs may be asked to provide telephone numbers or

verify telephone numbers for the respondents unable to be identified using other means. MAOs, at their expense, are expected to contract with any of the NCQA certified vendors for administration of the survey to do both the new baseline cohort and the re-measurement cohort (if the MAO participated when an earlier cohort was drawn for baseline measurement). Contracts with vendors are expected to be in place by January of each reporting year to ensure survey implementation by early-April of the reporting year. Further details will be provided by NCQA regarding administration of the survey the preceding fall.