SUPPORTING STATEMENT A
MEDICARE HEALTH OUTCOMES SURVEY
CMS-10203, OMB 0938-0701

Introduction

The Centers for Medicare & Medicaid Services (CMS) requests a revision to a previously approved survey from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 for the Medicare Health Outcomes Survey (HOS).

In this 2017 information collection request, Question 51 of the HOS has been revised to align with current USPSTF recommendations. There are no changes to the HOS-M. Burden adjustments (minus 61,072 hours) are the result of changes in the MA program, including changes in enrollment, the number of participating contracts, and contract size, rather than changes to the HOS survey protocol or instrument.

Background

CMS has a responsibility to Medicare beneficiaries to require that care provided by managed care plans under contract to CMS is of high quality. By coordinating care and providing health care services to their enrollees, health plans are directly responsible for maintaining or improving the physical and mental health statuses of their enrollees. One way of ensuring high quality in Medicare managed care organizations, more commonly referred to as Medicare Advantage Organizations (MAOs), is through the development of standardized, uniform performance measures that enable CMS to gather the data needed to evaluate the quality of care provided to Medicare beneficiaries. The Medicare Health Outcomes Survey (HOS) is one such measure. The HOS is unique among CMS quality measures because it assesses health status by asking beneficiaries themselves, measures change over a two year period, and provides contract-level data on change in functional status and quality of life that CMS is unable to assess in any other way. Among the principle uses of HOS data are to help CMS and MAOs monitor the quality and performance of MA contracts and identify areas in which to improve the quality of health care provided to beneficiaries enrolled in these health plans. Currently, five HOS measures are included in the annual Medicare Part C Star Ratings program and are used to calculate the MA Quality Bonus Payments that reward high performing contracts. The five measures are discussed below. Additional measures are in various stages of development. Please note, any changes to the Star Ratings measures must be proposed through rulemaking.

Collected annually since 1998, the Medicare Health Outcome Survey (HOS) is unique among CMS surveys in that it measures change over a two year period. HOS was also the first patient-reported outcomes measure used in Medicare managed care. Patient-reported outcomes (PROs) refer to self-reported accounts of a person's health status that come directly from the patient. Patient reports are a valuable a source of

information on outcomes, including health-related quality of life (HRQoL), functional status, symptoms and symptom burden, and health behaviors. PROs are increasingly identified as the most direct and relevant measures for demonstrating high-quality patient care. PRO-based performance measurement, based on the aggregation of PRO data for entities deemed accountable for the quality of care, is well-recognized as integral for accurate appraisals of quality.[1] PRO measure development has been a high priority in CMS's Quality Measure Development Plan for a number of years. Additionally, the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), and various medical specialty societies have implemented initiatives to promote the use of PROs as a basis for performance measurement.

The Medicare HOS currently uses the Veterans RAND 12-item Health Survey (VR-12), a self-reported measure of health status, to assess an MA contract's ability to maintain or improve the physical and mental health of Medicare beneficiaries over time. The VR-12 questions (HOS questions 1-9) correspond to seven (7) different health domains: general health perceptions, physical functioning, role limitations due to physical and emotional problems, bodily pain, energy/fatigue levels, social functioning, and mental health. The responses to these questions are scored using a set of U.S. population norms to obtain two scores for each respondent: a Physical Component Score (PCS) and a Mental Component Score (MCS). The difference between the baseline and follow-up scores are categorized as "Better+Same" or "Worse" than expected. If the change for an individual is less than two standard errors of measurement below the average change, the physical or mental health is considered "Better+Same"; otherwise, the change is considered to be "Worse." The individual "Better + Same" results are aggregated at the contract level. The expected PCS and MCS outcomes are adjusted for the case-mix of beneficiaries within the contract (using HOS questions 10, 20-35, 40, 58-59, 61-62, 65-66, 68) to control for pre-existing baseline differences across MAOs. The differences between the contract-level actual and expected percentages are adjusted by the national averages, and these adjusted MAO percentages are reported in the annual Medicare Part C Star Ratings as the following more heavily weighted outcome measures: "Improving or Maintaining Physical Health" and "Improving or Maintaining Mental Health."

CMS, in collaboration with the NCQA, launched the Medicare HOS as part of the Effectiveness of Care component of the former Health Plan Employer Data and Information Set, now known as the Healthcare Effectiveness Data and Information Set (HEDIS® [2]). The measure was initially titled *Health of Seniors*, and was renamed the *Medicare Health Outcomes Survey* during the initial year of implementation to reflect the inclusion of people with Medicare who are disabled and under age 65 in the sampling methodology. The HOS measure was developed under the guidance of a Technical Expert Panel (TEP) comprised of individuals with specific expertise in the

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[1] National Quality Forum. (2013). Patient-reported outcomes (PROs) in performance measurement. https://www.qualityforum.org/Publications/2012/12/Patient-Reported_Outcomes_in_Performance_Measurement.aspx

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

health care industry and outcomes measurement. The measure is periodically refreshed (most recently in 2013) to include the most recent advances in summarizing physical and mental health outcomes results and appropriate risk adjustment techniques. In addition to the core health outcomes measures reported about, the HOS is used to collect four HEDIS Effectiveness of Care measures: Fall Risk Management, Management of Urinary Incontinence in Older Adults, Osteoporosis Testing in Older Women, and Physical Activity in Older Adults (HOS questions 42-52). Contract-level results for three of these measures are reported in the annual Medicare Part C Star Ratings as the following process measures: "Reducing the Risk of Falling," "Improving Bladder Control," and "Monitoring Physical Activity." In addition, "Osteoporosis Testing" is part of the CMS Display Page.

An overarching goal of the Medicare HOS program is to gather valid, reliable, clinically meaningful health status data in Medicare managed care for use in health plan quality improvement activities, health plan accountability, and improving public health. To ensure the generalizability of the HOS results and allow data for the Star Ratings program, all MA contracts in effect on January 1 of the year prior with at least 500 current enrollees must participate and random sampling is employed to ensure each member of each contract has an equal chance of being selected to participate. Annually, a baseline sample of up to twelve hundred Medicare beneficiaries is drawn from each contract and members of the sample are surveyed in the spring. Two years later, the beneficiaries who completed a survey are surveyed again for follow-up measurement purposes. For each member who completes a baseline and a follow-up survey, a two-year change score is calculated, and after taking risk adjustment factors into account, the member's physical and mental health status are categorized as better, the same, or worse than expected. (Note: Members who are deceased at the time of follow-up are included in the "worse" outcome category.) Summary HOS results are calculated for each MAO based on aggregated member outcomes and are publicly reported, as was described earlier.

The HOS is also used to measure frailty in certain Medicare programs, including Program of All-Inclusive Care for the Elderly (PACE) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs). Frailty is well recognized as a high-risk state that is predictive of a range of adverse health outcomes, such as falls, disability, institutionalization, hospitalization, and mortality.[3] In 1997, the Balanced Budget Act mandated that Medicare capitated payments to PACE organizations be adjusted to account for the comparative frailty of PACE enrollees. Because risk adjustment models based solely on diagnoses and demographics failed to adequately predict future Medicare expenditures for frail community-dwelling populations, the addition of a frailty adjuster based on the average level of functional impairment of each organizations' enrollees was necessary. While currently there is no gold standard for assessing frailty, in geriatric assessment, basic activities of daily living (ADL) questionnaires are routinely administered. Since its

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[3] Fried LP, Tangen CM, Walston J, et al. (2001). Frailty in Older Adults: Evidence for a Phenotype. *The Journals of Gerontology: Series A*, 56 (3), M146–M157.

inception, the HOS has contained the Katz Index of Independence of Activities of Daily Living[4], a well-validated and widely used instrument which measures limitations in bathing, dressing, eating, transferring, walking, and toileting (HOS question 10, items a-f). Since 2005, the Medicare Health Outcomes Survey-Modified (HOS-M), a shorter, modified version of the HOS, has been administered to PACE enrollees, and HOS-M question 4 (items a-f) is used by CMS to assess the frailty of the population in these health plans in order to adjust annual capitated plan payments. Since 2012, CMS has also adjusted payments to FIDE SNPs based on plans' "similar average level of frailty...as the PACE program," as required by Section 3205(b) of the Affordable Care Act (ACA). Depending on their enrollment, MAOs sponsoring FIDE SNPs may elect to participate in the HOS or HOS-M at the plan benefit package (PBP) level. Frailty scores are calculated at the plan-level, using the aggregate counts of limitations on ADLs as reported by a plan's enrollees, based on the HOS or HOS-M from the year prior to the payment year.

Finally, HOS data are used by other CMS components, Federal agencies, and external researchers for such purposes as advancing research around health care quality and the sciences of health-related quality of life (HRQoL) and functional health outcomes measurement. For example, recent collaborations with the CMS Office of Minority Health (OMH) have produced data and reports focused on health needs[5] and racial and ethnic disparities in mental health among diverse groups of MA beneficiaries[6], including American Indian, Alaska Native, and Native Hawaiian or Other Pacific Islander (NHOPI) beneficiaries. Collaborations with colleagues at the Centers for Disease Control and Prevention (CDC) have produced recent publications examining HRQoL in the elderly[7] and characteristics of HRQoL measures.[8] Perhaps the most significant intra-agency collaboration is the effort between the National Institutes of Health's National Cancer Institute (NCI) and CMS that has linked Surveillance, Epidemiology and End Results (SEER) and HOS data to create the SEER-MHOS registry, a linked data research resource designed to improve understanding of health-related quality of life of elderly persons with cancer and elderly cancer survivors. Established in 2005, the database links clinical, demographic, and death information for cancer patients with de-identified data for Medicare beneficiaries age 65+ who are enrolled in MA health plans.[9] To date, more than 41 peer-reviewed publications have resulted, primarily focused on functional

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[4] Katz S, Downs TD, et al. (1970). Progress in development of the index of ADL. *Gerontologist, 10*, 20–30

[5] Ritenour D, Rodriguez J, Wilson-Frederick J, et al. (2017, August). Understanding the Health Needs of Diverse Groups of Asian and Native Hawaiian or Other Pacific Islander Medicare Beneficiaries. Retrieved http://hosonline.org/globalassets/hos-online/publications/cms-omh-data-highlight-vol10-aug-2017.pdf

[6] Ng J, Zhang Q, Scholle S, and Guerino, P. (2017, December) Racial and Ethnic Disparities in Mental Health among Diverse Groups of Medicare Advantage Beneficiaries. Retrieved http://hosonline.org/globalassets/hos-online/publications/data-highlight-vol11-dec-2017.pdf

[7] Haomiao J, Barile JP, Horner-Johnson, W, et al. (in press). Quality-Adjusted Life Years (QALY) for Fifteen Chronic Conditions and Combinations of Conditions among U.S. Adults Aged 65 and Older. *Medical Care.*

[8] Barile JP, Horner-Johnson W, Krahn G, et al. (2016). Measurement characteristics for two health-related quality of life measures in older adults: SF-36 and CDC Healthy Days items. *Disability Health, 9*, 567-574.

[9] Ambs A, Warren JL, Bellizz KM, Topor M, Haffer, SC, Clauser SB. (2008). Overview of the SEER-Medicare Health Outcomes Survey linked dataset. *Health Care Financing Review*, 29(4):5-21.

health and quality of life (see
https://healthcaredelivery.cancer.gov/cgi-bin-pubsearch/pubsearch/index.pl?
initiative=SEERMHOS).

 CMS has collected health status data from Medicare beneficiaries enrolled in Medicare managed care through annual implementation of the HOS since 1998. Initially, the Balanced Budget Act of 1997 established Medicare Part C and required CMS to collect quality information about Medicare health plans available under what were then known as the Medicare + Choice plans and provide this information to beneficiaries to assist them in their selection of a Medicare plan. Subsequently, the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) renamed Medicare's managed care program "Medicare Advantage," and under Section 1860D-4 (Information to Facilitate Enrollment), continued the collection and reporting requirements. The MMA also required CMS to provide results to Medicare beneficiaries prior to the annual enrollment period.

CMS uses a data collection model similar to the one used for the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, CAHPS Health Plan Survey (i.e., commercial health plan CAHPS), Hospital CAHPS, and Home Health Care CAHPS. CMS contracts with NCQA to train and oversee survey vendors to collect and submit data on behalf of the MA, section 1876 cost, and PACE contracts. CMS also contracts with the Health Services Advisory Group (HSAG) to analyze the HOS data. All contracts that are required to conduct HOS must contract directly with a CMS-approved HOS survey vendor. NCQA is responsible for training survey vendors, providing technical assistance and oversight to survey vendors to ensure that they are following approved data collection protocols, providing survey samples directly to the survey vendors, and collecting the data from the survey vendors. HSAG is responsible for analyzing the data for public reporting, producing reports that the health plans can use for quality improvement, and providing technical assistance to MA organizations, researchers, and other government entities.

This request for approval is for CMS to continue conducting the Medicare HOS survey annually to meet the requirements outlined above. This request revises one existing question to the 2017 HOS. There are no changes to the 2017 HOS-M.

A. JUSTIFICATION

1. Necessity of Information Collection

The collection of Medicare HOS is necessary to hold Medicare managed care contracts accountable for the quality of care they deliver to beneficiaries. HOS is unique among CMS health status measures because it assesses health status by asking beneficiaries themselves about their own health and it is unique for measuring change over a two year period. The HOS was the first patient-reported outcomes (PRO) measure used in Medicare managed care. Some aspects of physical and mental health outcomes can only

be captured through patient self-report, so HOS has become a central and critical part of our measurement of quality in the Medicare Advantage program. Twenty years after its inception, the HOS continues to generate valid, reliable, and meaningful data that are widely used for research purposes and includes two of the few available outcome measures that assess the quality of care provided by health plans. HOS also provides contract-level data on change in functional status and in quality of life that CMS is unable to assess in any other way.

The HOS reporting requirement allows CMS to obtain the information necessary for proper oversight of the MA program. HOS data are used to generate five measures and provides two outcomes measures that are heavily-weighted in the CMS Part C Star Ratings. It is critical to CMS' mission that the Agency collect and disseminate valid and reliable information that can be used to improve quality of care through identification of quality improvement opportunities, assisting CMS in carrying out its oversight responsibilities, and helping beneficiaries make an informed choice among health plans.

2. Information Users

The primary end users of HOS data are CMS, MAOs, Medicare beneficiaries, and researchers. The data are used by CMS to monitor health plan performance, construct a frailty adjuster for payment purposes, and inform other agency programs and priorities (e.g., disabled, poor, chronically ill, etc.). MAOs use the HOS results to target quality improvement activities and resources. Other stakeholders (i.e., other federal agencies, advocacy groups, health policy scholars, and health services researchers) use the HOS data to monitor the health of the Medicare population and vulnerable subgroups and to evaluate treatment outcomes and procedures.

Evidence of HOS utility abounds. Research based on HOS data has been published in academic peer-reviewed journals such as the *Journal of Ambulatory Care Management, Journal of Clinical Epidemiology, Medical Care, Disability Health, International Journal of Geriatric Psychiatry, Health Services Research, Health and Quality of Life Outcomes, International Journal for Quality in Health Care, Health Care Financing Review*, and *Cancer*. Topics that have been investigated using HOS data include quality of care, functional health, quality of life, health utilities, smoking obesity, depression, health disparities, and chronic illness.

HOS data are used by MAOs for quality improvement activities that include comparing depressive symptoms and nursing home utilization; generating recommendations for coordinating care for seniors with respect to depression, chronic conditions, mobility, and weight; developing member communications that address physical and mental health, fall risk prevention, exercise, urinary health, and medication use questions; and assisting plans to combine and compare their results across multiple contracts. Information about best practices in illness prevention and health promotion for the elderly and developing intervention strategies that impact patient outcomes are made

available to MA health plans in an MAO resource guide, along with technical reports on the functional status of older adults and a biannual newsletter.

Finally, HOS data are used in the CMS Star Ratings and the Star Ratings program has led to health plan quality improvement. For example, the average enrollment-weighted overall Star Rating for MA contracts has increased from 3.92 in 2015 to 4.06 in 2018. In 2015 approximately 60% of MA enrollees were in contracts with 4 or more stars; this has increased to 73% of enrollees in 2018.

3. Use of Improved Information Technology

The Medicare HOS collects self-reported information through a combination of mail and computer assisted telephone interviewing (CATI) techniques for survey administration. Other than the manual reply necessary for mail survey instruments, there are no barriers or obstacles that prohibit the use of improved technology for this information collection activity. The Medicare HOS instrument is distributed to beneficiaries by independent third party survey vendors and the resulting data are aggregated electronically. Most beneficiaries complete the survey either manually (accounting for roughly 79% at baseline and 87% at follow-up), which is the most cost effective means to collect information from them, or through CATI (accounting for roughly 21% at baseline and 13% at follow-up). Mail surveys are processed using scanned image readers to enhance coding accuracy and increase production speed. The CATI program records collected information, which reduces respondent burden by minimizing the potential for double reporting and inconsistent responses. CATI also enables the interviewer to move through skip patterns quickly, which reduces respondent burden by shortening the interview and eliminating the need for call backs to correct errors. This collection does not require a signature from the respondent.

4. Duplication of Efforts

Collection of the Medicare HOS does not duplicate any other effort and the information cannot be obtained from any other source. The Medicare HOS was the first outcomes measure used in Medicare managed care, and as noted above, collects data that are unique in multiple ways. The Medicare HOS measure was developed under the guidance of a Technical Expert Panel comprised of individuals with specific expertise in the health care industry and outcomes measurement. CMS and its data collection and data analysis contractors have not been able to identify any other source of data that would be an effective substitute for the Medicare HOS. Continuing interagency collaboration insures against the likelihood of duplicative data collection processes now and in the future.

5. Small Businesses

The burden on small MAOs is reduced by requiring a standardized and commonly accepted measure set in the managed care industry, with which MAOs can meet requirements of Medicare and some private purchasers for reporting performance. In

order to help control costs, CMS only surveys a sample of beneficiaries from each Medicare managed care plan. There is no way to further reduce the burden and still ensure the reliability of the information collected.

6. Less Frequent Collection

CMS collects the Medicare HOS data annually. Contracts between CMS and MAOs are renewable on an annual basis, so the Agency needs the annual performance data for program management and contracting decisions. Less frequent data collection would jeopardize our ability to measure differences in outcomes attributable to health plan contracts.

7. Special Circumstances

There are no special circumstances associated with this information collection request.

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on April 6, 2017 (82 FR 16843). Comments were received. The comments and our response have been added to this information collection request.

9. Payments/Gifts to Respondents

There are no provisions to provide any payment/gift.

10. Confidentiality

Individuals and organizations contacted are assured of the confidentiality of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C.552 (Freedom of Information Act), 5 U.S.C.552a (Privacy Act of 1974), and OMB Circular No. A-130. CMS policy requires that advance letters be sent to potential survey respondents to explain that participation is voluntary, their decision to participate or not will not affect their Medicare benefits, and that their privacy will be protected. Because the Privacy Act includes language that may be confusing to some respondents unfamiliar with legal writing, the HOS prenotification letter are written in a friendly, less formal style. In addition, each CMS-approved survey vendor maintains a dedicated 800 telephone number and an electronic mailbox which beneficiaries can contact for more information about the survey. Survey interviewers are trained to answer questions from beneficiaries about how their privacy will be protected. Interviewers explain to potential respondents that all employees who work on the surveys are required to sign an affidavit stating that they will not disclose the identities of survey respondents to anyone who does not work on the HOS program and is not legally authorized to have such information. Interviewers also explain that the answers respondents provide may be made available to researchers at CMS and other government agencies and research organizations, but only after all personal identifiers, including names, dates of birth, addresses, and Social Security numbers have been

removed. CMS makes data files available to certain stakeholders only as allowed by federal laws and regulations and CMS policy. CMS enters into Data Use Agreements (DUAs) with requestors only after careful review to ensure that data requestors adhere to CMS privacy and security requirements and data release policies. In all instances where identifying information is needed, the information release fully complies with all respects of the Privacy Act. The System of Records is SORN 09-70-0500, Health Plan Management System (HPMS), which allows information to collected and maintained on beneficiaries who are enrolled in Medicare health plans and prescription drug plans. The information retrieved from this SOR is disclosed to: (1) support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent, for evaluating and monitoring the quality of health care and contribute to the accuracy of health insurance operations; (3) support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects; (4) support the functions of Quality Improvement Organizations (QIO); (5) support litigation involving the Agency; and (6) combat fraud and abuse in certain health care programs.

11. Sensitive Questions

CMS is not asking questions which would be considered of a sensitive nature. The Medicare HOS is a functional health status survey that does request information about one's capability to perform certain physical and mental activities. However, the core component of the HOS instrument, the VR-12, is a standardized instrument that has been used in both clinical practice and research for a number of years. Demographic information in the survey, including income and race, is requested for the purpose of risk adjustment.

12. Burden Estimates (Hours & Wages)

The following organization types, with a minimum of 500 members and a Medicare contract in effect on or before January 1 of the previous year are required by CMS to administer the current HOS Baseline survey: 1) all MAOs, including all coordinated care plans, Private Fee-For-Service (PFFS) contracts, and Medical Savings Account (MSA) contracts; 2) all Section 1876 cost contracts; 3) Employer/Union Only Direct PFFS contracts; and 4) Medicare Medicaid Plans (MMPs).

Additionally, all MAOs with current contracts in place which administered a Baseline survey two years earlier are required to administer the current HOS Follow-Up Survey. In addition, all PACE organizations with a minimum of 30 members and a contract effective date on or before January 1 of the previous year are required by CMS to administer the HOS-M.

The HOS sampling strategy is designed to reduce burden on survey respondents. Because of variations in health plan population size, three sampling approaches are used. (MAOs with fewer than 500 members are exempt from HOS reporting.)

1)   MAOs with populations of 500 to 1,200: all eligible members are included in the sample;
2)   MAOs with populations of 1,201 to 2,999: 1,200 members are randomly selected for the Baseline survey. To ensure a sample size of 1,200, members who were sampled for and returned a completed survey the previous year are not excluded from sampling in the current year.
3)   MAOs with populations greater than 3,000: 1,200 members are randomly selected for the Baseline survey. To reduce burden on survey respondents, members who were sampled for and returned a completed survey the previous year are excluded from the current year sampling.

The HOS-M sample size is 1,200 for programs with at least 1,200 participants. For PACE organizations with less than 1,200 enrollees, the entire eligible enrollment is included.

Table 12 A.

	HOS Baseline	HOS Follow-Up	HOS-M	Total
Sample Size[1]	1,200	720	300	
Estimated Response Rate	60%	75%	75%	
Number of Estimated Respondents	720	540	225	
Survey Timing by Instrument	0.33	0.33	0.33	
Time Burden in Hours	237.6	178.2	74.25	
Number of Participating Plans[2]	462	367	107	
Total Time Burden in Hours	109,771	65,399	7,945	183,115
Average Hourly Wage Rate[3]	$25.35	$25.35	$25.35	$25.35
Total Cost to Respondents	$2,782,699.92	$1,657,874.79	$201,399.41	$4,641,974.12

[1] The HOS Follow-up sample size is based on a 60% response rate at Baseline. The HOS-M sample size is based on average PACE enrollment statistics.

Tests have shown that the average time to complete the survey is 20 minutes. The average response rate over the past five years is 55% at baseline, 75% at follow-up, and 75% for the HOS-M; however, for the purpose of this clearance package we will use the following figures so as to illustrate the greatest burden potential. The expected response rate for HOS baseline is 60%, the expected HOS follow-up response rate is 75%, and the expected HOS-M response rate is 75%. Based on a plan sample size of 1,200, 60% percent baseline response rate, and total plan participation in 2016, the maximum total estimated burden upon the beneficiaries is .33 hours x [(462 Baseline MAOs x 720 average baseline response) + (367 Follow-up MAOs x 540 average follow-up responses) + (107 PACE organizations x 225)] = 183,115 hours.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

There are costs to the Federal government in terms of its contracts with NCQA to administer the Medicare HOS data collection and with HSAG to provide data file preparation, analysis, and dissemination. Average contract costs for the Medicare HOS activities are $2,415,000 per year: $1,207,500 for each of two contracts, respectively.

15. Changes to Burden

As demonstrated in previously stated burden estimate calculations, changes to burden are the result of changes in the MA program, including changes in enrollment, the number of participating contracts, and contract size, rather than changes to the HOS survey protocol or instrument.

On average, the burden to the average Medicare beneficiary to complete a HOS or HOS-M survey has not changed; the survey burden remains at .33 hour. However, the number of MAOs required to report HOS Baseline has decreased by 34 contracts, and the number of MAOs that remain in the MA program and are required to report HOS Follow-Up has decreased significantly, by 85 contracts. Due to these changes and the modest adjustment in response rates, the number of respondents has decreased by approximately 84,000 respondents for Baseline and 127,250 respondents for Follow-up, decreasing the HOS survey burden by approximately 69,716 hours. The burden to PACE was calculated using a sample size based on actual average enrollment. The number of participating PACE organizations has increased 23%, by 20 contracts, increasing survey burden by approximately 1,485 hours. Thus, the total survey burden for HOS and HOS-M combined decreased approximately 68,230 hours.

See Attachment A for a crosswalk of the one change made to the survey instrument. This change and the minor change to the sampling protocol for large MAOs, as described in Section B.1.B.ii., are not expected to change burden.

16. Publication and Tabulation Dates

Three major types of analyses are planned: descriptive, explanatory, and predictive. A number of published studies have already been conducted. In addition, data files and reports will continue to be prepared over the course of the survey, as illustrated in the schedule of information collection and dissemination below:

04/2017	Data collection begins for Medicare HOS Cohort 20 Baseline and HOS-M
05/2017	Data collection begins for Medicare HOS Cohort 18 Follow-Up
05/2017	Disseminate 2016 HOS-M PACE Reports
06/2017	Disseminate 2016 Cohort 19 Baseline Reports
07/2017	Disseminate 2016 HOS-M PACE Data
08/2017	Disseminate 2014-2016 Cohort 17 Performance Measurement Reports
11/2017	Disseminate 2014-2016 Cohort 17 Performance Measurement Data
04/2018	Data collection begins for Medicare HOS Cohort 21 Baseline and HOS-M
05/2018	Data collection begins for Medicare HOS Cohort 19 Follow-Up
05/2018	Disseminate 2017 HOS-M PACE Reports
06/2018	Disseminate 2017 Cohort 20 Baseline Reports
07/2018	Disseminate 2017 HOS-M PACE Data
08/2018	Disseminate 2015-2017 Cohort 18 Performance Measurement Reports
11/2018	Disseminate 2015-2017 Cohort 18 Performance Measurement Data
04/2019	Data collection begins for Medicare HOS Cohort 22 Baseline and HOS-M
05/2019	Data collection begins for Medicare HOS Cohort 20 Follow-Up
05/2019	Disseminate 2018 HOS-M PACE Reports
06/2019	Disseminate 2018 Cohort 21 Baseline Reports
07/2019	Disseminate 2018 HOS-M PACE Data
08/2019	Disseminate 2016-2018 Cohort 19 Performance Measurement Reports
11/2019	Disseminate 2016-2018 Cohort 19 Performance Measurement Data

In addition, several types of Medicare HOS data files are available for research purposes. Medicare HOS data files are available as public use files (PUFs), limited data sets (LDSs), and research identifiable files (RIFs).

Medicare HOS PUFs contain the majority of the survey items collected on the Medicare HOS instrument (excluding beneficiary identifying information), as well as selected additional administrative variables. Medicare HOS PUFs are constructed to prevent the identification of any single beneficiary or health plan, and only respondents to the survey are included in the files. Medicare HOS PUFs are available at no cost and can be downloaded directly from the CMS website (http://hosonline.org/en/data-dissemination).

Medicare HOS LDSs and RIFs are comprised of the entire national sample for a given cohort (including both respondents and non-respondents), and contain all of the Medicare HOS survey items. The Medicare HOS LDSs include several variables describing health plan characteristics but contract numbers have been blinded and certain fields removed to prevent identification of individual health plans and contract. The LDS files also contain protected beneficiary-level health information such as date of birth, but specific direct person identifiers (i.e., name and health insurance claim number) are not included in LDSs. The Medicare HOS RIFs contain all of the Medicare HOS survey items all of the variables in an LDS as well as specific direct person identifiers (i.e., name and health insurance claim number) and health plan identifiers (i.e., contract numbers) not included in an LDS file. A signed Data Use Agreement (DUA) with CMS is required to obtain either LDS or RIF data files. Currently, a total of 47 DUAs have been approved by CMS or are in progress; an additional 49 DUAs that have been completed and closed. An additional 30 DUAs issued by the National Institutes of Health (NIH) National Cancer Institute (NCI) for LDS files under the SEER-MHOS data linkage project are currently active.

The table below summarizes data collection year and availability of baseline, follow-up, and analytic research files for the past three and next three cohorts:

HOS Cohort	Baseline Data Collection/ Baseline Report Availability	Follow-Up Data Collection/ Performance Measurement (PM) Report Availability	Analytic (PM) Data Availability
15	2012 _Summer 2013_	2014 _Fall 2015_	2012-2014 _Fall 2015_
16	2013 _Summer 2014_	2015 _Fall 2016_	2013-2015 _Fall 2016_
17	2014 _Summer 2015_	2016 _Expected Fall 2017_	2014-2016 Expected _Fall 2017_
18	2015 _Summer 2016_	2017 _Expected Fall 2018_	2015-2017 _Expected Fall 2018_
19	2016 _Expected Summer 2017_	2018 _Expected Fall 2019_	2016-2018 _Expected Fall 2019_
20	2017 _Expected Summer 2018_	2019 _Expected Fall 2020_	2017-2019 _Expected Fall 2020_

17. Expiration Date

The expiration date is displayed.

18. Exceptions to Certification Statement 19

There are no exceptions taken to item 19 of OMB Form 83-1.