Medicare Health Outcomes Survey

Supporting Statement A

Contents

Supporting Statement A....3
Paperwork Reduction Act Clearance Request....3
Background....3
Justification....4
1. Collection Necessity and Legal Requirements....4
2. Information Users....6
3. Use of Improved Information Technology....8
4. Duplication of Efforts....9
5. Small Businesses....9
6. Less Frequent Data Collection....10
7. Special Circumstances....10
8. Federal Register and Outside Consultation....10
9. Payments or Gifts to Respondents....10
10. Confidentiality....10
11. Sensitive Questions....11
12. Burden Estimates (Hours & Wages)....11
13. Capital Costs....12
14. Costs to Federal Government....12
15. Burden Changes and Adjustments....12
16. Publication and Tabulation Dates....14
17. Expiration Date....15
18. Exceptions to Certification Statement....15
List of Attachments....16
Attachment A: Crosswalk of Changes....16
Attachment B: HOS Questionnaire....16
Attachment C: HOS-M Questionnaire....16
Attachment D: Response Rates....16
Attachment E: HOS Mailing Materials....16
Attachment F: HOS-M Mailing Materials....16
Attachment G: CMS Response to Public Comments Received for CMS-10203....16

Supporting Statement A

Paperwork Reduction Act Clearance Request

The Centers for Medicaid & Medicare Services (CMS) requests the Office of Management and Budget's (OMB) continued approval of the Medicare Health Outcomes Survey (HOS). CMS, Medicare Advantage Organizations (MAOs), and researchers rely on the consistent collection of Medicare beneficiary health outcomes data from the HOS to understand trends in the health outcomes of the MAO population over time and to inform continuous quality improvement.

CMS received its previous OMB clearance (OMB 0938-0701) in August 2018. CMS requests a renewed three-year clearance to continue annual fielding of the HOS.

Background

The HOS is a longitudinal patient-reported outcome measure (PROM) that assesses self-reported beneficiary quality of life and daily functioning. As a PROM, the HOS measures the impact of services provided by MAOs, whereas process and patient experience measures only provide a snapshot of activities or experiences at a specific point in time.[1] PROM data collected by the HOS allows CMS to continue to assess the health of the Medicare Advantage population. This older population is at increased risk of adverse health outcomes, including chronic diseases and mobility impairments that may significantly hamper quality of life.[2] The HOS supports CMS's commitment to improve health outcomes for beneficiaries while reducing burden on providers. CMS accomplishes this by focusing on high-priority areas for quality measurement and improvement established in the agency's Meaningful Measures Framework.[3] The HOS uses quality measures that ask beneficiaries about health outcomes related to specific mental and physical conditions. (See **Attachment A** for a crosswalk of the survey changes from the last OMB package submission.)

[1] Martha Hostetter and Sarah Klein, "Using Patient-Reported Outcomes to Improve Health Care Quality," The Commonwealth Fund, Accessed May 11, 2020, https://www.commonwealthfund.org/publications/newsletterarticle/using-patient-reported-outcomes-improve-health-care-quality.

[2] Office of Disease Prevention and Health Promotion, "Older Adults", Healthy People 2020, May 20, 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults.

[3] Centers for Medicare & Medicaid Services, "Meaningful Measures Hub," Meaningful Measures Framework, September 10, 2019, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.

Consistent collection of HOS PROM data for the Medicare population has allowed CMS, MAOs, and researchers to understand trends in the Medicare population's health outcomes over time as well as beneficiary perspectives on their own health status.

Each year the HOS is administered (Baseline) to a random sample of MAO beneficiaries from participating MAOs that have a minimum of 500 enrollees. Two years later, the baseline respondents are surveyed again (Follow-up). For each member who completes the Follow-Up Survey, a two-year change score is calculated and (accounting for risk-adjustment factors) the member's physical and mental health status is categorized as "better than expected," "as expected," or "worse than expected." Summary HOS results are calculated for each MAO based on aggregated beneficiary outcomes. CMS includes multiple measures from HOS in the Medicare Star Ratings program to help consumers choose health plans.[4] Star Ratings serve as the basis for a quality bonus payments (QBPs) for Medicare Advantage plans that was implemented in 2012. Refer to **Attachment B** for the HOS instrument. The HOS-M is a shorter version of the HOS that is administered to beneficiaries enrolled in Programs of All-Inclusive Care for the Elderly (PACE). Refer to **Attachment C** for the HOS-M instrument.

Justification

1. Collection Necessity and Legal Requirements

The HOS meets the requirements for collecting and publicly reporting quality and performance indicators as required by the Balanced Budget Act of 1997. The Balanced Budget Act of 1997 (BBA) established a new Part C of the Medicare program, known then as the Medicare+Choice (M+C) program. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans (such as health maintenance organizations (HMOs), provider sponsored associations (PSOs), and preferred provider organizations (PPOs)), Medicare Medical Savings Account (MSA) plans, private-fee-for-service (PFFS) plans, and Religious Fraternal Benefit (RFB) plans. This act mandated the collection of Medicare+Choice and PACE quality and performance indicators and the provision of this information to

[4] Centers for Medicaid & Medicare Services, "Fact Sheet – 2021 Part C and D Star Ratings," Part C and D Performance Data, Accessed December 7, 2021, https://www.cms.gov/files/document/2021starratingsfactsheet10-13-2020.pdf

beneficiaries. [5] Further, this Act mandated that Medicare capitated payments to PACE organizations be adjusted to account for the comparative frailty of PACE beneficiaries. Risk adjustment models based solely on diagnosis and demographics failed to adequately predict future Medicare expenditures for frail community-dwelling populations, which necessitated the addition of a frailty adjuster based on the average level of functional impairment of each organization's beneficiaries (consequently, HOS-M was selected to assess frailty).

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 continued the collection and reporting requirements under Section 1860D-4 (Information to Facilitate Enrollment). The MMA also renamed the Medicare+Choice program "Medicare Advantage" (MA). Under the MMA, beneficiaries may choose from additional plan options, including special needs plans (SNPs). The MMA established an MA coordinated care plan specifically designed to provide targeted care to individuals with special needs. The MMA also required CMS to provide results to Medicare beneficiaries prior to the annual enrollment period.[6]

Fully integrated dual eligible special needs plans (FIDE-SNPs) fully integrate care for dually eligible beneficiaries under a single managed care organization. FIDE-SNPs were enacted by the Affordable Care Act (P.L. 111-148, as amended) and permanently authorized, along with regular D-SNPs, in the Bipartisan Budget Act of 2018 (P.L. 115-123). FIDE-SNPs with average frailty levels similar to PACE may be eligible for a payment adjustment to account for the cost of serving a high concentration of frail individuals, and MAOs sponsoring FIDE SNPs have the option of participating in HOS or HOS-M to support calculation of frailty scores.

Two longitudinal measures, Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health and three cross-sectional measures (Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control) are derived from the HOS and used in Medicare Star Ratings, which are the basis for Quality Bonus Payment (QBP) ratings. The Star Ratings program has led to health and drug plan quality improvement. The average enrollment-weighted overall Star Rating for Medicare Advantage Prescription Drug (MA-PD) contracts has increased. In 2015, approximately 60% of MA-PD beneficiaries were in contracts

[5] United States Congress, "H.R.2015 - Balanced Budget Act of 1997," Congress.gov, August 5, 1997, https://www.congress.gov/bill/105th-congress/house-bill/2015/text/enr.

[6] United States Congress, "Medicare Prescription Drug Improvement Act," Congress.gov, December 8, 2003, https://www.congress.gov/108/plaws/publ173/PLAW-108publ173.pdf.

with four or more stars; weighted by enrollment, approximately 77% of MA-PD beneficiaries were in contracts with four or more stars in 2021.

CMS continues to consider how new longitudinal patient-reported outcome measures (PROMs) may be developed from the HOS. For example, CMS is considering a new longitudinal measure, Physical Functioning Activities of Daily Living (PFADL), to further assess health status. PFADL measures the change in the physical functioning of beneficiaries enrolled in MAOs over a two-year period and complements the measurement of physical health status. PFADL was introduced as a display measure for 2021 (display measures are publicly reported for informational purposes only and are not included in the Star Ratings or used for QBP calculations.) CMS is in the process of exploring additional HOS measures for plans to use as a focus of their quality improvement efforts.

2. Information Users

Multiple stakeholders use HOS data. Beneficiaries use HOS survey measure results to make informed choices on which health plan is best for them. Information obtained from the HOS also provides data to assist consumer choice via the Medicare Plan Finder website (www.medicare.gov/find-a-plan), a site where people can compare plan performance. CMS continues to utilize the survey as an avenue for quality oversight and MAO accountability. MAOs use the data generated from the HOS in conjunction with Medicare Star Ratings scores to support quality improvement (QI) activities[7]. HOS survey results support the quality improvement efforts of individual plans by providing plans with detailed reports. Researchers continue to use the data from the HOS to advance the science of care for older adults and functional health outcomes measurement (see Table 1 for research topic areas).

CMS uses the HOS to support its quality oversight role of MAOs and to establish QBPs that incentivize quality improvement. Areas of focus include maintaining physical and mental health, increasing physical activity, reducing the risk of falling, and managing urinary incontinence. These themes continue to remain areas of high priority for the elderly population and are therefore incorporated into Medicare Star Ratings. Medicare Star Ratings are publicly

[7] Quality improvement: *the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (cited in* Crossing the Quality Chasm: A New Health System for the 21st Century. National Academy of Medicine. Washington, D.C.: National Academy, 2001. Print).

reported and translated into consumer-facing information for beneficiaries to provide transparency, hold MAOs accountable to beneficiaries, and highlight high performing MAOs.

MAOs use HOS data and Medicare Star Ratings scores to improve the care they provide to Medicare beneficiaries. MAOs are responsible for providing access to services that help to maintain and improve beneficiary health and function. HOS results assist MAOs in establishing QI initiatives and developing systems to track progress toward improving patient outcomes. HOS reports are designed to maximize the ability of MAOs to apply their HOS results to health promotion, quality improvement, and care management interventions and activities. Results help MAOs track the overall self-reported health outcomes of their beneficiary group longitudinally; identify the demographic profile of their beneficiaries and health status for each population; assess the functional health status of their beneficiaries; and evaluate the impact of interventions geared toward maintaining and improving the health of their older adult beneficiaries. These HOS-rooted QI initiatives support beneficiaries and providers alike. MAOs have implemented a variety of QI initiatives using HOS data and Medicare Star Ratings. These include, but are not limited to:

- Creating patient education materials.
- Advising beneficiaries of wellness programs.
- Partnering with community organizations that provide services to older adults.
- Supplying providers with tool kits that share best practices specific to bladder control, fall prevention, physical activity, and mental and physical health.
- Deploying MAO staff to provider offices to assess and better understand barriers to providing quality care to Medicare beneficiaries.
- Tailoring interventions and QI strategies to support providers struggling to maintain high quality care.

The HOS is also used extensively by researchers to advance the science of health outcomes, cancer research, care for older adults, and end-of-life care (see Table 1). Researchers continue to use de-identified survey data to publish studies on caring for beneficiaries with and without cancer, developing survey measures, identifying and tracking areas for health plan improvement, and differentiating health plan performance. CMS, in partnership with the National Cancer Institute (NCI), established the Surveillance, Epidemiology, and End ResultsMedicare Health Outcomes Survey (SEER-MHOS) Linked Data Resource to better understand the “health-

related quality of life of cancer patients and survivors enrolled in Medicare health plans."[8] This database links patient-reported quality of life, activities of daily living, and effectiveness of care derived from the HOS. SEER-MHOS data have been used in approximately 50 studies published in the last 10 years and another dozen studies currently in review for publication. HOS data inform manuscripts on topics such as trends in disparities of health-related quality of life for beneficiaries with cancer, a study of patient-reported geriatric assessment domains for patients with cancer, and patterns of patient-reported outcomes associated with pain and depression for patients with cancer. Without the HOS, this database would not include beneficiary self-reports of health-related quality, which providers and researchers consistently rely upon to target interventions to improve the quality of life of older cancer patients. As noted earlier, HOS data inform research in the following topic areas:

Table 1. Research Topic Areas Published Using the HOS

Category	Topic Areas
Beneficiary health	• Health-related quality of life for beneficiaries with and without cancer • Treatment, survivorship, and health outcomes of beneficiaries with cancer • Racial and ethnic disparities in beneficiaries with and without cancer • Falls among cancer survivors • Depression and chronic conditions in beneficiaries with and without cancer • Physical activity • Smoking cessation in beneficiaries with and without cancer
HOS performance	• Differentiating MAO plan performance • Identifying and tracking areas for MAO improvement
Survey and measure development	• Adapting health status measures and indices

3. Use of Improved Information Technology

The HOS is a mixed-mode survey, mail with telephone follow-up. CMS uses a mixedmode protocol to maximize response rates.[9] CMS-approved survey vendors administer the mail and telephone survey on behalf of MAOs. Beneficiaries receive two waves of questionnaire mailings. Each questionnaire mailing includes a barcode or an alphanumeric, unique identifier associated with the sampled beneficiary. Survey vendors use electronic telephone interviewing

[8] National Cancer Institute – Division of Cancer Control & Population Sciences, "History of the SEER-MHOS Linked Data Resource," National Cancer Institute, November 12, 2019, https://healthcaredelivery.cancer.gov/seermhos/overview/history.html.

[9] Don A. Dillman et al., "Response rate and measurement differences in mixed-mode surveys using, mail, telephone, interactive voice response (IVR) and the internet," May 12, 2008, https://doi.org/10.1016/j.ssresearch.2008.03.007.

systems to administer the telephone survey to mail survey non-respondents. Survey vendors must document in their Quality Assurance Procedures that they have met Telephone Consumer Protection Act (TCPA) requirements for dialing wireless phone numbers.

Each sampled beneficiary is tracked in a survey vendor's survey management system (SMS) throughout the HOS protocol. Returned questionnaires are scanned and tracked electronically in the survey vendor's SMS. Beneficiaries who return a mail survey in the first wave of mailing are removed from additional mailings and from telephone follow up. The telephone interviewing systems are also linked to a survey vendor's SMS and assist in electronic dialing and tracking of beneficiaries throughout the telephone protocol. If a beneficiary notifies a survey vendor that they do not want to be contacted again, the survey vendor flags the beneficiary as "Do Not Survey" and removes them from future surveys.

CMS is exploring web administration across multiple surveys and will submit a separate package for approval to test web mode of data collection should it proceed with testing it for this survey.

4. Duplication of Efforts

The HOS is unique and does not duplicate other survey efforts. Unlike other CMS sponsored surveys that measure beneficiary experience with their MAO, HOS measures changes in beneficiary health status at the health plan contract level. To that end, each HOS sample is drawn at the contract level to measure an MAO's ability to maintain or improve beneficiary health over time, making the MAO an accountable partner in supporting beneficiary health. At Baseline, a random sample of 1,200 beneficiaries is selected for the survey. The Follow-Up survey is administered to the plan members who responded to the Baseline survey two years prior. This allows for a comparison in beneficiary health status over time. This sampling protocol is unique to HOS; other surveys do not sample beneficiaries in the same manner.

5. Small Businesses

Small MAOs, with fewer than 500 beneficiaries, are excused from Baseline requirements to reduce the burden on smaller MAOs. Small MAOs that fielded the HOS survey two years prior are still required to report the Follow-Up survey so that CMS can calculate the longitudinal PCS and MCS scores used in Medicare Star Ratings. Administration of the Follow-Up survey is limited to beneficiaries who completed the survey two years prior. The surveys are administered by CMS-approved survey vendors on behalf of MAOs. The survey instruments and procedures

for completing the instruments are designed to minimize burden on all respondents and will not have a significant impact on small businesses or other small entities.

6. Less Frequent Data Collection

CMS relies on the annual collection of HOS data to provide up-to-date information to beneficiaries to assist them in making informed decisions when choosing a Medicare plan. The HOS is a longitudinal survey which measures beneficiary health at two points in time. The data derived from the HOS are used in Medicare Star Ratings. Two HOS measures, Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, are longitudinal outcome measures allowing CMS to assess the health of beneficiaries over time. Due to their importance in measuring beneficiary health, CMS triple weights outcome measures in Medicare Star Ratings. Less frequent data collection would result in gaps in information in Medicare Star Ratings and jeopardize CMS's ability to measure differences in outcomes attributable to MAOs.

Although the HOS is fielded every year, sampled beneficiaries may only receive the survey every two years (Baseline and Follow-Up surveys). The survey administration schedule strikes a balance between maximizing the collection of HOS data and curtailing respondent burden. In some instances, beneficiaries in small MAOs may receive the survey every year to ensure a large enough sample size to support robust statistical analyses.

7. Special Circumstances

There are no special circumstances impacting HOS and HOS-M administration.

8. Federal Register and Outside Consultation

The 60-day Federal Register Notice published in the *Federal Register* on 02/05/2021 (86 FR 8362). CMS received two comments; responses can be located in Attachment G.

The 30-day Federal Register Notice published in the *Federal Register* on 5/7/2021 (86 FR 24624).

9. Payments or Gifts to Respondents

CMS prohibits the use of incentives for survey participation. The HOS does not provide any payments or gifts to respondents. Respondents with Medicare may gain an informational benefit if they consult Medicare Star Ratings when reviewing Medicare Advantage enrollment options.

10. Confidentiality

Individuals contacted are assured confidentiality 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. The Systems of Records is the Health Plan Management System (HPMS) (SORN 09-70-0500) and the Enrollment Database (EDB) (SORN 09-70-0502).

11. Sensitive Questions

The HOS does not include sensitive questions. The core component of the HOS instrument, the Veterans RAND 12-Item Health Survey (VR-12), is a standardized instrument that has been used in both clinical practice and research and is not considered to be sensitive in nature. However, it is possible that some beneficiaries might feel that select questions are sensitive, such as questions about the management of urinary incontinence or race questions. The HOS collects data on these items to provide clinically salient information so that MAOs can implement quality improvement strategies. The demographic questions are used for risk adjustment purposes, so it is imperative that this information is collected to enable fair adjustment of MAO scores. Participation in the HOS survey is voluntary. Also, respondents may skip any question they prefer not to answer.

12. Burden Estimates (Hours & Wages)

The HOS sampling strategy is designed to minimize burden on survey respondents. The Baseline survey is administered to a sample of up to 1,200 beneficiaries from each MAO required to report (depending on plan size). All beneficiaries with valid MCS and PCS scores from completing the survey two years prior also receive a Follow-Up survey. All beneficiaries sampled for an annual survey administration (Baseline and Follow-Up) receive the same survey and may complete the survey by mail or telephone. Once a beneficiary completes the survey, the survey vendor no longer contacts the beneficiary.

Table 2 shows the estimated annualized burden for respondents’ time to participate in this data collection. Tests have shown the average time to complete the HOS is about 19 minutes.

Table 2. Estimated Annualized Burden (Hours and Cost) – HOS and HOS-M Based on 2020 Response Estimates

HOS Survey	Number of Participating Plans[a]	No. of Respondents per Plan[b]	No. of Responses	Average Burden per Response (hours)	Hourly Wage Rate[c]	Total Annual Burden (hours)	Total Annual Respondent Cost[d]
HOS Baseline	509	720	366,480	0.32	$25.72	117,274	$3,016,130.40
HOS Follow-Up	435	540	234,900	0.32	$25.72	75,168	$1,933,227.00
HOS-M	124	225	27,900	0.32	$25.72	8,928	$229,617.00
					Total	201,370	$5,178,974.40

[a.] The number of participating plans is based on the 2020 participating plan list.

[b.] The number of respondents per plan is calculated as follows: Baseline – average number of members sampled per plan (1,200) with an expected 60% response rate (720); Follow-Up – average number of members responding to Baseline survey two years prior (720) at a 75% response rate at Follow-Up (540); HOS-M – average number of sampled members per plan (300) at a 75% response rate (225).

[c.] The hourly wage rate is based on national wage data for all occupations in 2020 from the U.S. Bureau of Labor Statistics.[10] The labor rate does not include fringe benefits and overhead since respondents' activities would occur outside the scope of any employment. U.S. Bureau of Labor Statistics website: https://www.bls.gov/oes/current/oes_nat.htm#00-0000 Note: The May 2019 data, released on March 31, 2020 (last accessed January 1, 2021, are the most recent OES data available.

[d.] The total annual respondent cost = the number of responses multiplied by the cost per response ($25.72 x .32 = $8.23).

13. Capital Costs

There are no capital costs associated with HOS administration.

14. Costs to Federal Government

The costs to the federal government originate from CMS's two contractors. Each contractor operates a five-year contract to oversee HOS administration—one contractor trains and oversees survey vendors and manages data submission activities and the other contractor performs all data analysis and dissemination efforts, including producing reports for the plans to use for quality improvement. The average annual cost to the Federal Government is $3,000,000.

15. Burden Changes and Adjustments

The burden adjustments on MAOs and PACE plans are due to changes in the number of

[10] United States Bureau of Labor Statistics, "Economic News Release," July 7, 2020, https://www.bls.gov/news.release/empsit.t19.htm

MAOs required to administer the HOS and the number of PACE plans required to administer the HOS-M. The total number of MAOs required to report HOS Baseline and Follow-Up increased by 47 and 68 MAOs, respectively, since the previous OMB submission. The increase in the number of contracts required to report HOS Baseline and Follow-Up in 2020 was largely due to changes in the number of MA contracts. The burden adjustments on PACE plans are a result of changes in the number of PACE plans required to report HOS-M. The number of PACE plans required to administer the HOS-M increased by 17 since the last OMB package. There has been tremendous growth in PACE during the last decade and the program continues to grow.

CMS modified the requirement for beneficiaries in Institutional Special Needs Plans (ISNP) by excluding these beneficiaries, who are in long-term care in a skilled nursing facility, from the HOS sample, thereby reducing survey burden on these beneficiaries. Any MAO whose membership is made up entirely of I-SNP beneficiaries is no longer required to participate in the survey.

CMS is seeking to further reduce the burden on respondents by eliminating six questions:

- Three questions concern common chronic medical conditions: (arthritis of the hip or knee, arthritis of the hand or wrist, and sciatica). Another question CMS seeks to remove asks about smoking. None of these four questions from the survey are used in Medicare Star Ratings, reporting, or for other purposes. Additionally, the Medicare CAHPS survey has related questions on smoking.
- CMS would like to remove the osteoporosis testing in older women question from the HOS following recommendations made by the measure steward (NCQA), to keep the survey aligned with the latest U.S. Preventative Services Task Force (USPSTF)[11] clinical recommendations. CMS also proposes to remove the phrase "suggest you take vitamin D" from the falls prevention question to align with the USPSTF clinical recommendations per the measure steward.[12]
- CMS is seeking to remove the income question, a question that is burdensome for respondents (phone interviewees are required to listen to each of ten categories). It accounts for the most 'missingness' in both phone and mail administration

[11] The Osteoporosis Testing in Older Women measure was retired from the Healthcare Effectiveness Data and Information Set (HEDIS®) by the measure steward, the National Committee for Quality Assurance. It is not currently used in the calculation of Medicare Star Ratings.
[12] Per the USPSTF clinical recommendations, the use of vitamin D has no benefit on preventing falls in older adults.

modes. CMS has access to alternate information to serve as proxies for beneficiary income using socioeconomic measures such as Medicaid status, home ownership, and Supplemental Security Income (SSI) indicator.

Based on the proposed six question deletions, the time required to administer the HOS survey is reduced slightly, from .33 to .32 of an hour, in Table 2. Estimated Annualized Burden (Hours and Cost) – HOS and HOS-M Based on 2020 Response Estimates.

16. Publication and Tabulation Dates

HOS data are used for descriptive, explanatory, and predictive analyses. A number of analyses have already been conducted on HOS data; these analyses (complete with data files and reports) continue to be prepared over the course of the survey program. HOS Baseline Reports, Follow-Up Reports, and Performance Measurement Data are created for each cohort. CMS continues to work to deliver data to plans as soon as possible to ensure that the data are relevant, actionable, and timely. Due to these efforts to date, the delivery of data to MAOs now occurs three months earlier than it has in previous years. Table 3 displays the project schedule and the availability of the data.

Table 3. HOS Results Report Availability

HOS Cohort	Data Collection Dates	Baseline Report Available	Follow-Up Performance Measurement Report Available	Performance Measurement Data Available
21	**Baseline:** Spring 2018 **Follow-Up:** Summer 2020[a]	May 31, 2019	*Expected 2021*[a]	*Expected 2021*[a]
22	**Baseline:** Spring 2019 **Follow-Up:** Summer 2021[a]	May 29, 2020	*Expected 2022*[a]	*Expected 2022*[a]
23	**Baseline:** Summer 2020 **Follow-Up:** Summer 2022[a]	*Expected 2021*[a]	*Expected 2023*[a]	*Expected 2023*[a]

a. The publication date of select reports may be impacted due to adjustments in the HOS data collection dates due to the public health emergency.

Additionally, several types of HOS data files are available for research purposes. HOS data files are available as Public Use Files (PUFs), Limited Data Sets (LDSs), and Research Identifiable Files (RIFs). HOS PUFs contain most of the survey items collected from the HOS instrument (excluding beneficiary identifying information) and select additional administrative variables. HOS PUFs are constructed in a manner that prevents the identification of any single

beneficiary or plan. Only respondent data is included in the PUFs (non-respondent data is removed). HOS PUFs are available at no cost and can be downloaded directly from the CMS website.

HOS LDSs are comprised of the entire national sample for a given cohort (including both respondents and non-respondents) and contain all the HOS survey items. Additionally, LDSs contain protected beneficiary-level health information such as date of birth; however, specific direct person identifiers (i.e., name and health insurance claim number) are removed from the LDSs to ensure beneficiary confidentiality. The MAO contract number is blinded in the LDS and certain fields describing MAOs have been modified (e.g., categorical enrollment) or excluded (e.g., plan name) to prevent identification of specific MAO contracts. A signed Data Use Agreement (DUA) with CMS is required to obtain the LDS files.

HOS RIFs are also comprised of the entire national sample for a given cohort (including both respondents and non-respondents) and contain all of the HOS survey items. RIFs contain all of the variables included in the LDS files, as well as specific direct person identifiers (i.e., name and health insurance claim number) and plan identifiers (i.e., plan name and other plan characteristics). A signed DUA with CMS is required to obtain the RIF data.

17. Expiration Date

The OMB approval expiration date is displayed on the HOS and HOS-M surveys. The new clearance approval expiration date will also be displayed. Refer to **Attachment B** or **Attachment C** for an example of how the approval expiration date is displayed.

18. Exceptions to Certification Statement

There are no exceptions to Item 19 of OMB Form 83-1 associated with HOS data collection.

List of Attachments

Attachment A: Crosswalk of Changes

Attachment B: HOS Questionnaire

Attachment C: HOS-M Questionnaire

Attachment D: Response Rates

Attachment E: HOS Mailing Materials

Attachment F: HOS-M Mailing Materials

Attachment G: CMS Response to Public Comments Received for CMS-10203