Supporting Statement B
For Revision of Currently Approved Collection:
Medicare Current Beneficiary Survey (MCBS)

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B. Statistical Methods

The revision to this OMB package includes the following modifications to the Community questionnaire and Facility instrument sections to improve policy relevance, reduce survey costs, and increase efficiency.

To reduce respondent burden, the requested deletions and revisions in the Community questionnaire include:

- Removing the Access to Care Questionnaire (ACQ), consisting of 32 items. Seven ACQ items will be retained and migrated to the revised Care Coordination Questionnaire (CCQ).
- Removing seven items about the cost of vaccines from the Immunization Questionnaire (IMQ).
- Streamlining the collection of awareness of the right to file an appeal with Medicare in the Beneficiary Knowledge and Information Needs Questionnaire (KNQ).
- Streamlining the collection of knowledge and use of the Low-Income Subsidy (LIS) and Medicare Savings Program (MSP) in the Income and Assets Questionnaire (IAQ).
- Revising thirteen items on prescription drug purchasing behavior in the Drug Coverage Questionnaire (RXQ).
- Removing two items about religious affiliation from the Demographics and Income Questionnaire (DIQ).
- Removing two items about household composition from the Enumeration Summary section (ENS).
- Removing 24 items from the HFQ including 17 detailed follow-up items about diabetes management and 7 items about hypertension, urinary incontinence, and bowel incontinence.
- Streamlining the collection of health care screening information in the Preventive Care Questionnaire (PVQ).
- Removing four items about satisfaction with health care services from the Satisfaction with Care Questionnaire (SCQ).

The requested deletions and revisions in the Facility instrument include:

- Removing one facility contact item from the Facility Questionnaire (FQ) section.
- Removing three items that collect facility structure and facility contact details from the Residence History (RH) section.
- Removing sixty verification items that appear when a billing, insurance, or payment discrepancy is identified from the Expenditures (EX) section.
- Removing seventeen items that collect information on general health status, vision, Medicare eligibility, procedures, preventive screenings, and record identification from the Health Status (HS) section.
- Revising the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) series to align with the flow used in the Community questionnaire.

The requested additions to the Community questionnaire include:

- Modernizing the Care Coordination Questionnaire (CCQ), formerly referred to as the Usual Source of Care Questionnaire (USQ) to include 15 new items about wait time for appointments, coordination of health care information and services, urgent care clinic visits; 15 new items about trust in health care providers, and 31 new items on pre-authorization of health care services, which are administered conditionally to a subset of respondents.
- Five new items about prescription drug discount programs in the Drug Coverage Questionnaire (RXQ).
- One new item about hypertension management and three new items about nutrition in the Health Status and Functioning Questionnaire (HFQ).

The requested burden neutral operational changes include:

- Adding a self-administered web-based mode to the Facility instrument to supplement telephone interviewing. The updated multimode Facility data collection design includes a phone administered Facility screener followed by three survey sections that may be self-administered via web or interviewer-administered via phone. While the structure of the facility interview has changed, the survey content remains consistent with previous years as existing content has been migrated and consolidated into the new survey sections.
- Updating the Community brochure for respondents and adding a new material providing information on the video interviewing process. Mentions of the video interviewing option were added to the existing Community Advance Letters, and all materials with the MCBS logo were updated to reflect the new MCBS logo.
- Adding four new items to the suite of existing facility respondent materials that provide information to facility respondents on the web instrument workflow and how to complete the web survey.

B1. Universe and Respondent Selection

The target universe is current Medicare beneficiaries entitled to hospital and/or supplementary medical insurance and living in the 50 states or the District of Columbia. Both institutionalized and non-institutionalized beneficiaries are represented. Table B.1 summarizes the number of beneficiaries in the target universe based on CMS administrative records through 2025. The seven age groups shown in the table correspond to the primary sampling strata from which the samples for the MCBS are drawn[1]. The age groups are defined by the beneficiaries' age as of December 31 of the given year for 2018 and later.

Table B.1: Universe Counts Broken Down by MCBS Age Groups (in thousands)

Age Interval	2018	2019	2020	2021	2022	2023	2024	2025
Disabled <45	1,791.78	1,771.52	1,744.56	1,715.78	1,646.76	1,585.22	1,541.14	1,498.30
45 to 64	6,903.46	6,773.12	6,641.56	6,411.54	6,153.78	5,897.58	5,645.22	5,425.44

[1] Note that, beginning in Fall 2026 under the sample redesign, the age groups are collapsed into three groups (<65, 65-79, and 80+).

Age Interval	2018	2019	2020	2021	2022	2023	2024	2025
65 to 69	15,978.62	16,368.74	16,895.90	16,975.40	17,149.42	17,538.10	17,742.46	17,775.14
70-74	13,647.66	14,322.88	14,967.58	15,115.86	15,278.12	15,631.94	15,976.76	16,351.80
75-79	9,463.14	9,820.30	10,117.54	10,576.94	11,296.14	11,789.56	12,453.50	12,952.82
80-84	6,301.04	6,441.96	6,610.14	6,737.94	7,098.58	7,447.08	7,767.44	7,961.18
85+	7,001.80	7,052.58	7,099.28	6,902.06	6,966.30	7,062.08	7,204.38	7,357.22
Total (64 and under)	8,695.24	8,544.64	8,386.12	8,127.32	7,800.54	7,482.80	7,186.36	6,923.74
Total (65 and over)	52,392.26	54,006.46	55,690.44	56,308.20	57,788.56	59,468.76	61,144.54	62,398.16
Total (All)	61,087.50	62,551.10	64,076.56	64,435.52	65,589.10	66,951.56	68,330.90	69,321.90

Source: Universe counts are based on a 5-percent extract of the Medicare administrative records and are computed as 20 times the extract counts.

Notes: Puerto Rico beneficiaries are excluded from sample design counts.

Totals do not necessarily equal the sum of rounded components.

Beginning in Fall 2026 under the sample redesign, age groups are collapsed into three groups (<65, 65-79, and 80+).

Regardless of design, the target sample size of the MCBS varies slightly each year. Most recently, it has been designed to yield 8,200-8,500 completed cases providing Cost Supplement data per year (approximately 17-18 percent of these being disabled enrollees under the age of 65, approximately 48-49 percent being age 65 to 79, and approximately 33-34 percent being enrollees 80 years of age and older) from 2023 onwards. The redesigned sample from 2026 onward maintains approximately the same overall targets.

To achieve the desired number of completed cases, the MCBS selects new sample beneficiaries each year (referred to as the Incoming Panel) to compensate for nonresponse, attrition, and retirement of sampled beneficiaries in the oldest panel (referred to as the exit panel) and to include the current-year enrollees, while continuing to interview the non-retired portion of the continuing sample. The Incoming Panel is always added in the Fall round (also referred to as the Baseline interview); the retiring or exit panel occurs in the Winter round (and is the 11th and final interview for all respondents).

Each year, an analysis of non-response and attrition is conducted to determine the optimal sample size for the Fall round Incoming Panel. Through 2009, approximately 6,500 beneficiaries were added to the sample in the Fall (September – December) round each year to replace the exiting panel and to offset sample losses due to non-response and attrition. Beginning in the Fall round of 2010 and continuing through the decade, the number of beneficiaries included in the Incoming Panel sample release was gradually increased to compensate for declining response rates. Beginning in 2020 when interviewing shifted from in-person to telephone due to the COVID-19 pandemic, the Incoming Panel sample size was approximately 15,100. This increase is a reflection

of the continued decline in response rates and the additional difficulty of locating respondents via telephone[2]. The sample size results in over 34,000 interviews completed per year.

The methodology for drawing the samples is described later in this document. The number of cases to be selected each year for the Incoming Panel (designated sample sizes) is larger than the targeted number of completes to compensate for non-response, ineligibility, and attrition. Since 2020, more sample has been necessary to compensate for a switch from in-person interviewing to telephone interviewing and the expected lower response rates associated with that mode. With the reintroduction of some in-person interviewing in late 2021, and the shift to multimode data collection, these additional sample needs have stabilized and sometimes decreased slightly.

Proxy interviews are attempted for deceased sample persons. If data are collected through the date of death, then these cases are counted as completed interviews. Sampled beneficiaries remain in the survey when they are unavailable for an interview in a given round; that is, they are carried forward into the next round. For these individuals, the reference period for their next interview is longer as it covers the period since their last interview. This ensures that there will not be a gap in coverage of utilization and expenditure data. If a sampled beneficiary is not interviewed for two consecutive rounds, they are not scheduled for any further interviews and are removed from case management. Such cases are treated as nonresponding cases.

Cross-sectional sample sizes for other domains. There are multiple domains of interest in the MCBS (for example, respondents with end-stage renal disease, persons residing in nursing homes, managed care enrollees, Medicaid recipients, and beneficiaries aligned to a provider participating in accountable care organizations). Under the Fall 2026 redesign of the MCBS sampling, the MCBS will continue to maintain a minimum target of 8,200 to 8,500 completed responses in the annual Cost Supplement file to ensure that analysis can be performed on MCBS data for many domains of interest.

Sample sizes for longitudinal analyses. Beginning in 2018, under the rotating panel design specified for the MCBS, respondents remain in the sample for up to eleven rounds of data collection over a four-year period; prior to 2018, respondents remained in the sample for up to twelve rounds of data collection. The historical response rates and attrition rates observed in the MCBS are used to determine the rotational sample size and configuration of each new Incoming Panel. The rotational sample design attempts to achieve consistency in subgroup sample sizes across all panels comprising a particular calendar year.

Table B.3 (in section B2 below) presents the round-by-round conditional and unconditional response rates as of Round 97 (Fall round of 2023) for the samples (referred to in the table as "panels") selected in 2015 through 2023. For example, from the bottom part of the table, it can be seen that by the 10th round of data collection for the 2020 panel, 12.3 percent of the 2020 panel were still in a formal responding status (that is, either the sampled beneficiary was alive and still participating in the study or had died but a cooperative proxy was found for the collection of data on the last months of life) or had participated in the survey until death, leaving enough data to estimate the last months of life. For the 2021 and 2022 panels, the unconditional response rates as of Round 97 were 14.6 percent (through the 7th round of data collection) and 20.4 percent (through the

[2] Note that telephone numbers for beneficiaries are not available in the CMS administrative data used for sampling. Telephone numbers were appended to sampled addresses using vendor matching software; these numbers only sometimes reached the intended respondent. Additional manual locating was conducted by the field team to improve locating rates.

4th round of data collection), respectively. The 2023 panel (the new panel selected in Round 97) had an initial response rate of 45.2 percent in its first round of data collection.

Round 103 (Fall 2025) is the latest round for which MCBS data have been fully processed. There were 2,024 interviews successfully completed at Round 103 with still-living members of the 2022 panel. For brevity, we refer to these 2,024 interviews as "live completes." For the 2023 and 2024 panels there were 2,505 and 3,282 live Round 103 completes, respectively. For the first round of data collection for the 2025 panel, there were 5,710 completes at Round 103.

The MCBS has used a variety of techniques to maintain respondent participation in the survey and reduce attrition. These will be continued and adapted to comply with the time frames for initiating and implementing the continuing sample.

B2. Procedures for Collecting Information

This section describes the procedures used to select the samples for the national survey. It includes a general discussion of the redesign approach implemented in Fall 2026 and its statistical methodology for stratification and rotational panel selection, estimation procedures, and the degree of precision needed. This is followed by a presentation of how instrument sections are used to enhance the analytic potential of the MCBS data. Rules for allowing proxy responses have not changed under the 2026 redesign plan and are also described below.

a. Statistical Methodology for Stratification and Sample Selection

This section opens with a recap of the prior three-stage clustered design, compared to the new state-stratified national design implemented in 2026. This is followed by a general discussion of the selection of the incoming samples under the prior design and 2026 redesign, and the use of Medicare administrative enrollment data each year to reduce problems associated with duplication of samples across the years. Because it will take four years (2026-2029) to fully implement the state-stratified national design, both designs are described below.

1. *Prior (2025 and earlier) three-stage clustered design compared to the new 2026 state-stratified national redesign.* Throughout most of the MCBS history up to 2025, the MCBS employed a complex multistage probability sample design. At the first stage of selection, the sample consisted of 104[3] primary sampling units (PSUs[4]) defined to be metropolitan areas and clusters of nonmetropolitan counties. At the second stage, a sample of 703 secondary sampling units consisting of Census tracts or groups of tracts (SSUs[5]) was selected within the sampled PSUs. At the third and final stage of selection,

[3] Note that prior to 2017, 107 PSUs were used for sampling for the MCBS. These included three PSUs in Puerto Rico. Beginning in 2017, Puerto Rico was removed from the MCBS sampling frame.

[4] The strata used for selection of the PSUs covers the 50 states and the District of Columbia. Since PSUs were selected randomly with probabilities proportionate to size, there are some states without any sample PSUs within their boundaries. Within major strata defined by region and metropolitan status, PSUs were sorted by percent of beneficiaries enrolled in HMOs and/or percent of beneficiaries who are minorities based on data in CMS administrative files. Substrata of roughly equal size were created from the ordered list for sample selection.

[5] The second-stage units (SSUs) consist of Census tracts or clusters of adjacent tracts. A minimum measure of size was used to determine whether a Census tract was large enough (i.e., had enough Medicare beneficiaries) to stand on its own as an SSU or would need to be combined with one or more adjacent tracts. A frame of 24,212 SSUs was constructed, and a sample of 703 SSUs was selected using systematic probability proportional to size. These SSUs have been used for sampling MCBS beneficiaries since 2014 and were sized to be used for up to 20 years. An additional sample of 339 reserve SSUs was also selected to support an expansion of the sample or the study of special rare populations in future years. To date, these reserve SSUs have not yet been used for sampling for the MCBS.

stratified samples of beneficiaries within the selected Census tracts were sampled annually at rates that depended on age group and Hispanic or non-Hispanic ethnicity. The geographically-clustered nature of the current design was developed to support in-person interviewing by ensuring that sampled beneficiaries are clustered into relatively small areas. Under this design, the sampled beneficiaries within each state are not representative of their state as a whole, and 14 states contain no PSUs (and thus no beneficiaries selected for data collection), resulting in a design which supports only national-level estimation. It is not possible to produce representative estimates for states or other sub-national regions.

Starting with the 2026 full clearance revisions (approved by OMB on 1/6/2026), CMS proposed and OMB approved a significant change to the sample design. Beginning with the Incoming Panel selected for Fall 2026, the redesign employs a national frame, which covers all 50 states and the District of Columbia. This redesigned approach no longer relies on PSUs or SSUs, and all beneficiaries in the United States are eligible for sampling and recruitment. The sample is stratified by state (a total of 51 strata that include the 50 states and the District of Columbia) to provide approximately equal numbers of beneficiary interviews within each state. Within each state, beneficiaries are selected at rates designed to preserve adequate representation of the under-65 disabled population, beneficiaries 65-79 years of age, and beneficiaries 80 years of age and older. There is no longer additional stratification based on ethnicity.

While both the prior design and the 2026 redesign yield nationally representative samples, the new design includes sampled beneficiaries and completed interviews in each of the 50 states and the District of Columbia. Once fully implemented, the 2026 redesign design will allow for state-level and sub-national region-level estimation while continuing to support national-level estimation for the many domains of interest.

When the 2026 redesign is fully implemented, the MCBS can expect to achieve similar response rates as seen under the current design. However, CMS will monitor national- and state-level response rates under the new design and adjust the sampling strategy as necessary if any changes are identified.

Table B.2: Conditional and Unconditional Response Rates as of the 2023 Panel for Medicare Current Beneficiary Survey by Interview Round

Conditional Response Rates (%) for Medicare Current Beneficiary Survey by Interview Round

Time in Sample	2015 Panel (n at R73= 8621)	2016 Panel (n at R76= 12145)	2017 Panel (n at R79= 11623)	2018 Panel (n at R82= 11523)	2019 Panel (n at R85= 11615)	2020 Panel (n at R88= 15952)	2021 Panel (n at R91= 15950)	2022 Panel (n at R94= 17139)	2023 Panel (n at R97= 15077)
1	53.3	54.7	55.3	55.9	55.1	41.9	38.1	38.4	45.2
2	83.2	81.4	79.9	80.9	73.4	78.3	76.6	77.8	
3	82.7	83.9	83.1	82.2	83.5	82.2	80.6	78.5	
4	80.0	84.2	85.1	84.7	83.9	81.9	81.7	81.1	
5	88.3	87.9	88.1	74.9	84.4	86.5	86.5		
6	88.0	87.7	85.7	89.3	89.1	88.1	87.7		
7	87.7	88.1	89.4	88.9	86.1	87.8	87.6		
8	91.5	90.9	80.3	89.9	90.5	89.0			
9	92.0	89.2	92.7	92.4	91.8	91.9			
10	91.9	93.2	91.4	89.7	90.9	92.4			
11	96.8	91.4	95.7	96.5	96.9				

Unconditional Response Rates (%) for Medicare Current Beneficiary Survey by Interview Round

Time in Sample	2015 Panel (n at R73= 8621)	2016 Panel (n at R76= 12145)	2017 Panel (n at R79= 11623)	2018 Panel (n at R82= 11523)	2019 Panel (n at R85= 11615)	2020 Panel (n at R88= 15952)	2021 Panel (n at R91= 15950)	2022 Panel (n at R94= 17139)	2023 Panel (n at R97= 15077)
1	53.3	54.7	55.3	55.9	55.1	41.9	38.1	38.4	45.2
2	44.2	44.3	43.7	44.8	40.2	32.5	29.0	29.5	
3	31.7	38.1*	37.7	37.6	37.9	27.2	23.5	24.0	
4	32.9	33.3	33.7	34.3	32.1	22.8	19.3	20.4	
5	31.3	29.0	28.2*	26.7*	28.0	19.8	17.9		
6	28.1*	27.5*	27.3	27.6	25.2	17.1	16.0		
7	25.6	25.5	26.2	24.5	21.9	15.1	14.6		
8	23.0	21.9*	21.6*	22.5	20.1	14.0			
9	22.7*	22.1	22.7	21.0	18.6	13.0			
10	21.7	21.8	20.7	19.0	17.1	12.3			
11	21.7	20.4	20.3	18.8	17.1				

Note: In rounds where some cases are intentionally not fielded, or “not in round” (NIR), unconditional response rates will be lower than they would have been if all eligible cases were fielded.

* Cells reflect rounds that included intentional NIRs.

2. *Selection of beneficiaries.* An annual Incoming Panel sample of beneficiaries is selected from the Medicare administrative enrollment data. Beginning with the 2026 redesign, each year's national sample are stratified by state and by three age groups (beneficiaries under-65, 65-79, and 80 or older). Beneficiaries are selected from within each state to achieve a minimum of 277completed interviews, a target developed to achieve the desired level of precision in state-level estimates by 2029, after the four-year staged implementation of the design[6]. Beneficiaries residing in the same state and who are in the same age-group strata will have equal probabilities of selection and equal design-based weights. Since 2015, and continuing under the redesign, beneficiaries eligible *anytime* during the sampling year are also included in the Medicare administrative enrollment sampling frame (referred to as current-year enrollees). Nursing home residents continue to be drawn into the sample in exactly the same manner as other beneficiaries residing in the community.

b. Estimation Procedure

To date, sampling weights have been calculated for each annual data release including the Survey File limited data sets (previously referred to as the Access to Care files) and the Cost Supplement limited data sets (previously referred to as the Cost and Use files). In both cases, cross-sectional weights representing the ever-enrolled Medicare population, as well as longitudinal weights representing populations continuously-enrolled for multiple years, have been calculated. Some questionnaire sections fielded in the Winter or Summer rounds have specific cross-sectional weights calculated for them as well. Beginning in 2024, new weights specific to the Fall round of data collection have also been released as part of the Survey File Early Release limited data sets. In all cases, weights reflect differential probabilities of selection and differential nonresponse, and are adjusted to account for overlapping coverage of the panels included in the data files. Replicate weights were also calculated so that users could calculate standard errors using replication methods. In addition to the replicate weights, stratum and unit codes exist on each weight file for users who prefer to use Taylor Series methods to estimate variances. Under the 2026 redesign, all of these weights will continue to be produced, and the analytical utility of the MCBS data will not be reduced. Data users will continue to be able to employ replication methods of variance estimation at the national level, and will be able to produce new state-level estimates using Taylor Series methods.

Besides standard weighting and replicate weighting, another part of the estimation program includes imputation of the data to compensate for item non-response. Imputation procedures for charges for non-covered services and sources of payment for covered services in the Cost Supplement files and Survey File items where appropriate have been developed. Beginning with the 2015 data, unit-level imputation was also instituted to compensate for missing initial-round utilization and cost data[7] for current-year enrollees. The weighting and imputation of data continue each year.

c. Degree of precision needed for the purpose described in the justification

A broad range of statistics are produced from the MCBS. There is no single attribute of beneficiaries and their medical expenses that stands out as the primary goal of the survey. Thus, there has been no simple criterion for the degree of reliability that statistics for each

[6] A new panel is introduced each year; after four years of selecting panels using the redesigned methodology (2026-2029), the MCBS will have fully implemented the redesign. Sample sizes across states are designed to be robust enough for state-level estimation after full implementation.

[7] Events and costs incurred after enrollment in Medicare but prior to the first interview.

analytic domain should satisfy. Even with a larger sample size, there are many small domains of interest for which it would be necessary to use modeling techniques or to wait several years for sufficient data to accumulate.

The 2026 MCBS redesign employs a national, rather than geographically clustered, approach to the selection of the sample. The redesign sample is stratified by state (50 states plus DC) and age domain, though the age strata are reduced to three groups under the redesign (under-65, 65-79, and 80 or older) compared to the seven age groups under the prior design. While the overall national number of completed interviews per year is similar under the new design, state-level precision targets were established. These targets were designed to achieve a maximum coefficient of variation of 7 percentage points on a hypothetical 50 percent top-line state-level estimate. This was done to eventually support state-level estimation after the redesign is fully implemented in 2029, with approximately 280 beneficiaries per state.

Although the number of age group strata are reduced, CMS anticipates maintaining representation of the under-65 disabled population at approximately the same level as was achieved under the prior design. CMS anticipates approximately 17-18 percent of completed interviews to be allocated to the disabled beneficiaries who are not yet 65, resulting in about 2,500-2,550 such beneficiaries in the annual Survey File limited data sets and about 1,400-1,450 beneficiaries under 65 in the annual Cost Supplement limited data sets. This age category was selected because it indirectly reflects the means by which the disabled person becomes eligible for Medicare. Under the 2026 redesign, all beneficiaries under 65 within a state are selected together, minimizing the variability of estimations within this subgroup. For example, depending on the prevalence of the characteristic being estimated, the MCBS has achieved standard errors for estimates of percentages ranging from 2-3% or lower for subgroup estimates based on 1,000 respondents.

Similar to the under-65 age group, the MCBS continues to represent Medicare beneficiaries 65 and older as well, with oversampling to represent the oldest beneficiaries. CMS anticipates that beneficiaries 65-79 years of age will comprise approximately 48-50 percent of completed interviews, resulting in about 6,900-7,000 such beneficiaries in the annual Survey File limited data sets and about 3,900-4,000 beneficiaries aged 65-79 in the annual Cost Supplement limited data sets. Beneficiaries who are 80 years or older are oversampled so that they comprise approximately 33-34 percent of beneficiaries with completed interviews resulting in about 4,750-4,800 such beneficiaries in the annual Survey File limited data sets and about 2,675-2,725 beneficiaries 80 or older in the annual Cost Supplement limited data sets. A major reason for oversampling the oldest beneficiaries is to obtain an adequate sample of nursing home stays. Variations in sampling weights across the age and state strata will inflate sampling errors, but the resulting effective sample sizes should be adequate for most analyses at the national level.

Since many of the cost and reimbursement statistics derived from the MCBS may be heavily right-skewed (i.e., reflecting the higher end of the cost/reimbursement spectrum to a disproportionate degree), the accuracy may be lower in relative terms but still acceptable. For example, the relative standard error of the mean total Medicare reimbursements derived from the MCBS has generally ranged from 2.0-2.5% for the total sample, and 4.0-8.0% for subgroups.

d. Review of interview content for periodic data collection cycles to reduce burden.

1. *Content and timing of instrument sections.*

   The primary variables of interest for the MCBS are the use and cost of health care services and associated sources and amounts of payment. While Medicare claims files

supply information on billed amounts and Medicare payments for covered services, the survey provides important self-reported information on use of services not covered by Medicare and on payment sources and amounts for costs not reimbursed by Medicare. For both the Community and Facility components, the primary focus of the data collection is on use of services (dental, hearing and vision care, hospital, physician, medical providers, prescription medication and other medical services), sources and amounts of payment, and health insurance coverage. The MCBS interview collects continuous information on these items through thrice-yearly interviews; that is, once a new respondent completes their Baseline interview, they are asked utilization and cost questions each round.

Continuous data on utilization and expenditures are required for a number of reasons. First, several of the distinct expenditure categories involve relatively rare medical events (inpatient hospital stays, use of home health care, purchase of durable medical equipment, and so forth), so limiting the reference period would mean insufficient observations for annual estimates. Second, episodes of medical care often consist of a series of services over weeks or months; data collected several times a year allow examination of the grouping of services and costs around particular episodes of care. Third, payment for medical services often occurs considerably later than the utilization, so collection of complete information about a particular event can often only be obtained sometime after the event occurs.

The administration of the instruments will continue to follow the established pattern of data collection. Baseline interviews will be conducted in the initial interview with new Incoming Panel respondents. This will be followed with 10 interviews to collect utilization, cost and other important topics, referred to as Continuing interviews. Since the Baseline interview always occurs in the last five months of a calendar year, collection of utilization and expenditure data in the second interview means the reference period will always begin prior to January 1st. This creates use and expenditure estimates on a calendar year basis.

The literature (initially reported by Neter and Waksberg in 1964[8] and confirmed in subsequent research by other analysts) indicates that collection of behavioral information in an unbounded recall period can result in large recall errors. The Incoming Panel interviews covered in this clearance request - Fall 2027 (Round 109), Fall 2028 (Round 102), and Fall 2029 (Round 115) - prepares the respondent for the collection of utilization and expenditure information in subsequent rounds, thus “bounding” the recall period for the next interview. During the Baseline interview, the respondent is provided with a calendar and interviewers emphasize the importance of this tool for use in future interviews. This calendar marks the recall period for the respondent and serves as the means to record utilization as well as a prompt to retain statements and bills.

2. *Content of the instruments, Rounds 107-115.*

   The majority of the instrument sections as currently approved by OMB are unchanged. Table B.3 presents the core and topical sections that comprise the MCBS Community instrument. As shown in the table, the content and order of administration varies based on season of data collection (Fall, Winter, Summer) and the type of interview (Baseline, Continuing). Those sections with an asterisk (*) include a revision contained in this

[8] Neter J. Waksberg J. A Study of Response Errors in Expenditures Data from Household Interviews. Psychology. Journal of the American Statistical Association. March 1964.

clearance request (either adding or deleting questions). Occasionally an item may be moved from one questionnaire section to another to improve the flow and use of the data, or for other operational or analytic purposes.

Table B.3: Community Instrument Sections and Order of Administration^

Section Listed in the order in which the section is administered.	**Type of Section** Core or Topical)	**Season of Administration** (Rounds Administered)	**Interview Type** (Baseline, Continuing, Both)
Introduction (INQ)	Core	All (Round 107-115)	Both
Enumeration (ENS)*	Core	All (Round 107-115)	Both
Housing Characteristics (HAQ)	Topical	Fall (Rounds 109, 112, 115)	Both
Health Insurance (HIQ)	Core	All (Round 107-115)	Both
Mobility of Beneficiaries (MBQ)	Topical	Fall (Rounds 109, 112, 115)	Both
Preventive Care (PVQ)*	Topical	Fall (Rounds 109, 112, 115)	Both
Health Status and Functioning (HFQ)*	Core	Fall (Rounds 109, 112, 115)	Both
Nicotine and Alcohol Use (NAQ)	Topical	Fall (Rounds 109, 112, 115)	Both
Satisfaction with Care (SCQ)*	Core	Fall (Rounds 109, 112, 115)	Both
Cognitive Measures (CMQ)	Core	Fall (Rounds 109, 112, 115)	Both
Demographics and Income (DIQ)*	Core	Fall (Rounds 109, 112, 115)	Baseline
Immunization (IMQ)*	Topical	Winter (Round 107, 110, 113)	Continuing
Beneficiary Knowledge and Information Needs (KNQ)*	Topical	Winter (Round 107, 110, 113)	Continuing
Care Coordination Questionnaire (CCQ)[9]*	Core	Winter (Round 107, 110, 113)	Continuing
Telemedicine (TLQ)	Topical	Winter (Round 107, 110, 113)	Continuing
Chronic Pain (CPQ)	Topical	Summer (Rounds 108, 111, 114)	Continuing
Income and Assets (IAQ)*	Core	Summer (Rounds 108, 111, 114)	Continuing
Debt (DBQ)	Core	Summer (Rounds 108, 111, 114)	Continuing
Drug Coverage (RXQ)*	Topical	Summer (Rounds 108, 111, 114)	Continuing
Dental, Vision, and Hearing Care Utilization (DVH)	Core	All (Round 107-115)	Continuing
Emergency Room Utilization (ERQ)	Core	All (Round 107-115)	Continuing
Inpatient Utilization (IPQ)	Core	All (Round 107-115)	Continuing
Outpatient Utilization (OPQ)	Core	All (Round 107-115)	Continuing
Institutional Utilization (IUQ)	Core	All (Round 107-115)	Continuing
Home Health Utilization (HHQ)	Core	All (Round 107-115)	Continuing
Medical Provider Utilization (MPQ)	Core	All (Round 107-115)	Continuing
Prescribed Medicine Utilization (PMQ)	Core	All (Round 107-115)	Continuing
Other Medical Expenses (OMQ)	Core	All (Round 107-115)	Continuing
Statement Cost Series (STQ)	Core	All (Round 107-115)	Continuing

[9] Formerly referred to as the Usual Source of Care Questionnaire (USQ).

Section Listed in the order in which the section is administered.	**Type of Section** Core or Topical)	**Season of Administration** (Rounds Administered)	**Interview Type** (Baseline, Continuing, Both)
Post-Statement Cost (PSQ)	Core	All (Round 107-115)	Continuing
No Statement Cost Series (NSQ)	Core	All (Round 107-115)	Continuing
Cost Payment Summary (CPS)	Core	All (Round 107-115)	Continuing
End Section (END)	Core	All (Round 107-115)	Both

^The Access to Care Questionnaire (ACQ) is not included in Table B-3 as it is being removed as of Winter 2027.

The Facility instrument collects information that is similar in content to the Community instrument. Table B.4 presents the core and topical sections that comprise the MCBS Facility instrument. As with the Community instrument, the content and order of administration varies based on season of data collection (Fall, Winter, Summer) and the type of interview (Baseline, Continuing). Those sections with an asterisk (*) include a revision contained in this clearance request (either adding or deleting questions).

Table B.4: Facility Instrument Sections and Order of Administration

Survey Number	**Section**	**Type of Section** (Core or Topical)	**Season of Administration** (Rounds Administered)	**Interview Type** (Baseline, Continuing, Both)
Survey 1	Facility Questionnaire (FQ)	Core	All (Round 107-115)	Both
Survey 1	Residence History (RH)	Core	All (Round 107-115)	Both
Survey 1	Background Questionnaire (BQ)	Core	Fall (Rounds 109, 112, 115)	Baseline
Survey 2	Health Insurance (IN)	Core	Fall (Rounds 109, 112, 115)	Both
Survey 2	Expenditures (EX)	Core	All (Round 107-115)	Continuing
Survey 3	Use of Health Services (US)	Core	All (Round 107-115)	Continuing
Survey 3	Health Status (HS)	Core	Fall (Rounds 109, 112, 115)	Both

The revision to this OMB package includes the following content changes to the Community and Facility instruments.

Summary of instrument changes beginning in Winter 2027 Round 107 through Fall 2029 Round 115:

Deletions and revisions in the Community questionnaire include:

- Removing the Access to Care Questionnaire (ACQ), consisting of 32 items, to reduce respondent burden. Seven ACQ items will be retained and migrated to the revised Care Coordination Questionnaire (CCQ).
- Removing seven items about the cost of vaccines from the Immunization Questionnaire (IMQ) to reduce respondent burden.
- Streamlining the collection of awareness of the right to file an appeal with Medicare in the Beneficiary Knowledge and Information Needs Questionnaire (KNQ) to reduce respondent burden.
- Streamlining the collection of knowledge and use of the Low-Income Subsidy (LIS) and Medicare Savings Program (MSP) in the Income and Assets Questionnaire (IAQ) to reduce respondent burden.
- Revising thirteen items on prescription drug purchasing behavior in the Drug Coverage Questionnaire (RXQ) to align with survey best practices.
- Removing two items about religious affiliation from the Demographics and Income Questionnaire (DIQ) to reduce respondent burden.
- Removing two items about household composition from the Enumeration Summary section (ENS).
- Removing 24 items from the HFQ to reduce respondent burden including 17 detailed follow-up items about diabetes management and 7 items about hypertension, urinary incontinence, and bowel incontinence.
- Streamlining the collection of healthcare screening information in the Preventive Care Questionnaire (PVQ) to reduce respondent burden and align with healthcare screening guidelines.
- Removing four items about satisfaction with health care services from the Satisfaction with Care Questionnaire (SCQ) to reduce respondent burden.

Deletions and revisions in the Facility instrument include:

- Removing one facility contact item from the Facility Questionnaire (FQ) section.
- Removing three items that collect facility structure and facility contact details from the Residence History (RH) section.
- Removing sixty verification items that appear when a billing, insurance, or payment discrepancy is identified from the Expenditures (EX) section.
- Removing seventeen items that collect information on general health status, vision, Medicare eligibility, procedures, preventive screenings, and record identification from the Health Status (HS) section.
- Revising the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) series to align with the flow used in the Community questionnaire.

Additions to the Community questionnaire include:

- Modernizing the Care Coordination Questionnaire (CCQ), formerly referred to as the Usual Source of Care Questionnaire (USQ) to include 15 new items about wait time for appointments, coordination of health care information and services, urgent care clinic visits; 15 new items about trust in health care providers, and 31 new items on pre-authorization of health care services, which are administered conditionally to a subset of respondents.
- Adding five new items about prescription drug discount programs in the Drug Coverage Questionnaire (RXQ). Adding one new item about hypertension management and three new items about nutrition in the Health Status and Functioning Questionnaire (HFQ).

Burden neutral operational changes include:

- Implementing a multimode Facility data collection design, including a phone administered Facility screener followed by three survey sections that may be self-administered via web or interviewer-administered via phone.
- Adding four new items to the suite of existing Facility respondent materials.
- Updating Community respondent materials.

Removing the Access to Care Questionnaire. In accordance with OMB's terms of clearance to reduce respondent burden and ensure analytic efficiency, CMS is deleting the Access to Care Questionnaire (ACQ). A total of 32 items from the ACQ will be removed starting in Winter 2027. Seven items from the ACQ will be incorporated into the newly established Coordination of Care Questionnaire (CCQ). These prior ACQ items cover topics that continue to be of relevance to CMS, including emergency department visit wait times and difficulty with obtaining referrals to specialists.

Removing items from the Immunization Questionnaire (IMQ). In Winter 2025, immunization collection was expanded to include information about the cost of shingles, pneumonia, respiratory syncytial virus (RSV), and flu vaccines. To reduce respondent burden, seven immunization items from the IMQ related to the cost of vaccines will be removed starting in Winter 2027.

Streamlining the collection of Medicare program information in the Beneficiary Knowledge and Information Needs Questionnaire (KNQ). In Winter 2023, one item about beneficiaries' knowledge about their right to file a complaint or appeal under the Medicare program was added to KNQ. Starting in Winter 2027, the administration schedule of this item will be updated such that it is administered only once per panel, as opposed to annually.

Streamlining the collection of Federal assistance program knowledge and awareness from the Income and Assets Questionnaire (IAQ). In Summer 2025, the redesigned IAQ included a new series about Federal assistance program participation and awareness. Beneficiaries were first asked two items about awareness of the Low-Income Subsidy (LIS) and Medicare Savings Program (MSP) programs; those who responded affirmatively were asked if they participated in the respective program(s). Starting in Summer 2027, this series will be streamlined such that use of the LIS and MSP programs will be administered annually to all beneficiaries but awareness questions about LIS and MSP will only be asked once per panel, instead of annually.

Revising thirteen items on prescription drug purchasing behavior in the Drug Coverage Questionnaire (RXQ). In Summer 2027, the reference period for twelve items on the frequency of certain prescription drug purchasing behaviors will be changed from the current year to the

past twelve months. The code frame for these items will also be revised from a 3-point scale to a 5-point scale to reflect questionnaire design best practices.[10]

Removing two items about religious affiliation from the Demographics and Income Questionnaire (DIQ). CMS introduced two items on religious affiliation in Fall 2023 to expand socio-demographic information collected by the MCBS. In Fall 2027, the items capturing religious affiliation will be removed to reduce respondent burden.

Removing two operational items about household members from the Enumeration Summary (ENS) section. The ENS section currently captures operational information about household members, including age and employment status, to inform routing logic and text fills for downstream questionnaire sections. To reduce respondent burden, follow-up items on why individuals no longer live in the beneficiary's household will be removed from the ENS.

Streamlining the Health Status and Functioning Questionnaire (HFQ). The HFQ is administered annually during the Fall round Baseline and Continuing interviews and collects important information on the beneficiaries' general health status, health conditions, ability to perform various physical activities, Instrumental Activities of Daily Living, Activities of Daily Living, and mental health. During a review of this section, CMS identified several items to remove or revise to reduce redundancy and improve the policy relevance of the section. The following changes will be made to the Community questionnaire in Fall 2027:

- ***Removing 17, revising two, and migrating one detailed follow-up items about diabetes management.*** The HFQ includes important information about beneficiaries with diabetes, including diabetes type, insulin use, related comorbidities like foot conditions, and diabetes management. To reduce respondent burden, the following changes will be made in Fall 2027:
    - Removing one redundant item on gestational diabetes.
    - Removing five items on oral diabetes medication. The use of any prescribed oral diabetes medications is already collected in the Prescribed Medicine Utilization Questionnaire (PMQ). As the PMQ captures details such as medication dosage and frequency of use, additional items asking about oral diabetes medication are not needed in the HFQ. Given the redundancy of these items, they will be removed from the questionnaire.
    - Revising one and removing five items on checking for sores or irritation on the feet. Rather than asking if the beneficiary ever checks for sores, the question text will be revised to ask if the beneficiary checks for sores *every day*. With this revision, the follow up items on the frequency of checks will be removed.
    - Migrating one item on measuring blood pressure. All respondents will now be asked about measuring blood pressure at home in the Preventive Care Questionnaire (PVQ), regardless of whether they have diabetes or other health conditions.
    - Removing one item on taking aspirin for diabetes. In 1997, the American Diabetes Association issued guidance that recommended daily low-dose aspirin for diabetic patients, who commonly also experience atherosclerotic cardiovascular disease

[10] https://onlinelibrary.wiley.com/doi/book/10.1002/9781394260645

(ASCVD).[11] Following 2019 guideline changes related to aspirin use among those with ASCVD[12], the use of aspirin has decreased, thereby making this item less relevant.[13]

  - Removing one item on how the beneficiary treated their most serious episode of hypoglycemia due to low response variability.
  - Removing one item on when the beneficiary attended a diabetes self-management course. As such courses are typically completed once and there are no guidelines for being up to date, this item is not analytically useful.
  - Removing three and revising one item on blood tests to diagnose diabetes. Rather than administering items with different reference periods to Baseline and Continuing respondents, the HFQ will ask all respondents who did not report a diabetes diagnosis whether they received a blood test to assess their diabetes risk in the past twelve months. The follow-up item about knowledge of these tests will also be removed.

- ***Removing two and revising one item on urinary incontinence.*** Two items on urinary incontinence management will be removed to reduce respondent burden. One item will be revised to ask whether the respondent has been treated with medicine or surgery, rather than whether they have discussed these treatments with a healthcare professional.

- ***Removing four and revising two items on bowel incontinence.*** Four items were added to the HFQ in the Fall 2024 questionnaire to capture the prevalence and type of bowel incontinence, including leaking gas, leaking a small amount of stool, leaking a moderate amount of stool, and leaking a large amount of liquid stool. Beginning in Fall 2027, beneficiaries will only be asked how often they have leaked stool that required a change of underwear. This change will allow CMS to continue measuring prevalence of bowel incontinence while reducing respondent burden. In addition, one item about bowel incontinence management will be added to align with the revised urinary incontinence series, such that the information provided by the urinary and bowel incontinence series will be standardized.

- ***Removing one, revising one, and migrating one item on hypertension management.*** To reduce redundancy and streamline the HFQ, the item asking whether the respondent was told they had high blood pressure on two or more medical visits will be removed. As a result of this removal, introductory text for the hypertension series will be moved to the new first item in the series. Finally, the item about measuring blood pressure at home will be migrated to PVQ and asked of all respondents, regardless of whether they have diabetes or other health conditions.

Streamlining the collection of health care screening information in the Preventive Care Questionnaire (PVQ). The PVQ is administered annually during the Fall round Baseline and Continuing interviews and collects information about preventive health care measures taken by the beneficiary, including blood pressure and cholesterol checks, HIV testing, and guideline-recommended screenings, such as prostate blood tests for men. Through a recent review of the PVQ, CMS identified several items that are redundant, no longer relevant, or need to be updated to align with current healthcare screening guidelines. Starting in Fall 2027, the following changes will be made to the Community questionnaire:

[11] https://diabetesjournals.org/care/article-pdf/20/11/1772/583603/20-11-1772.pdf

[12] https://www-ahajournals-org.proxy.uchicago.edu/doi/10.1161/cir.0000000000000678

[13] https://pubmed.ncbi.nlm.nih.gov/40243986/

- ***Migrating one item on measuring blood pressure at home from the HFQ to the PVQ.*** Currently, the HFQ asks only beneficiaries with diabetes or hypertension about home blood pressure monitoring. To streamline the questionnaire, these items will be removed from HFQ, and beginning in Fall 2027, all respondents will be asked about this topic in the PVQ.

- ***Removing two items on oral cancer exams.*** The National Institute of Dental and Craniofacial Research recommends incorporating head and neck examinations for oral cancer as part of routine dental check-ups, which are recommended every six months[14]. The current PVQ asks Baseline respondents whether the beneficiary has ever received an oral cancer exam, and if yes, how long ago it occurred. Continuing respondents are asked whether they have received an exam in the past year. To align with clinical guidance, the Baseline-only items will be removed, and all respondents will be asked if they had an oral cancer exam in the past year.

- ***Removing three and revising two items about why the beneficiary did not receive a preventive test or screening.*** For certain screening tests, including HIV and pap smears, the PVQ currently asks respondents who report not receiving a recent test or screening the reason why they have not been tested or screened. To reduce respondent burden, starting in Fall 2027, the PVQ will no longer ask respondents why they have not been tested for HIV or received a pap smear. This will include the removal of one "other, specify" item. CMS will also streamline the code list at the two items capturing why the beneficiary has not received a mammogram or prostate blood test. Beginning in Fall 2027, redundant response options or response options with low usage will be removed and new response options will be added.

- ***Revising one item on pap smears.*** Gynecological exams may include a pap smear to screen for cervical cancer. The item about receiving a pap smear will be revised to ask about gynecological exams to more accurately reflect clinical guidelines.[15]

Removing four redundant items about satisfaction with health care services from the Satisfaction with Care Questionnaire (SCQ). The SCQ is an important topical section in the Community questionnaire which provides CMS and other stakeholders with information about the respondent's opinion about the health care that the Medicare beneficiary has received. Through a recent review of the SCQ, CMS identified several items that are redundant. Starting in Fall 2027 the Community questionnaire will remove the following SCQ questions:

- One question on the availability of health care at night and on weekends.

- One question on SCQ was redundant with CCQ. A question on the ease and convenience of getting to a doctor or other health professional from where the beneficiary lives will be removed from SCQ because distance to the beneficiary's usual source of care is captured in the CCQ.

- One question about the concern of doctors or other health professionals for the beneficiary's overall health rather than just for an isolated symptom or disease.

- One question on the ability to get all health care needs taken care of at the same location.

Revisions and removals of existing Facility instrument content.

[14] Detecting Oral Cancer: A Guide for Health Care Professionals

[15] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/the-utility-of-and-indications-for-routine-pelvic-examination

- **Removing one facility contact item from the Facility Questionnaire (FQ) in Survey 1.** With the migration of items from the Facility Screener into the FQ, one redundant item that confirms facility contact information will be removed.

- **Removing items from the Residence History (RH) section in Survey 1.** Three items that collect facility structure details and the relationship of the facility contact to the beneficiary will be removed, as the information is no longer needed for survey operations.

- **Removing discrepant confirmation items from the Expenditures (EX) section in Survey 2.** Sixty items that appear when a billing, insurance, or payment discrepancy is identified will be removed. These items prompt interviewers to verify the discrepancy and, if needed, back up to correct previously entered information. These items are rarely administered and have limited analytic utility.

- **Removing items from the Health Status (HS) section in Survey 3.** Seventeen items that collect information on general health status, vision, Medicare eligibility, procedures, preventive screenings, and record identification will be removed due to their low response variation, and thus, limited analytic utility.

- **Revising the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) series in Survey 3.** The ADL and IADL items in the Facility instrument were modified to align with the same series used in the Community questionnaire. This change was made to improve consistency across the MCBS instruments and improve the utility of Facility functional status data. This alignment involves the removal of 13 existing items that were no longer consistent with the parallel Community questionnaire and the revision of six existing Facility instrument items.

Adding new items about care coordination, trust in health care providers, and pre-authorization of health care services to the Care Coordination Questionnaire (CCQ). Formerly referred to as the Usual Source of Care Questionnaire (USQ), this questionnaire section is administered annually in the Winter round and collects information on whether the beneficiary has a provider or clinic they usually go to when sick or in search of health advice. Previously, the USQ focused narrowly on beneficiaries' experiences with their usual source of care. However, Medicare beneficiaries may receive care across multiple settings and provider types, including specialists, urgent care centers, retail clinics, and telehealth providers. The revised questionnaire section, renamed the Care Coordination Questionnaire (CCQ), expands measurement to capture the full range of care sources and coordination across them. This revision enables more accurate assessment of care fragmentation, access pathways, and beneficiary navigation of the health care system. Starting in Winter 2027, CMS seeks approval to add the following new items to the CCQ to improve the policy relevance of MCBS data for evaluating delivery system reforms and initiatives aimed at strengthening care coordination and integration:

- ***Fifteen new items about care coordination***, including: wait times for different types of provider visits, coordination of health care information and services for emergency department visits and hospital stays, and experiences with urgent care clinic visits. Items asking about reasons for a visit to an emergency room or urgent care clinic were adapted from CMS's Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS)[16]; other items in this category were adapted from existing MCBS content.

[16] https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/emergency-department-cahps

- ***Seven items about emergency department visit wait times and difficulty with obtaining referrals to specialists*** were migrated from the Access to Care Questionnaire (ACQ).

- ***Fifteen new items about trust in health care providers***. Patient trust in healthcare providers and Medicare directly impacts patient engagement, treatment adherence, and health outcomes —all critical metrics for the administration's patient-centered reform agenda. Items measuring beneficiary trust in their primary care provider, the healthcare profession, and the Medicare program were adapted from three abbreviated five-item scales developed during a study supported by the Robert Wood Johnson Foundation and the University of Massachusetts Medical School Division of Geriatric Medicine[17]. These items were fielded in the Fall 2025 MCBS Beneficiary Trust Pulse Supplement under CMS's Generic Clearance (0938-1275, GenIC #8) where they were easily understood, had low levels of non-response and across beneficiaries, and showed expected variation in response frequency distribution. Incorporating these items into the main survey will enable CMS to produce nationally representative and state-level estimates of trust in health care providers and to monitor changes over time. Collecting these measures within MCBS allows CMS to examine how trust varies by demographic, socioeconomic, and coverage characteristics and how it relates to beneficiary experiences, health care utilization, adherence to medical recommendations, and preventive service uptake captured elsewhere in the survey.

- ***Thirty-one new items about pre-authorization of health care services***. Administrative data do not capture beneficiary awareness, delays in care, service abandonment, or perceived access barriers resulting from the prior authorization process. As prior authorization policies continue to evolve across Medicare coverage types, beneficiary-reported data are necessary to understand how these requirements affect access to care and utilization. Under CMS's Generic Clearance (0938-1275, GenIC #8), OEDA partnered with the Center for Medicare & Medicaid Innovation as well as the Center for Medicare to administer questions about beneficiary experience with the prior authorization process as part of the Fall 2025 MCBS Beneficiary Trust Supplement. These items cover pre-authorization of services such as prescription drugs, visits to health care providers, and specific treatments or procedures. Incorporating these items into the main MCBS Community questionnaire will enable analysis of the relationship between prior authorization experiences, detailed coverage characteristics (e.g., Medicare Advantage, supplemental coverage), and subsequent health care utilization captured in MCBS. These data will support evaluation of access associated with prior authorization policies.

  These 31 items will not be asked of all respondents. Results from the MCBS Beneficiary Trust Pulse Supplement (0938-1275, GenIC #8) indicate that just over half of respondents were ineligible for this series as they had not had experience with pre-authorization of services during the reference period. Respondents will receive follow-up questions for each type of treatment or service they indicated requiring prior authorization. Prior authorization was most often required for a prescription drug from a pharmacy and/or a treatment, procedure, or surgery, with respondents receiving approximately eight follow-up items on average.

Adding five new items about prescription drug discount programs in the Drug Coverage Questionnaire (RXQ). The RXQ collects information regarding the beneficiary's experiences with and knowledge of their current prescription drug coverage, including coverage through stand-alone Medicare Prescription Drug plans, Medicare Advantage plans, and private plans.

[17] https://pmc.ncbi.nlm.nih.gov/articles/PMC1262715/

However, Medicare beneficiaries may also obtain prescription medications through mechanisms outside of insurance benefits, including prescription discount card programs, manufacturer-sponsored assistance programs, or other alternative purchasing arrangements. These programs have risen in popularity, with a 2026 survey of adults using prescription drugs reporting that 42% had used a discount card or coupon to reduce the cost of a prescription drug in the past 12 months.[18] Such transactions are not consistently reflected in administrative claims data, which limits CMS's ability to fully measure total out-of-pocket spending, medication acquisition pathways, and the relationship between cost burden and adherence.

As CMS continues to evaluate policies intended to improve prescription drug affordability and access, comprehensive data on how beneficiaries obtain and pay for medications are necessary to ensure accurate estimates of spending, subsidy interactions, and program participation. New items on the knowledge and use of prescription drug discount programs will provide estimates of program participation among the Medicare population. They will also provide insight into the types of bias present in current measures of out-of-pocket spending, financial burden, and access to medications among Medicare beneficiaries.

The existing RXQ section asks generally whether beneficiaries have purchased discounted prescription drugs without using any insurance. This item will be revised to serve as a universe filter for the five new items on prescription drug programs. Based on their response to this item, respondents will be asked up to five follow-up items about their knowledge and use of programs, including:

- ***One item on prescription discount services.*** This item will measure frequency of use of services that provide coupons or prescription savings cards that can be used while filling a prescription. Examples of such services include GoodRx, RxSaver, and WellRx. GoodRx alone reports that its platform is used by nearly 25 million consumers annually.[19]

- ***One item on manufacturer discount cards.*** This item will measure frequency of use of coupons or copay cards provided directly by a drug manufacturer to the consumer.

- ***Three items on TrumpRx.*** Launched in February 2026, TrumpRx is a federal government-run website that lists discounted drug prices for individuals to buy without using drug insurance. These drugs can be obtained at participating pharmacies using coupon cards displayed on TrumpRx or directly through manufacturers' websites. Respondents will first be asked if they have ever heard of TrumpRx. This item is modeled after the Make America Healthy Again knowledge items fielded in the Fall 2025 MCBS Beneficiary Trust Pulse Supplement (0938-1275, GenIC #8). Those who report they have heard about the program will be asked if they have visited or accessed the official website for TrumpRx. Finally, respondents who report visiting the TrumpRx website will be asked if they have used it to fill a prescription. Understanding the extent to which Medicare enrollees are aware of and using TrumpRx will provide the federal government with valuable data on whether additional outreach should occur and if these efforts can be specialized for different segments of the Medicare populations. Certain demographic groups may be less aware of the various provisions and may benefit from tailored outreach and education efforts.

Adding one new item about hypertension management in the Health Status and Functioning Questionnaire (HFQ). The HFQ collects information on the prevalence of chronic

[18] https://www.kff.org/public-opinion/public-views-on-prescription-drug-costs-regulation-affordability-and-trumprx/

[19] https://investors.goodrx.com/news-releases/news-release-details/goodrx-reports-fourth-quarter-and-full-year-2025-results

conditions to provide a comprehensive view of Medicare beneficiary health status. Hypertension is a chronic condition of particular policy interest given the high prevalence among Medicare beneficiaries and impact on Medicare spending. In 2021, the life-time prevalence of hypertension was approximately 64 percent among Medicare beneficiaries with traditional Medicare. [20] Hypertension puts individuals at risk of heart disease, which is a leading cause of mortality among older adults.[21] Medications to treat hypertension are also among the most frequently prescribed in Medicare.[22]

To supplement existing items on the prevalence of hypertension, one item will be added to assess whether the beneficiary's hypertension is "well controlled." The definition for "well controlled" will align with clinical guidelines.[23] Later in the hypertension series, respondents are asked an existing item about how confident they are in their ability to follow recommendations to control blood pressure. With the addition of the new hypertension control item, the universe for this existing confidence item will be adjusted so that respondents who report having well-controlled blood pressure all the time will now skip this item.

The MCBS does not currently produce estimates for the prevalence of controlled and uncontrolled hypertension among Medicare beneficiaries in different health status groups (e.g., uncontrolled hypertension among beneficiaries who have diabetes or who have a particular body mass index). Collecting up-to-date information within the MCBS will allow CMS to generate group-level estimates aligned with current clinical standards, thereby improving modeling of coverage impacts, beneficiary eligibility, and federal spending projections. This information will also enhance the precision of the number of diagnosed chronic conditions measure, which serves as a critical health status indicator used by the Office of the Actuary, the Center for Medicare and Medicaid Innovation (CMMI), and the Congressional Budget Office (CBO) for policy analysis, coverage analysis, and budget projections.

Adding three new items about Nutrition to the HFQ. CMS will add a three-item series on nutrition to the MCBS to better understand how nutrition influences health trajectories among older adults and people with disabilities. Two items related to intake of fruit and vegetables will be added, along with one item which asks if a health care professional has talked with the beneficiary about healthy eating. All three items were previously fielded to MCBS respondents as part of the Patient-Reported Indicator Survey (PaRIS)[24], where they were easily understood.

Burden-neutral operational changes include the addition of a web-based mode for the Facility instrument and updates to respondent materials for the Facility and Community instruments.

- **Adding a web-based survey mode for the Facility Instrument and related revisions to the Facility Screener**. The Facility screener, which screens for MCBS facility eligibility, will continue to be completed as an interviewer-administered phone survey for new facilities and will include items formerly administered as part of the Facility Questionnaire (FQ). In order to facilitate self-administration of the web survey, existing content has been migrated into three survey sections: Survey 1, Survey 2, and Survey 3. For both interviewer-

[20] https://www.cms.gov/files/document/data-snapshot-hypertension-jan-2023.pdf

[21] https://www.cdc.gov/nchs/fastats/older-american-health.htm

[22] https://aspe.hhs.gov/sites/default/files/documents/920ec8349c53a362b27e3b10669dafd4/generic-drug-landscape-ib.pdf

[23] https://www-ahajournals-org.proxy.uchicago.edu/doi/10.1161/CIR.0000000000001356

[24] OMB Control Number 0938-1434

administered or self-administered interviews, the Facility instrument will now consist of three sections:

  - **Survey 1** contains content migrated from the Facility Questionnaire (FQ), Residence History (RH), and Background Questionnaire (BQ) and asks about Facility contact information and Facility information such as the CMS Certification Number (CCN) and certification and licensing status, residence history for the beneficiary, and beneficiary sociodemographic information.
  - **Survey 2** contains content migrated from the Health Insurance (IN) and Expenditures (EX) sections and asks about beneficiary health insurance and expenditures.
  - **Survey 3** contains content migrated from the Health Status (HS) and Use of Health Services (US) sections and asks about beneficiary health status and use of health services.

- **Adding new Facility materials.** In preparation for the implementation of the facility web survey mode, CMS has also developed an initial change letter, which explains the option to complete web interviews for existing continuing facility cases, a screener advance letter, which is sent to facilities ahead of the screening call to explain the process, survey-specific invitation letters for each section of the web survey – including a separate letter designed for billing office staff – and reminder letters/postcards, to be sent as needed to non-responders

- **Updating Community materials.** The Community brochure has been updated to modernize and streamline language and update statistics and publications. In response to the inclusion of video enhanced telephone interviewing, CMS is adding a new material designed to serve as a gaining cooperation tool for continuing respondents to provide information on the video interviewing process. Mentions of the video interviewing option were added to the Community Advance Letters. All materials with the MCBS logo were updated to reflect the new MCBS logo.

Rounds 107 through 115 Data Collection Procedures

The MCBS Community questionnaire is conducted primarily by telephone with supplemental in-person outreach and the use of video calls. Below we describe the data collection outreach process and related materials (found in Attachment 1). Outreach strategies and materials vary based on sample type: Incoming Panel sample requires more dedicated outreach to introduce beneficiaries to the survey and gain initial cooperation. Outreach for subsequent Continuing interviews serves to remind beneficiaries of the importance of continued participation.

Outreach to Incoming Panel sample persons in the community. In the Fall rounds (Round 109, 112, 115), all newly selected beneficiaries will be mailed a **Community Advance Letter** from the CMS. This letter serves to provide notification to the beneficiary that an interviewer will contact them to request an interview. It also includes a copy of the **MCBS Community Brochure**. The letter is printed in both English and Spanish for all beneficiaries and a Language Insert is included to provide an explanation of the survey for respondents who do not speak English or Spanish. Following this letter, outreach is made by telephone to locate the beneficiary and begin the interview.

Refusal and Reminder Letters are sent as needed based on case disposition and call history. These materials may also contain the MCBS Community Brochure and answers to frequently asked questions. **Thank You Letters** acknowledging participation and an **Annual Respondent Newsletter** provide additional ways to build rapport and gain cooperation with beneficiaries and

further improve response rates. Finally, an **MCBS Calendar** is available to respondents who would like to use it to track health care events and purchases. The calendar may be provided during an in-person interview or by mail.

Field interviewers also receive printed copies of the respondent materials described above which can be shown or mailed to respondents who do not recall receiving them in the mail. For limited in-person outreach, interviewers also have a **Frequently Asked Questions document** which contains answers to frequently asked questions and can be read to or by the respondent.

Regardless of mode of administration, Community interviews (Rounds 107-115) will be administered to the respondent or a designated proxy using a CAPI program on a laptop computer. Attachment 2 includes a copy of all questionnaire sections administered in the Baseline interview, the Continuing interview, and the Showcards used by the interviewer to assist in the interviewing process[25].

Interviews with sample persons in institutions. For all facility residents, the Facility Eligibility Screener is administered by phone each time a respondent is found to have entered a facility, or in the case of Baseline respondents, is currently in a facility (Attachment 3). The Facility instrument to be used in Rounds 107-115 is shown in Attachment 4.

An advance letter is sent to all facilities prior to an interviewer contacting the facility for an interview (Attachment 5). CMS has also developed additional materials to gain cooperation including providing information on how to prepare for the interview, introducing the study to staff at third-party billing offices who may provide additional survey responses, and thanking the facility staff for participation. With the introduction of web surveys, CMS has also developed an initial change letter, which explains the option to complete web interviews for existing continuing facility cases, a screener advance letter, which is sent to facilities ahead of the screening call to explain the process, survey-specific invitation letters for each section of the web survey – including a separate letter designed for billing office staff – and reminder letters/postcards, to be sent as needed to non-responders (Attachment 5).

Some facility administrators will require consent of the sample person or a next of kin before releasing any information. The data collection contractor will offer to obtain such written consent, using the Resident Consent Form, and Next of Kin Consent Form. These forms as well as a HIPAA letter are included in Attachment 5.

e. Proxy rules.

For Community respondents, the preferred mode is self-response. Respondents are asked to designate proxy respondents. These are individuals who are knowledgeable about the respondent's health care. In the MCBS, only those individuals who are designated by the respondents can serve as proxy respondents. In addition, a proxy is utilized if a beneficiary had been reported as deceased during the current round's reference period or if a beneficiary who was residing in the community in the previous round had since entered into a long-term care facility. Proxy interviews are only used for the Community interview, as the Facility interview is conducted with a staff member located at the facility.

Upon screening a facility where a sampled beneficiary is determined to be living, the interviewers identify the appropriate staff at the facility best able to respond. MCBS interviewers do not interview residents in a facility. Instead, interviewers are trained to

[25] Showcards are available to respondents to download in order to follow along during phone interviews.

determine and seek out the appropriate staff for the interview. If a respondent is incarcerated, no interview is conducted.

B3. Methods for Maximizing Response Rates and Dealing with Issues of Non-Response

The sample for the MCBS is a heterogeneous population that presents a unique challenge for maximizing response rates. The survey selects respondents from two Medicare groups – those age 65 and over and those younger than 65 who have disabilities. Advancing age, poor health or poor health of a family member are common reasons for refusal. On the other hand, older persons are the least mobile segment of the population and thus, for a longitudinal survey, there is generally a low instance of failing to locate respondents.

Because this is a longitudinal survey, maximizing response rates is essential. When beneficiaries are selected from the enrollment database, name and address are available, but telephone numbers are not. Prefield locating activities (including electronic database searches using LexisNexis® Accurint®, Verisk Marketing Solutions®, and TransUnion® TLOxp batch processing) are used to verify or update selected sample addresses and to obtain telephone numbers when available.

Data collection staff may use additional outreach strategies and resources to establish legitimacy and encourage cooperation. A **Community Authority Letter** (Attachment 1) provides a summary of the survey to national organizations such as AARP and can be shared with regional or local groups (social service and health departments, area agencies on aging, and others) if interviewers or managers receive questions about the legitimacy or purpose of the survey. General information about the MCBS is also made available to senior centers and other networks to which respondents are likely to belong or reach out (such as the 1-800-Medicare hotline).

Additional mailings, including reminder letters or refusal conversion letters, are sent to respondents via regular or priority mail (FedEx or similar) to encourage their participation in the survey. Further, additional locating and tracing efforts may be used during data collection to maximize response and in some cases, interviewers may supplement phone interviews with video capability to build rapport and encourage longer term participation.

In addition to outreach, the following efforts remain in place to maintain a sense of validity and relevance among the survey participants.

a. Interviewer training emphasizes effective approaches for communicating with older adults and people with disabilities and ways to overcome difficulties respondents may have in participating.
b. Experienced NORC field management staff conduct specialized follow up with respondents who express concerns about participating due to privacy or confidentiality questions.
c. A dedicated project email address (mcbs@norc.org) and toll-free number (1-844-777-2151) are available to answer respondent's questions. This information is listed on various materials provided to the respondent.
d. A project website (mcbs.norc.org) contains information for respondents on the project and has recently been updated to include a short explanatory video. Respondents are also informed about the CMS MCBS Project Page – www.cms.gov/mcbs.
e. Respondents receive an annual MCBS newsletter, which includes information about the survey as well as seasonal topics such as winter safety tips for seniors. Attachment 1 contains an example of a recent newsletter.

f. Whenever possible, the respondent is paired with the same interviewer throughout the survey. This maintains rapport and establishes continuity of process in the interview, whether conducted by phone or in-person.
g. Interviewers are encouraged to use personal touches such as thank you notes and birthday cards to maintain contact with respondents.

CMS intensively monitors both unconditional and conditional response rates. The unconditional response rate is the percentage of sample that was released during the fall round of the selection year and responded to the survey in a given year. The unconditional response rates, also called cumulative response rates, use the original selected sample size as the baseline in their calculation. Conditional response rates are the percentages of sample that were *eligible* at the beginning of the Fall round of a particular year and responded during that year. Conditional response rates use the sample who are eligible to participate in the survey (a subset of the sample released in the Fall round of the selection year) as the baseline in their calculation. In other words, they are conditioned on eligibility. Both indicators are very important for understanding trends about response rates and where interventions should optimally be targeted. These trends are monitored over the full historical span of the survey, providing important insights in changes to response rates over time.

Response is tracked throughout each round by a host of key indicators including panel, HHS region, residential status (community or facility), current year Medicare enrollees or not-current year enrollees and demographic variables. In addition, performance by field interviewers is also tracked to identify any staff who need additional training or support to improve their interview completion rates. CMS continually analyzes response rates and uses an adaptive design approach to target additional outreach efforts where needed.

Over the rounds, the following patterns of nonresponse have been observed, which have or have not changed over time. In the most recent three rounds for which a full analysis of response rates have been completed, the round-level response rates for continuing panels remain high, ranging from 78.3% for the 2020 panel in Round 89 to 95.7% for the 2017 panel in Round 89. Despite these high rates, each year continuing panels are subjected to a nonresponse adjustment based on new response propensity models by panel. Incoming Panels at the first interview (e.g., the 2021 panel at Round 91) show a larger propensity for nonresponse due to having never been reached prior to the first interview. In Round 91 the response rate for the 2021 Incoming Panel was 38.1%. Once again, CMS relies on cells derived from response propensity models to account for differential effects of demographic and geographic characteristics on the resulting data. By accounting for these characteristics in constructing the adjustment cells, we reduce the potential for nonresponse bias that could arise due to these differential factors.

Adaptive design methods have also been applied to measure the representativeness of the MCBS incoming sample. In 2017, CMS conducted a review of the Representativity Indicators (R-indicators) or metrics for the Fall 2017 Baseline interview to monitor the representativeness of the achieved sample. The R-indicators provided a quantitative assessment of which segments of the sample were over/under producing and causing the achieved sample to be imbalanced in terms of sample representativeness.

A sample R-indictor as well as two partial R-indicators (variable and category) are used to monitor representativeness of the panel. The variable R-indicator measures the representativeness of the sample associated with each variable (looking at the strength of each co-variate subpopulation such as race, ethnicity, age, sex, region) to predict response propensity.

The category R-indicator then looks at the categories of each variable to measure representativeness of the responding sample.

Since their inception, R-indicators have not been observed outside these thresholds; consequently, no data collection interventions were needed to improve the representativeness of the achieved sample. Use of R-indicators, along with a continual review of annual and historical response rates and non-response bias analysis are important tools in understanding response and ensuring that the sample as a whole, as well as subpopulations, are represented to produce high quality data.

The most recent non-response bias analysis for the MCBS was conducted based on the 2021 Panel and was released in the final 2021 Methodology Report[26]. This analysis also included beneficiaries who participated in COVID-19 surveys. While non-response is carefully monitored every year, a complete non-response bias analysis is updated every three years to ascertain trends both annually and for subpopulations. The next non-response bias analysis for the MCBS will be conducted based on the 2024 Panel and released with the forthcoming 2024 documentation.

In the most recent non-response bias analysis, Fall 2021 respondents and non-respondents were compared on various measures, including frame characteristics, Medicare claims payments, and chronic conditions, in order to identify areas of potential bias. The effects of weighting on potential nonresponse bias were also investigated: unweighted and weighted proportions of respondents across select frame-level attributes were compared to corresponding benchmarks. Small but statistically significant differences were found across many of these measures. Among the demographic characteristics, Incoming Panel nonrespondents appeared more likely to be female and younger, but the differences were not large. Continuing Panel nonrespondents generally tended to skew older than the respondents and were more likely to be Hispanic. In all panels, there were proportionately more respondents than nonrespondents located in the Northeast. Some of these demographic differences, such as imbalances among the youngest age group of respondents, are related to lower phone match rates which make it more difficult to conduct interviews by phone. Significant differences were also found across various claims payment measures but were minimal and not consistently in the same direction (i.e., sometimes respondents had higher claims payments in certain settings, and other times non-respondents did). The same was true for beneficiaries with chronic conditions: Incoming Panel respondents in the Fall round were more likely to have a few of the chronic conditions than nonrespondents, but in later rounds and for the continuing panels, nonrespondents were more likely to have some of the chronic conditions than were respondents. While many differences were found, most were not large in a practical sense. Furthermore, across most of these measures, weighted respondent distributions were closer to benchmarks than unweighted respondent distributions, suggesting that the potential bias identified via these analyses is expected to be minimized by the weighting procedures.

In contrast to most surveys, the MCBS has a large amount of information to characterize nonrespondents. This information, including Medicare claims data, can be used for imputation if necessary. While the nonresponse bias analysis excluded Medicare Advantage (MA) enrollees from many analyses, it has been noted in recent years that MA beneficiaries are more likely to respond to the MCBS than beneficiaries enrolled in original Medicare. Beginning in 2017, CMS introduced additional nonresponse adjustments and calibration of the MCBS weights to match enrollment benchmarks by Fee-for-Service (FFS)/MA status, to reduce or eliminate any potential bias the differential response rates by enrollment status may have introduced.

[26] https://www.cms.gov/files/document/2021-mcbs-methodology-report.pdf

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NORC interviewers conduct phone interviewing, supplemented by in-person outreach where feasible within the budget constraints. Phone interviews may be enhanced with video calling when respondents are interested and can access this technology. To supplement Facility phone interviews, CMS has added a self-administered web survey. A small proportion of interviews will continue to be conducted in person, based on location. Results of several in-depth analyses along with feedback from field staff have shown that phone data collection works well for a majority of interviews, maintaining stability in representativeness and data quality. The phone mode also offers a cost-effective option for both contacting and interviewing. Limited in-person interviews are generally used for locating respondents where phone outreach has failed, non-response follow-up, and to administer the interview to beneficiaries with high levels of utilization or difficulty using the phone. With the introduction of the self-administered web surveys for Facility interviews, CMS will evaluate the effectiveness of web surveys and adjust the mix of interview modes as needed to balance cost effectiveness and data quality.

B4. Tests of Procedures or Methods

The MCBS has two generic clearances. The generic clearance for Questionnaire Testing and Methodological Research for the MCBS (OMB No. 0938-1275), and the generic clearance for the MCBS Pulse (OMB No. 0938-1494).

MCBS' generic clearance for Questionnaire Testing and Methodological Research for the MCBS was first approved by OMB in May 2015 and most recently received approval for revision on June 26, 2024 (OMB No. 0938-1275, expiration 06/30/2027). The generic clearance encompasses development and testing of MCBS questionnaires, instrumentation, and methodological experiments. It contains approval for six types of potential research activities:

1) cognitive interviewing, 2) focus groups, 3) usability testing, 4) field testing (both within and outside the MCBS production environment), 5) respondent debriefing questionnaire, and 6) research about incentives. Any future changes to the MCBS instrumentation, data collection methods, or procedures that require testing will be submitted as individual collection requests under the generic clearance.

In Fall 2025, CMS fielded the "MCBS Pulse Beneficiary Trust Supplement" under the CMS Generic Clearance (OMB No. 0938-1275, expiration 06/30/2027). The MCBS Pulse Beneficiary Trust Supplement focused on beneficiary trust in Medicare and their experiences with the program. A total of 4,043 interviews were completed with existing and recently exited MCBS respondents between October 22, 2025 and December 30, 2025. Items administered under the Pulse Supplement were easily understood, had low levels of non-response and across beneficiaries, showed expected variation in response frequency distribution. CMS is requesting permission via this full clearance revision to incorporate a subset of the items, including those on trust in health care providers and pre-authorization of health care services, into the main MCBS.

MCBS' Generic Clearance for the Collection of Medicare Current Beneficiary Survey (MCBS) Respondent "Pulse" Feedback was first approved by OMB in June 2026 (OMB No. 0938-1494, expiration 06/30/2029). The new MCBS Pulse generic clearance provides CMS with time-sensitive data to inform early stage program planning and decision-making.

B5. Individuals Consulted on Statistical Aspects of Design

The person responsible for statistical aspects of design is:

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The contractor collecting the information is NORC at the University of Chicago.