

Medicare Health Outcomes Survey (HOS) Glossary

Activities of Daily Living (ADLs)	Activities of daily living are the everyday activities involved in personal care such as feeding, dressing, bathing, getting in or out of chairs, toileting, and walking. Physical or mental disabilities can restrict a person's ability to perform personal ADLs. The HOS collects information on limitations in ADLs.
Analytic Sample	Analytic samples are defined below for the two annual Medicare HOS reports: <i>Baseline</i> analytic sample is limited to seniors, age 65 or older at baseline, who had a physical component summary (PCS) score or a mental component summary (MCS) score and a valid reporting unit (Medicare Advantage Organization). <i>Performance Measurement</i> analytic sample is limited to seniors, age 65 or older at baseline, who had a PCS or MCS score at baseline, and a valid reporting unit (Medicare Advantage Organization) at follow up.
Behavioral Risk Factor Surveillance System (BRFSS)	The Behavioral Risk Factor Surveillance System (BRFSS) is a continuous, state-based, random telephone survey of community dwelling U.S. adults aged 18 and older. The BRFSS is administered and supported by the Centers for Disease Control and Prevention (CDC).
Beneficiary	An individual receiving benefits from the Medicare program.
Body Mass Index (BMI)	Body Mass Index (BMI) is a measure of body fat that applies to men and women, and is calculated based on height and weight. The formula is: $BMI = [\text{weight in pounds}/(\text{height in inches})^2] \times 703$. The HOS collects information on height and weight categories for calculation of BMI results.

CAPP	<p>Boston University School of Public Health, Health Policy & Management Department, CAPP: Center for the Assessment of Pharmaceutical Practices (formerly Health Outcomes Technology Program [HOT]) subcontracts with the National Committee for Quality Assurance for the Medicare HOS Program to support the science of survey design and methodology. Analytic work included psychometric comparisons of 36 item surveys used in the Medicare managed care and the Veteran's Health Administration programs, comparisons of health outcomes between the Medicare Advantage and VA patient populations, and analysis of case mix methodology employed by the HOS.</p> <p>Center for the Assessment of Pharmaceutical Practices Health Policy & Management Department Boston University School of Public Health 715 Albany Street (T-3W) Boston, MA 02118</p>
Case-Mix Adjustment	<p>A method that adjusts the resulting data for patient characteristics, which are known to be related to systematic biases in the way people respond to survey questions. This is accomplished using linear regression techniques, and assumes that the control variables (covariates) have been measured accurately and that the model is correctly specified and applicable to all cases.</p>
CATI	<p>Survey vendors use a standardized version of a computer assisted telephone interviewing (CATI) script to collect telephone interview data from a sampled member or a proxy. Survey vendors attempt telephone follow up in English or Spanish when members fail to respond after a second mail survey or return an incomplete mail survey.</p>
CDC	<p>The Centers for Disease Control and Prevention (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve health for people in the United States.</p>
CMS	<p>The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare, Medicaid, and Child Health Insurance Programs.</p> <p>Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, MD 21244</p>

CMS Regions and Regional Offices

CMS has Regional Offices in ten major cities throughout the U.S., in addition to their Central Office in Baltimore. Each Regional Office covers a specific group of states, which are listed below. Additional information is provided on the Regional Office Overview section of CMS’ website (www.cms.gov).

Region	Regional Office	States
Region 1	Boston	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region 2	New York	New York, New Jersey, U.S. Virgin Islands, Puerto Rico
Region 3	Philadelphia	Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia
Region 4	Atlanta	Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee
Region 5	Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region 6	Dallas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region 7	Kansas City	Iowa, Kansas, Missouri, Nebraska
Region 8	Denver	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region 9	San Francisco	Arizona, California, Hawaii, Nevada, and the Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands.
Region 10	Seattle	Alaska, Idaho, Oregon, Washington

CPM

The National Committee for Quality Assurance’s (NCQA) Committee on Performance Measurement (CPM) oversees the development of the HEDIS[®] measurement set. The CPM is a broad-based group representing employers, consumers, health plans and others that decide on the content of HEDIS. The CPM determines which measures are included and field tests determine how the items are measured.

Cohort	<p>A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a random sample of Medicare beneficiaries is drawn from each Medicare Advantage Organization (MAO) and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, these same respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was one thousand. Effective 2007, the MAO sample is increased to twelve hundred.</p>
Data Evaluation	<p>The process by which discrepancies within the data are identified and resolved, including issues related to file structure, record numbers, range, and consistency. Health Services Advisory Group (HSAG) conducts data evaluation for all HOS cohorts.</p>
Depression Screen	<p>A participant in the Medicare HOS is considered to have a positive depression screen when he or she answers “yes” to <i>any</i> of the following four depression questions:</p> <ul style="list-style-type: none"> • Number of days in the past week feeling depressed • Two weeks in the past year feeling sad, blue, or depressed • Depressed or sad much of the time in the past year • Two years or more in life feeling depressed or sad most days <p>For the 1998-2008 surveys, the additional question about the number of days feeling depressed in the past week was not included in the surveys.</p>
Disenrollment	<p>Beneficiaries who respond at baseline and are no longer in their original MAO at follow up are considered disenrolled. There are two types of disenrollment defined below:</p> <p style="padding-left: 40px;"><i>Involuntary:</i> The beneficiary’s MAO is no longer a part of the HOS as of the follow up remeasurement.</p> <p style="padding-left: 40px;"><i>Voluntary:</i> The beneficiary’s MAO continues in the HOS; however, the beneficiary is no longer enrolled in the MAO as of the follow up remeasurement.</p> <p>It is possible that beneficiaries who respond at baseline may remain in their MAO and not participate at follow up, if the MAO did not meet the minimum enrollment requirement of having 500 members for the sampling.</p>

Eligible HOS Sample

Eligible samples are defined below for the two annual Medicare HOS reports:

Baseline eligible sample includes those beneficiaries who were randomly selected from their MAO, were seniors (age 65 or older) or disabled (less than age 65), and did not have an ineligible HOS survey. For data collection years 1998-2008, a member was required to be continuously enrolled in their MAO for a six month period. Effective 2009, this requirement is waived. For data collection years 1998-2009, beneficiaries with End Stage Renal Disease (ESRD) were excluded. Effective 2010, those with ESRD are no longer excluded.

Performance Measurement eligible sample is limited to those seniors (age 65 or older at baseline) who had a baseline PCS or MCS score, were alive at follow up, and were still enrolled in their original MAO at the time of the follow up.

Eligible HOS-M Sample

Beginning in 2010, the eligible sample for the Medicare HOS-M report includes those beneficiaries in PACE Organizations who were randomly selected from their HOS-M plan, were seniors and disabled members (55 and older), and did not have an ineligible HOS-M survey. For the data collection years 2005-2009, seniors and disabled members from Dual-eligible Demonstration Projects in Massachusetts, Minnesota, and Wisconsin were also included.

ESRD

End Stage Renal Disease (ESRD) is characterized by permanent kidney failure that is treated with dialysis or a transplant. Since 2010, those with ESRD are included in the HOS baseline sampling.

Fall Risk Management (FRM)

Fall Risk Management (FRM) is an NCQA HEDIS[®] measure that is comprised of four questions, which collect information on a beneficiary’s history of falls or problems with balance or walking, a discussion of falls with a medical provider, and a provider’s management of fall risk. The FRM measure is collected using the HOS measure.

HEDIS[®]

The Healthcare Effectiveness Data and Information Set (HEDIS[®]) is the most widely used set of performance measures in the managed care industry, and is developed and maintained by NCQA. The Medicare HOS is a HEDIS Effectiveness of Care measure.

Healthy Days Measures	The HOS instrument incorporates three Healthy Days questions from the CDC's BRFSS. Two items ask beneficiaries about their physical and mental health during the previous thirty days, and one item asks how their poor physical or mental health limited them from doing their usual activities, such as self-care, work, or recreation. For additional information regarding the Healthy Days Measures and findings, please visit the CDC Health Related Quality of Life (HRQOL) website at www.cdc.gov/hrqol . Comparative national and state-level Healthy Days Measures data, including demographic breakdowns by age, sex, or race/ethnicity groups within each state, can be found on the CDC HRQOL Prevalence Data page at: http://apps.nccd.cdc.gov/HRQOL .
HIC Number (HIC #)	The Health Insurance Claim Number ([HIC] usually the Medicare number) is the beneficiary level unit of analysis for the HOS reports.
HOS Measure	The HOS measure assesses an MAO's ability to maintain or improve the physical and mental health functioning of its Medicare members over time. See Medicare Health Outcomes Survey (HOS).
HPMS	The Health Plan Management System (HPMS) is CMS' data collection and maintenance system that houses MAO-related information, including summary level HOS results.
HRQOL	The concept of Health-Related Quality of Life (HRQOL) refers to a person or group's perceived physical and mental health over time. HRQOL is used to measure the effects of chronic illness to better understand how an illness interferes with a person's day-to-day life, and to measure the effects of numerous disorders, disabilities, and diseases in different populations. Tracking HRQOL can identify subgroups with poor physical or mental health and guide policies or interventions to improve their health.
HSAG	<p data-bbox="669 1516 1448 1745">Health Services Advisory Group (HSAG) contracts with CMS to provide HOS data evaluation and analysis, develop and disseminate data files and reports, educate data users and stakeholders on HOS findings and applications, and conduct applied research with HOS data to support CMS priorities.</p> <p data-bbox="669 1766 1448 1869">Health Services Advisory Group 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016</p>

Ineligible HOS Survey

Ineligible surveys are defined below for the Medicare HOS baseline and follow up cohorts:

Baseline ineligible survey meets one of the following criteria: the beneficiary is deceased, not enrolled in the MAO, has an incorrect address and phone number, or has a language barrier.

Follow Up ineligible survey meets one of the following criteria: no longer enrolled in the MAO, has an incorrect address and phone number, or has a language barrier.

Ineligible HOS-M Survey

Ineligible surveys for the Medicare HOS-M meet one of the following criteria: the beneficiary is deceased, not enrolled in the health plan, has an incorrect address and phone number, or has a language barrier.

Likert Scale

An ordinal scale of responses to a question in an ordered sequence, such as from “(1) strongly disagree” through “(2) no opinion” to “(3) strongly agree.” Rensis Likert, a social psychologist, developed an empirical method for assigning numerical scores to this type of scale.

Management of Urinary Incontinence in Older Adults (MUI)

Management of Urinary Incontinence in Older Adults (MUI) is an NCQA HEDIS[®] measure that is comprised of four questions to gather data on UI experiences, UI problems, patient/provider discussion of UI, and receipt of UI treatment. Urinary incontinence is the involuntary leakage of urine. The MUI measure is collected using the HOS measure.

Medical Outcomes Study 36-Item Health Survey (MOS SF-36)

The Medical Outcomes Study 36-Item Health Survey (MOS SF-36) is a generic, multi-purpose health survey with 36 questions. The 36-item survey is used to compute physical component summary (PCS) and mental component summary (MCS) Scores. See Medicare HOS Version 1.0 (HOS 1.0)

Medicare

CMS administers Medicare, the nation’s largest health insurance program, which covers over 46 million Americans. Medicare is a Health Insurance Program for people age 65 or older, people under 65 with certain disabilities, and people with ESRD. Coverage is provided through the Original Medicare Plan (sometimes referred to as "fee-for-service") or through a private Medicare Advantage health plan. Visit www.Medicare.gov for additional information about the Medicare Program.

Medicare Advantage Organization (MAO)

A Medicare Advantage Organization (MAO) is an organization participating in Medicare Part C and may be a coordinated care plan including plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), or regional or local preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, or medical savings account (MSA) plans. A Special Needs Plan (SNP) includes any type of coordinated care plan that meets CMS' SNP requirements and either exclusively enrolls special needs individuals as defined in Section 422.2; or enrolls a greater proportion of special needs individuals than occur nationally in the Medicare population as defined by CMS. Most MAOs include Medicare prescription drug coverage (Medicare Part D).

Medical Savings Account (MSA) Plan

An MSA plan combines a high-deductible health plan with a medical savings account. Enrollees of Medicare MSA plans can initially use their savings account to help pay for health care, and then will have coverage through a high-deductible insurance plan once they reach their deductible. Medicare MSA plans provide Medicare beneficiaries with more control over health care utilization, while still providing coverage against catastrophic health care expenses.

Medicare Fee-For-Service

The Original Medicare Plan is a "fee-for-service" plan. A Medicare beneficiary is usually charged a fee for each health care service or supply that is provided. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance).

Medicare Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the first national health outcomes measure for the Medicare population in managed care settings. Collected since 1998, the Medicare HOS is the only patient-reported outcomes measure in Medicare managed care, and therefore remains a critical part of assessing MAO quality. The Medicare HOS assesses an MAO's ability to maintain or improve the physical and mental health functioning of its Medicare members over time. The survey is administered to a random sample of members from each MAO at the beginning and end of a two-year period. The HOS results are used to provide external performance measurement, to target quality improvement activities, to monitor the health of the general population, and to evaluate treatment outcomes and procedures.

Medicare HOS Baseline Report

The *Baseline* Report is part of a larger effort by CMS to improve the health care industry's capacity to sustain and improve health status and functioning within the Medicare population. The report contains information on baseline measures of physical and mental health, chronic medical conditions, functional status (i.e., ADLs), HEDIS[®] measures, clinical measures, and other health status indicators. The *Baseline* Report is produced and made available to all participating MAOs and QIOs after each baseline cohort data collection is completed.

Medicare HOS Performance Measurement Report

The *Performance Measurement* Report results reflect an MAO's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period of time. The performance measurement results provide measures of change in physical and mental health over time for a representative sample of beneficiaries in an MAO. Additionally, baseline and follow up information is provided for chronic medical conditions, functional status (i.e. ADLs), clinical measures, and other health status indicators. The *Performance Measurement* Report is produced and made available to all participating MAOs and QIOs after the collection of follow up data on each cohort.

Medicare HOS Version 1.0 (HOS 1.0)

The Medicare HOS questionnaire consists of three components: physical and mental health status questions; questions for case-mix and risk adjustment purposes; and additional health questions. The original Medicare HOS Version 1.0 (HOS 1.0) was used for data collection years 1998-2005 and included a generic 36-item health status measure as the core physical and mental health outcome measure. See Medical Outcomes Study 36-Item Health Survey (MOS SF-36).

Medicare HOS Version 2.0 (HOS 2.0)

Implemented in 2006, the Medicare HOS Version 2.0 (HOS 2.0) reduced the core physical and mental outcome measure from 36 items to 12 items. See Veterans RAND 12-Item Health survey (VR-12). Conversion formulas have been developed and validated for the 36-item measure and the 12-item measure that will allow comparison of HOS 1.0 and HOS 2.0 results. Additional changes to the original HOS measure include the removal of redundant or less useful items, the addition of HEDIS[®] measures for osteoporosis testing and fall risk management, and height and weight questions.

Medicare Health Outcomes Survey-Modified (HOS-M)

The Medicare Health Outcomes Survey-Modified (HOS-M) is an abbreviated version of the Medicare Health Outcomes Survey (HOS). The HOS-M focuses on frail and elderly beneficiaries, and provides a summary of their demographic information, physical and mental health status, and selected health symptoms. The instrument contains 6 Activity of Daily Living (ADL) items as the core items used to calculate a frailty adjustment factor for payment purposes. The survey also includes 12 physical and mental health status questions, one question about memory loss interfering with daily activities, and one question about urinary incontinence.

Mental Component Summary (MCS) Score

The Mental Component Summary (MCS) score is derived from the core outcome measure included in the HOS, and is a reliable and valid measure of mental health. For the MCS, very high scores (scale 0-100) indicate frequent positive affect, absence of psychological distress, and no limitations in usual social and role activities due to emotional problems. In rare instances a negative score may be calculated due to the MRE method used for missing data imputation.

Modified Regression Estimate (MRE)

The Modified Regression Estimate (MRE) is a method in which surveys with missing data can be scored through an imputation process. The PCS and MCS scores are calculated from the VR-12, using MRE for imputation and scoring. The MRE uses complete cases to estimate a regression equation where only those items that are present are utilized. Depending on the pattern of missing item responses, a different set of regression weights is required.

NCQA

The National Committee for Quality Assurance (NCQA) contracts with CMS to implement the HEDIS[®] Medicare HOS, which includes managing the data collection and transmittal of the HOS, supporting the development and standardization of the HOS measure, annually certifying and evaluating HOS vendors, and conducting ongoing quality assurance of the survey process.

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Osteoporosis Testing
in Older Women (OTO)

Osteoporosis Testing in Older Women (OTO) is an NCQA HEDIS[®] measure that assesses the percentage of women aged 65 and over who report ever having received a bone density test to check for osteoporosis. Osteoporosis is characterized by low bone mass and deterioration of bone strength, which lead to an increased risk of fractures. The OTO measure is collected using the HOS measure.

Outcome

The Medicare HOS defines outcome as a change in health status over time, which is characterized in terms of the direction and magnitude for a given respondent. The three major Medicare HOS outcomes are death, change in physical health, and change in mental health.

Outlier(s)

For the *Performance Measurement* analysis, MAOs displaying characteristics that are significantly different from the HOS national average in terms of physical or mental health are identified as outliers. Based on the results, an MAO that is designated as “worse than expected” for a measure is a negative outlier and an MAO designated as “better than expected” is a positive outlier.

Program of All-Inclusive
Care for the Elderly (PACE)
Organization

A Program of All-Inclusive Care for the Elderly (PACE) Organization delivers all needed medical and supportive services to provide the entire continuum of care and services to seniors with chronic care needs, while maintaining their independence in their homes for as long as possible. Social and medical services are delivered primarily in an adult day health center, supplemented by in-home and referral services as needed. The majority of beneficiaries are dual eligible; that is, they receive both Medicare and Medicaid coverage. PACE Organizations participate in the HOS using the Medicare HOS-Modified.

Performance Measurement
Results

The adjusted differences between the HOS baseline and two-year follow up scores, which are presented as better, same, or worse than expected for PCS and MCS.

Physical Activity
in Older Adults (PAO)

Physical Activity in Older Adults (PAO) is an NCQA HEDIS[®] measure that is comprised of two questions to gather data on a patient's discussion and the management of physical activity with a doctor or other health provider. Regular leisure time physical activity includes light to moderate activity that causes only light sweating or slight or moderate increases in breathing or heart rate (i.e., activity at least 5 times per week for at least 30 minutes) or vigorous activity that causes heavy sweating or large increases in breathing or heart rate (i.e., activity at least 3 times per week for at least 20 minutes). The PAO measure is collected using the HOS measure.

Physical Component
Summary (PCS) Score

The Physical Component Summary (PCS) score is derived from the core outcome measure included in the HOS, and is a reliable and valid measure of physical health. For the PCS, very high scores (scale 0-100) indicate no physical limitations, disabilities or decline in well being; high energy level; and a rating of health as "excellent." In rare instances a negative score may be calculated due to the MRE method used for missing data imputation.

Plan Benefit Package (PBP)

A PBP is a unique benefit package within an MAO contract that provides a proscribed set of benefits to a beneficiary. PBPs may vary as to the services they cover. PBPs may include MA plans with Medicare Part D prescription drug coverage (MA-PD), MA plans without Part D prescription drug coverage (MA-Only), and MA plans with Part D prescription drug coverage only (PDP) which add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare PFFS Plans, and Medicare MSA Plans.

Preferred Provider Organization
(PPO)

A PPO is a plan that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and, only for purposes of quality assurance requirements in Section 422.152(e), is offered by an organization that is not licensed or organized under State law as an HMO. There are two types of PPOs. Local PPOs are plans that serve the counties the PPO chooses to include in its service area and regional PPOs are plans that serve one of 26 regions established by Medicare (these may be a single state or multi-state area).

Private Fee-For-Service (PFFS) Plan	A PFFS plan is offered by a state licensed risk bearing entity that has a yearly contract with CMS to provide beneficiaries with all their Medicare benefits plus any additional benefits the company decides to provide. Beneficiaries who enroll in a PFFS MAO are not required to use a network of providers. Beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS MAO.
Proxy	An individual who completed a survey on behalf of the beneficiary.
QIO	Under the direction of CMS, the Quality Improvement Organization (QIO) Program consists of a national network of 53 QIOs, responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly patients from underserved populations.
QualityNet	QualityNet application is the interactive, secure website that allows direct exchange of files between two or more organizations or individuals of an organization, including QIOs.
Research Data Assistance Center (ResDAC)	The Research Data Assistance Center (ResDAC) at the University of Minnesota is a CMS contractor that provides assistance to academic, government and non-profit researchers interested in using Medicare and/or Medicaid data. ResDAC is available to assist in the completion and/or review of data requisition forms for Medicare HOS research data files prior to their submission to CMS. For additional information and assistance, refer to the ResDAC website at www.resdac.org . ResDAC may also be contacted by calling 1-888-9RESDAC (1-888-973-7322) between the hours of 8am to 4:30pm CST Monday through Friday or by e-mailing resdac@umn.edu .

Respondent Sample

Respondent samples are defined below for the two annual Medicare HOS reports:

Baseline respondent sample, for the purpose of calculating the *Baseline* response rate, is limited to eligible beneficiaries, including seniors and disabled, who have a baseline PCS or MCS score. For the baseline analysis, however, the *Baseline* analytic sample is limited only to eligible seniors, who have a baseline PCS or MCS score.

Performance Measurement respondent sample is limited to those seniors eligible for remeasurement who have a follow up PCS or MCS score.

Response Rate

Response rates are defined below for the two annual HOS reports:

Baseline response rate is calculated based on the number of eligible beneficiaries who have a PCS or MCS score at baseline, divided by the number of eligible beneficiaries sampled (excluding ineligible surveys).

Performance Measurement response rate is calculated based on the number of eligible beneficiaries who have a PCS or MCS score at follow up, divided by the number of eligible beneficiaries sampled (excluding ineligible surveys).

RTI

RTI International subcontracts with NCQA on the Medicare HOS Program. RTI is involved in the sample selection for each round of the Medicare HOS. Additionally, RTI is involved in research, which compares HOS results in the managed care setting to those in the fee-for-service population.

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SAS®

A software package used for data processing and statistical analysis.

SEER-MHOS	Surveillance, Epidemiology and End Results (SEER) – Medicare Health Outcomes Survey (MHOS) is a surveillance data set that links data on cancer patients to patient-reported HRQOL outcomes available in the HOS. Information about the SEER-MHOS linked data set may be found on the National Cancer Institute (NCI) website at: http://outcomes.cancer.gov/surveys/seer-mhos .
Special Needs Plan (SNP)	SNPs were created by Congress in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries who require more coordinated care: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. These beneficiaries are sicker and frailer than most beneficiaries served through the MA program, and thus are more challenging to treat.
Survey Vendor	An independent survey organization that is trained and certified by NCQA to administer the HOS Survey.
Veterans RAND 12-Item Health Survey (VR-12)	The Veterans RAND 12-Item Health Survey (VR-12) is a generic health questionnaire developed from the Veterans Health Study, and was adapted from the RAND 36-Item Health Survey and the Medical Outcomes Study. The taxonomy underlying the construction of the VR-12 scales and summary measures is comprised of a total of 14 items. Twelve items are used to compute the eight scales that aggregate one or two items each, and the PCS and MCS scores. Two items assess change in health, one focusing on physical health and one on emotional problems. See Medicare HOS Version 2.0 (HOS 2.0).