Supporting Statement A
or Revision of Currently Approved Collection:
Medicare Current Beneficiary Survey (MCBS)

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BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) is the largest single payer of health care in the United States. CMS plays a direct or indirect role in administering health insurance coverage for more than 160 million people across the Medicare, Medicaid, CHIP, and Health Insurance Marketplace populations[1]. A critical aim for CMS is to be a trustworthy partner in supporting innovative approaches to improving quality, accessibility, and affordability in health care, an effective steward of taxpayer funds, and a major force against fraud, waste, and abuse across all its programs. CMS also aims to empower patients by giving them greater control over their health care information and improving their access to healthcare services through technology.

CMS activities result in substantial data generation. Although administrative data are a critical resource for CMS and its partners, there remains an important need for self-reported data to obtain information that is not captured through CMS operations. For example, information on beneficiary insurance coverage and payments from non-Medicare sources (including beneficiary out-of-pocket spending) can only be collected by surveying beneficiaries because these data are not available to CMS from administrative sources. In addition, a Medicare beneficiary's satisfaction with, access to, and quality of care are important pieces of information that can only be captured by obtaining the beneficiary's unique perspective. These survey-collected data elements, combined with CMS administrative data, complete the picture of a beneficiary's health care experience and provide a vital component in the development and evaluation of models and analysis conducted by CMS.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through operational or administrative data on the Medicare program. The MCBS is a continuous, multi-purpose longitudinal survey of Medicare beneficiaries that is sponsored by CMS and directed by the Office of Enterprise Data and Analytics (OEDA). The survey is conducted through a contract with NORC at the University of Chicago (NORC).

The MCBS has been continuously fielded since 1991, encompassing over 1.2 million interviews with more than 140,000 sampled beneficiaries. The survey captures beneficiary information whether aged or disabled, living in the community or facilities, or serviced by managed care or fee-for-service. Questions are asked about beneficiaries' health care use, payments over time, income, and medical debt. Respondents are asked about their sources of health care coverage and payment, their demographic and housing characteristics, their health and work history, and their experiences and perceptions of quality with their health care system. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g., fee-for-service claims, prescription drug event data, enrollment data, Medicaid payments and eligibility, and Medicare Advantage encounter records) to provide users with more accurate and complete estimates of total health care costs and utilization.

The primary goals of the MCBS are to:

[1] https://www.cms.gov/about-cms

- provide information on the Medicare beneficiary population that is not available in CMS administrative data and that is uniquely suited to evaluate or report on key outcomes and characteristics associated with beneficiaries treated in innovative payment and service delivery models;
- determine expenditures and sources of payment for all services (including services not covered by Medicare) used by Medicare beneficiaries, including copayments, deductibles, and non-covered services;
- ascertain all types of health insurance coverage among Medicare beneficiaries (e.g., Medigap coverage, retiree coverage) and relate this coverage to payment for specific services; and
- track changes in key beneficiary metrics over time, such as changes in health and functional status, spending down to Medicaid eligibility, access and satisfaction with the Medicare program and providers, and fluctuations in out-of-pocket spending.

The MCBS respondents are interviewed up to three times per year over a four-year period; the rounds (e.g., the survey administration schedule) are referred to as Fall, Winter, and Summer. Newly sampled beneficiaries always join in the Fall round; the panel's first round includes a Baseline interview and establishes a recall boundary for the next interview (the interview reference period is since the date of the previous interview). For the next 10 rounds (referred to as Continuing interviews), cost and utilization information and other health related questionnaire sections are administered to the panel. The panel exits the survey after its 11th interview which occurs in the Winter round.

To maximize efficiency and control costs, the majority of interviews are conducted by phone supplemented by in-person interviewing. Phone interviews may also be enhanced with video calling when respondents are interested and can easily access this technology. In addition, beginning in Summer 2027, the MCBS will add a self-administered web-based mode to the Facility instrument to supplement telephone interviewing.

The MCBS has been at the forefront of survey collection and data processing, most notably as one of the first surveys to successfully 1) implement a computer assisted personal interview (CAPI) and 2) match survey and claims data to adjust and correct for underreporting in survey reported health care utilization. The CMS vision for the MCBS is to continue to provide timely, policy-relevant, unique, high-quality, and high-value data; increase the survey's ability to develop, monitor, assess, and evaluate the impact of CMS care delivery and payment models; and to continue to break ground in innovative, efficient, and analytically powerful new areas of survey data administration, design, and development. To succeed in these areas, CMS is continuing to make improvements to:

- enhance data timeliness and ensure collected information can inform current policy initiatives;
- reduce respondent burden and maintain the sustainability of the survey;
- develop and implement more efficient, cost-effective, accurate, and innovative sampling and data collection strategies;

- increase response rates and understand and address non-response bias;
- improve the integration of existing and new sources of administrative data with MCBS survey collected data; and
- enhance the understanding, usefulness, and promotion of MCBS through the dissemination of user tools and key scientific findings based on MCBS data.

This is a request to revise the MCBS's current OMB clearance (OMB No. 0938-0568, Expiration Date 01/31/2029) starting in Winter 2027. The purpose of this revision is to seek approval for CMS to reduce overall respondent burden by removing content from the Community and Facility instruments that is no longer relevant to the goals of the survey, updating existing content to better meet the policy needs of CMS and stakeholders, and adding new items on care coordination, prescription drug discount programs, and hypertension management. To reduce respondent burden wherever possible, CMS routinely reviews MCBS survey content to remove unnecessary items and streamline sections.

CMS routinely reviews MCBS content to: 1) promote efficiency by streamlining the questionnaire and reducing respondent burden; 2) assess utility of information collected by the MCBS and remove questions that are no longer relevant, and 3) maintain the production of high-quality data by removing content that is no longer performing well. Starting with the 2026 full clearance revisions (approved by OMB on 1/6/2026), CMS reduced MCBS respondent burden by 8%. In accordance with OMB's terms of clearance specified in the approval of the 2026 MCBS, CMS identified additional deletions in the Community and Facility instruments to reduce the respondent burden associated with the MCBS. When implemented, the revision to this OMB package will continue the downward trend in respondent burden with a **net decrease** of an additional one percent.

Table A-1 shows the requested deletions and revisions in the Community questionnaire to reduce respondent burden.

Table A-1: Summary of Removed and Revised Community Items by Questionnaire Section and Administration Schedule

Content Area	# of Items Removed	# of Items Revised	Questionnaire Section	Administration Schedule
Access to Care	32	0	Access to Care Questionnaire (ACQ)	Annually, Winter Round
Cost of Vaccines	7	0	Immunization Questionnaire (IMQ)	Annually, Winter Round
Right to File an Appeal	0	1	Beneficiary Knowledge and Information Needs (KNQ)	Annually, Winter Round
Low-Income Subsidy (LIS) and Medicare Savings Program (MSP) Use	0	4	Income and Assets Questionnaire (IAQ)	Annually, Summer Round

Content Area	# of Items Removed	# of Items Revised	Questionnaire Section	Administration Schedule
Prescription Drug Purchasing Behavior	0	13	Drug Coverage Questionnaire (RXQ)	Annually, Summer Round
Religious Affiliation	2	0	Demographics and Income Questionnaire (DIQ)	Baseline Interview, Fall Round
Household Member Details	2	0	Enumeration Summary Section (ENS)	Annually, Fall Round
Diabetes Management, Hypertension, Urinary and Bowel Incontinence	24	6	Health Status and Functioning Questionnaire (HFQ)	Annually, Fall Round
Health Care Screening	5[2]	3	Preventive Care Questionnaire (PVQ)	Annually, Fall Round
Satisfaction with Health Care Services	4	0	Satisfaction with Care Questionnaire (SCQ)	Annually, Fall Round

Table A-2 shows the requested deletions and revisions in the Facility instrument to reduce respondent burden.

Table A-2: Summary of Removed and Revised Facility Items by Questionnaire Section and Administration Schedule

Content Area	# of Items Removed	# of Items Revised	Survey	Questionnaire Section	Administration Schedule
Confirming Facility Administrator Information	1	0	1	Facility Questionnaire (FQ)	All rounds
Facility Structure Details	1	0	1	Residence History (RH)	All rounds
"Other" Relationship of Contact for SP	2	0	1	Residence History (RH)	All rounds
Billing & Payment Discrepancies	60*	0	2	Expenditures (EX)	All Rounds

[2] Of the five deletions in PVQ, three items were removed from the Fall round Baseline interview. One item was removed from both the Fall round Baseline and Continuing interviews.

Content Area	# of Items Removed	# of Items Revised	Survey	Questionnaire Section	Administration Schedule
Functional Status: IADLs & ADLs	13	6	3	Health Status (HS)	All Rounds
General Health Status	1	0	3	Health Status (HS)	All Rounds
Vision	2	0	3	Health Status (HS)	All Rounds
Medicare Eligibility	3	0	3	Health Status (HS)	All Rounds
Procedures & Preventive Screenings	2	0	3	Health Status (HS)	All Rounds
Record Identification	9	0	3	Health Status (HS)	All Rounds

*This series contained items that were fielded in very rare situations where discrepant information was entered in the Expenditures section. These items were rarely administered and have limited analytic utility.

The requested additions are shown in Table A-3 by questionnaires section and administration schedule.

Table A-3: Summary of New Items by Questionnaire Section and Administration Schedule

Content Area	# of Items Added	Questionnaire Section	Administration Schedule
Care Coordination	15	Care Coordination Questionnaire (CCQ)[3]	Annually, Winter Round
Trust in Health Care Providers	15	Care Coordination Questionnaire (CCQ)	Annually, Winter Round
Pre-Authorization of Health Care Services	31[4]	Care Coordination Questionnaire (CCQ)	Annually, Winter Round
Prescription Drug Discount Programs	5	Drug Coverage Questionnaire (RXQ)	Annually, Summer Round

[3] Formerly referred to as the Usual Source of Care Questionnaire (USQ).
[4] These items will not be asked of all respondents. It is expected that just over half of respondents will be ineligible for this series and therefore will skip it entirely. For respondents who are eligible for these items, it is anticipated that most respondents will only receive approximately eight questions on average.

Content Area	# of Items Added	Questionnaire Section	Administration Schedule
Nutrition	3	Health Status and Functioning (HFQ)	Annually, Fall Round
Hypertension Management	1	Health Status and Functioning (HFQ)	Annually, Fall Round

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

While the administrative data available to CMS via claims records are rich in breadth and accuracy, they do not contain important information that can only be obtained by interviewing beneficiaries. In particular, the current administrative information collected by CMS does not provide the complete picture needed for CMS to evaluate its programs and comply with legislative mandates found in:

a. Section 1115A of the Social Security Act, as established by Section 3021 of the Affordable Care Act (ACA) of 2010; and

b. Section 723 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

c. Section 1875 of the Social Security Act (42 United States Code 1395ll[5]).

Survey-collected data elements collected in the MCBS, combined with CMS administrative data, complete the picture of a beneficiary's health care experience and provide the necessary information for CMS program performance and compliance.

A2. Purpose and Use of Information Collection

The MCBS supports CMS's program evaluation and compliance with legislative mandates by providing comprehensive data on Medicare beneficiaries' health care use, expenditures, and sources of payment. These data include information on co-payments, deductibles, and non-covered services, as well as beneficiaries' health insurance coverage and its relationship to payment sources. MCBS data are used to monitor service delivery, sources of payment for covered and non-covered services, beneficiary cost sharing and financial protection, access to and satisfaction with care, and care integration. The MCBS also allows CMS to examine changes over time, such as shifts in health status, "spending down" to Medicaid eligibility, and the effects of programmatic and policy modifications.

Through its unique design, the MCBS offers critical insights into the Medicare program that support both CMS and external stakeholders in understanding program performance and evaluating potential policy initiatives. For example, CMS uses MCBS data to estimate the number of beneficiaries who may be eligible for proposed care and payment models, assess utilization patterns and sources of usual care, and identify factors influencing when and where beneficiaries seek services. MCBS data were instrumental in the initial implementation of the

[5] https://www.hhs.gov/foia/privacy/sorns/09700519/index.html

Medicare prescription drug benefit and continue to support the evaluation of prescription drug spending and beneficiaries' out-of-pocket costs.

The MCBS panel design provides essential longitudinal data, enabling the complete capture of costs associated with specific utilization, measurement of change over time and supporting both pre- and post-implementation analyses, as well as observational studies with comparison groups. This longitudinal perspective is particularly valuable for evaluating beneficiaries' experiences within CMS models or other CMS programs.

A further distinguishing feature of the MCBS is its ability to follow individuals as they move between community settings, nursing facilities, and hospitals. This capacity yields critical information on the characteristics of the institutionalized population, care transitions across providers, and the total cost of episodes of illness, including the level and type of system interventions such as home health care. These data allow CMS and its stakeholders to better assess how care is delivered across settings and the resources used throughout an episode of care.

Looking ahead, the MCBS will continue to play a vital role in helping policymakers administer, monitor, and evaluate the Medicare program, with particular emphasis on supporting CMS efforts to test innovative payment and service delivery models aimed at reducing costs and improving quality. The survey's integration of beneficiary-reported data with CMS administrative data enables analyses that cannot be conducted using administrative data alone, such as changes in beneficiaries' financial well-being, Medicaid eligibility, cost sharing and premiums, and awareness and use of Medicare-covered preventive services.

CMS and other data users rely on the MCBS to assess the impact of major policy changes and health care reforms on Medicare beneficiaries, both before and after implementation. Researchers can relate the dynamics of aging patterns to age-specific rates of use of health care services. The survey supports their analyses of aging trends, total health care expenditures, and changes in private health insurance benefits, including long-term care insurance.

- **Within CMS**. Survey results have been and will continue to be used by various components within CMS. CMS routinely uses the data collected by the MCBS to assess the potential number of beneficiaries eligible for proposed new care and payment models or new programs, their utilization and patterns of usual care over time, and the decisional factors that help determine when and where beneficiaries seek care. CMS relies on the MCBS to produce estimates of health care utilization, costs, and well-being for various populations and benchmark measures produced from administrative data, where appropriate.

  As an example, the MCBS is used by the CMS Office of the Actuary to track trends in out-of-pocket spending and Medicare supplemental insurance (Medigap), as well as evaluate budgetary impacts of changes to the Medicare program. The MCBS also contributes critical data to the annual Trustees' Report.

  MCBS data are also used by the CMS Office of Communications to track beneficiary's knowledge about Medicare, especially following the implementation of a new program or services (e.g., Part D, "Welcome to Medicare" benefits, etc.), and to design more effective and targeted outreach strategies. Self-reported MCBS data on health status, chronic conditions, smoking and alcohol use, and preventive screenings are used to track whether

CMS is meeting population health objectives.

Analysis of the facility component also allows CMS to better understand characteristics of beneficiaries residing in facilities and examine expenditures that are covered by Medicaid, the shifts between private pay and Medicaid, and the cost implications for both Medicare and Medicaid in the areas of spending down assets and spousal impoverishment.

- **Other Governmental / quasi-governmental, outside CMS**. Data from the MCBS support a wide range of critical functions across government and research organizations. The Congressional Budget Office uses MCBS data to develop budget options and estimate the number of beneficiaries that may be affected by proposed policy changes. Similarly, the Medicare Payment Advisory Commission (MedPAC) relies on the MCBS for data on health care access and beneficiary financial protection. MedPAC regularly incorporates MCBS data into its Annual Reports, using the survey results for both descriptive statistics and policy simulations. Additionally, numerous federal agencies and private foundations focused on health care innovation and analysis utilize MCBS data in their research and policy development efforts.

  Beyond its use in federal policy analysis, MCBS data support research on health care utilization and cost such as assessing the aggregate cost of short- and long-term stays in nursing homes, as well as combined hospital and nursing home stays. In addition, MCBS data are used to forecast future needs related to chronic condition management and long-term care services by analyzing trends in health care use, alongside morbidity, disability, and mortality indicators.

  The comprehensive nature of the MCBS appeals to a broad spectrum of users. In addition to its extensive use within CMS, the MCBS provides unique and meaningful data to external researchers, as demonstrated by more than 4,500 research articles and citations using the MCBS to date. Each year, over 250 MCBS Limited Data Set (LDS) files are purchased and distributed to researchers, and the MCBS Microdata Public Use File (PUF) is downloaded more than 150 times per month. MCBS survey data are also vital in the production of several highly regarded publications, including CMS's Annual Trustees Report, MedPAC's annual data book "Health Care Spending and the Medicare Program," and the Federal Interagency Forum on Aging Related Statistics' chartbook "Older Americans: Key Indicators of Well-Being."

- **MCBS Limited Data Sets (LDS)** are available to researchers with a data use agreement. Additionally, MCBS Microdata Public Use Files (PUFs), which include the annual Survey File PUF and the annual Cost Supplement File PUF, are available free for download with accompanying documentation. CMS provides a bibliography that includes research using MCBS data. This publication highlights the breadth of research that is made possible by MCBS data and is a helpful resource to CMS staff and other government researchers. Topics of research found in the MCBS Bibliography include chronic conditions, effects of Medicare drug coverage, use of preventive services, underuse of medications, hospital readmission, out-of-pocket costs and financial barriers to care, assistance with activities of daily living, obesity, quality of care, alcohol use, hospice and home health care, disability trends, treatments for dementia, depression, beneficiary knowledge, caregiving, use of durable medical equipment, falls, supplemental insurance coverage, and access to and use of

telemedicine. These are just a few examples of actual uses of MCBS data for policy research; bibliographies by year can be found at CMS MCBS Bibliography.

A3. Use of Information Technology and Burden Reduction

The MCBS takes full advantage of advances in survey methodology by administering the survey through advanced survey technology. Whether by phone or in-person, the MCBS is administered by trained field interviewers using computer-assisted personal interviewing (CAPI), which functions with programmed edit checks and reduces respondent burden by minimizing the potential for double reporting and inconsistent responses. CAPI technology enables the interviewer to move through complex skip patterns quickly, which reduces respondent burden by shortening the interview. CAPI also greatly increases the efficiency of the interview in the following ways:

a. CAPI tailors the sequence of questions to the responses of the interviewee, resulting in few – if any – interviewer skip errors. The natural flow of the interview is maintained even when the pattern of questions is complex.

b. CAPI is programmed to automatically provide "fills", or word choices within questions. For example, the sample person's first name can be filled for the duration of the interview when the interview is conducted with a proxy, rather than filling with "you/yours" as it would for an interview with the sample person.

c. CAPI maintains rosters or lists created during the interview, such as household members, health insurance plans, medical conditions, providers, visit dates, prescription drugs, and people who help with daily activities. These rosters are used to structure questions, e.g., cycling through a series of doctor visits and checking for missing information. Interviewers can select items from a roster, add items, or correct them. Rosters are carried over from one interview to the next.

d. CAPI displays questions with identical question stems and response options in a grid-style format for more efficient survey administration instead of displaying each question on separate screens.

e. CAPI edits entries for range and consistency alerting the interviewer to ensure data are accurate.

f. CAPI is programmed to produce instantaneous calculations, such as the amount remaining to be paid on a medical bill after totaling several payments.

g. CAPI allows for the instrument to be pre-loaded with responses recorded from previous data collection rounds and from administrative records to reduce respondent burden and provide for more accurate reporting of subsequent responses.

h. Interviewers use the computer to electronically transmit completed cases to the central office, and the central office uses automated management processes to balance interviewer caseload in order to provide for data collection efficiency in the field.

Locating respondents uses available technologies that have reduced on-the-ground searches.

A4. Efforts to Identify Duplication and Use of Similar Information

This information collection is unique and does not duplicate any other effort and the same information cannot be obtained from any other source. This is especially true due to the unique panel design which follows respondents over a four-year period both in the community as well as in long-term care facilities. This design enables CMS to capture more complete data associated with costs and utilization of health care.

During the development and initial administration of the MCBS, a number of people inside and outside the Federal government were consulted. This consultation included issues of design, content, and statistical methodology and analysis. This effort was replicated in 2013 using an independent contractor. In both instances, none of the people contacted were aware of duplicative information, nor were they aware of any other survey that duplicates the efforts of MCBS.

Further, in 2015-2016, the DHHS underwent an intensive review of health surveys to align like-questions, reduce duplication, and ensure that official estimates were being provided by the appropriate survey[6]. The DHHS review determined that data collected by the MCBS are unique even though similar topics are asked by other federal surveys including the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES). Although NHIS, for example, asks similar questions about health insurance coverage, the usage of MCBS data is different, particularly given the ability to link MCBS survey data to Medicare administrative data and cost related data. Unlike other federal surveys, CMS uses health insurance information collected by the MCBS to determine the cost burden of premiums paid by beneficiaries as well as to determine the cost of additional supplemental plans paid for the Medicare covered and non-covered medical expenses. Using the MCBS, CMS examines the cost of reported medical events, and determines with Medicare administrative data and cost information collected from the beneficiary what the true out of pocket costs are to the beneficiary. CMS also uses the information to see whether private plans such as employer provided plans are paying for the Medicare premiums for Part D and/or Part C for currently employed beneficiaries as well as retired beneficiaries.

In addition, CMS has undertaken exhaustive reviews of the literature and other data sources. In no instance has CMS identified another source of data that would be an effective substitute for the MCBS.

A5. Impact on Small Businesses and Other Small Entities

Most of the data collected for the MCBS will be from individuals in households. However, in any given round, approximately 800 to 1,100 sample persons will reside in government-sponsored, non-profit, and for-profit institutions such as nursing and personal care homes. Some of these institutions likely qualify as small businesses. For data collected on sample persons in these institutions, their employees serve as proxies for each sample person in their care.

Interviewers who collect data on beneficiaries living in facilities make every effort to determine, for each type of question, which staff members are most able to answer them. The data collection procedures are designed to minimize the burden on facility staff by utilizing as much administrative data as possible to streamline the data collection process.

[6] HHS Data Council Co-Chairs memorandum to the Secretary of the Department of Health and Human Services, May 11, 2016

A6. Consequences of Collecting the Information Less Frequently

The longitudinal design of the MCBS allows CMS to accurately measure health care cost and utilization as well as changes in health care conditions over time. The sections of the survey that measure health care cost and use are administered each round to ensure that the survey comprehensively captures all interactions with health care providers and services throughout the survey year. Due to the continuous nature of health care services, and the lagging bills and statements associated with care, less frequent administration of the survey's cost and use sections would translate to inaccurate and incomplete data, which would hinder CMS's ability to make informed program and policy decisions.

In the first round of interviewing in the MCBS, the respondent is provided with a calendar and asked to record all visits to health care providers and health care expenditures; they are also asked to retain all statements including private insurance documents, prescription drug documents and Medicare statements/bills. After the initial Baseline interview, the recall period for the MCBS is "since the time of the last interview" (usually not greater than four months).

As part of the currently approved clearance, CMS revised the longitudinal design in 2018 by reducing the number of rounds respondents participate in from 12 interviews to 11 interviews. Analysis of data collected in the 12th interview revealed that this 'exit' interview did not provide essential cost and use information and therefore was eliminated.

By re-interviewing the same respondents a total of 11 times during a four-year period, the MCBS supports longitudinal as well as cross-sectional analyses. Longitudinal data provide the basis for models that analyze quantitative change over time. Policy changes can only be effectively understood by modeling the consequences of those changes on the same individuals over time. For example, the MCBS data allow CMS to understand how changes in copays or coverage affect the type of physicians a beneficiary may choose or the type of services a beneficiary seeks. Additionally, three interviews a year that collect full cost and event data allow CMS to assess changes in health and well-being in an elderly population at the beneficiary level.

MCBS survey sections that capture health status and functioning and experiences with care are administered annually to ensure accurate and complete reporting. If administered less frequently, the MCBS would no longer provide comprehensive reporting on changes in chronic health conditions and functional status, onset of new health conditions, and transitions of care. As part of CMS's content reduction process, CMS regularly reviews survey items to determine if less frequent administration is required for analytic use. Through this process, CMS has identified a subset of items, including some highlighted in this revision, which may be administered once per panel due to lack of variability in response over time. This allows important information to be collected but reduces respondent burden by collecting the information less frequently.

A7. Special Circumstances Relating to Guidelines of 5 CFR 1320.5

None of the special circumstances listed by OMB apply to the MCBS.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside Agencies

The 60-day Federal Register notice was published on April 30, 2026 (91 FR 23271). No comments were received.

CMS also regularly solicits input on questionnaire content from an extensive list of stakeholders as well as notification of opportunities to comment on the website (CMS.gov/MCBS and Research Statistics Data and Systems MCBS). Also, CMS participates in interagency working groups as well as research conferences to consult with a wide variety of data users and policy officials interested in MCBS data.

The 30-day Federal Register notice was published on July 24, 2026 (91 FR 46785).

A9. Explanation of Any Payment or Gift to Respondents

The MCBS does not provide payments or gifts as incentives to respond. The most important incentive the survey uses is to persuade the respondent that his or her participation is a service to the future of Medicare. Respondents are provided with a calendar to record all health events and provider visits for easy reference during future interviews.

A10. Assurances of Confidentiality Provided to Respondents

On February 14, 2018, CMS published in the Federal Register a notice of a modified or altered System of Record (SOR) (System No. 09-70-0519). The notice was published in 83 Federal Register 6591.

The Community Advance Letter (Attachment 1) mailed to the respondent for in person and telephone interviewing includes the following statement regarding confidentiality of data:

> "…your information will be kept private to the extent permitted by law, as prescribed by the Federal Privacy Act of 1974."

The Community brochure (Attachment 1), which is mailed to all newly added sample members each Fall round, contains the following on respondent rights and privacy:

> "The information you provide will be kept private to the extent permitted by law, as prescribed by the Privacy Act of 1974. The information you give will only be used for research and statistical purposes."

The Frequently Asked Questions (FAQs) document (Attachment 1) provided during in person interviews to the Community respondent at the door or discussed with Community respondents and/or facility administrators and proxy respondents during phone interviews contains a statement of privacy protection consistent with the Privacy Act of 1974.

Interviewer training stresses the importance of maintaining confidentiality and project protocols are documented within the Field Interviewer manual. Field outreach and contacting procedures have been established to maintain and ensure confidentiality. These include the utilization of standard computer security procedures (dual authentication password protection for each

interviewer laptop) and prohibitions on submitting personally identifiable information through electronic mail submission.

The Facility Advance Letter (Attachment 5), sent to any new facility participating in the MCBS via in person or telephone interviews, includes the following statement:

> "No residents of your facility will be contacted directly. All of the information your organization provides will be kept private to the extent permitted by law, as prescribed by The Federal Privacy Act of 1974. Your participation is voluntary, and your relationship with programs administered by CMS will not be affected in any way by whether or not you participate."

The Facility Web Screener Letter, a new material designed to be used with the implementation of the web survey mode, includes the following:

> "Your participation is voluntary and won't affect your relationship with programs administered by CMS. Your answers are private, as prescribed by The Privacy Act of 1974. Your cooperation with the MCBS will not violate HIPAA privacy regulations or impose additional disclosure burdens on your facility."

Participating facilities also receive a HIPAA Letter (Attachment 5), which includes the following regarding the Health Insurance Portability and Accountability Act (HIPAA) regulations:

> "I am writing to address any concerns you may have about your facility's participation in the Medicare Current Beneficiary Survey (MCBS) as it relates to the Health Insurance Portability and Accountability Act (HIPAA) regulations. Please be assured that the standards of privacy of protected individually identifiable health information implemented under the HIPAA privacy regulation do not affect the data being collected for MCBS. Specifically, your cooperation with the MCBS will not violate the HIPAA privacy regulations. Nor will it require any additional privacy disclosure record keeping.
>
> Under the HIPAA regulations, your facility does not need an individual's authorization to disclose their protected health information to a health plan, such as the Medicare program, when the information is being disclosed for receiving organization's health care operations activities. This holds if both your facility and the Medicare program has or had a relationship with the individual whose protected health information is being requested, and the protected information pertains to such relationship. See 45 CFR § 164.506(c) (4).
>
> Furthermore, participating in the MCBS will not impose additional disclosure record keeping burdens on your facility. Disclosures under 45 CFR § are explicitly exempt from the HIPAA disclosure accounting provisions. See 45 CFR § 164.528 (a) (1) (i)."

The Resident Consent Form (Attachment 5) contains the following statement:

> "The information collected for MCBS will be protected by NORC at the University of Chicago, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study. Identifiable information will not be disclosed or released to

anyone except those involved in research without the consent of the individual or the establishment except as required under the Privacy Act of 1974 (Public Law 93-579)."

Any data published will exclude information that might lead to the identification of specific individuals (e.g., ID number, claim numbers, and location). CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to the individual privacy or other personal or property rights of the individual.

All NORC survey staff directly involved in MCBS data collection and/or analysis activities are required to sign a Non-Disclosure Agreement as well as a NORC confidentiality agreement.

A11. Justification for Sensitive Questions

In general, the MCBS does not ask sensitive questions. However, for a small number of respondents, there may be some questionnaire items that are considered to be sensitive. All interviewers are trained on how to handle respondent concerns about questions being sensitive.

For example, the Community instrument asks for respondents' perception of their health care, including any issues they may have experienced with their health care providers. These items may be considered sensitive by some respondents, depending on their health care experiences. It also includes some questions about activities of daily living, such as whether the respondent needs help bathing. Some respondents consider these questions to be sensitive.

A12. Estimates of Annualized Burden Hours and Costs

Table B-12 shows the estimates of the annual respondent burden, based on the projected number of completed interviews per round and the estimated length of each interview (including the net additions and deletions requested in this clearance). On average, the annual burden for the MCBS is based on three interviews (e.g., rounds) per respondent. The number of actual respondents who complete an interview changes every round and every year. Response rates per round and annually are carefully monitored and reviewed to determine the size of the next Incoming Panel. The size of the new panel is designed to provide a stable number of respondents across all panels participating in the survey annually and this size changes annually depending on prior year response rates and the number of active participants still engaged in the survey.

Table B-12: Estimates of the Annual Respondent Burden starting in Winter 2027

Community Rounds 107-115	Time Per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Winter 2027 Round 107 Continuing Interview	53.9 minutes	1	10,619	9,539
Summer 2027 Round 108 Continuing Interview	60.9 minutes	1	7,880	7,998
Fall 2027 Round 109 Baseline Interview	58.9 minutes	1	5,766	5,660

Community Rounds 107-115	Time Per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Fall 2027 Round 109 Continuing Interview	66.1 minutes	1	6,852	7,549
Field Manager Follow-up with 5% of Completed Interviews	5 minutes	1	1,556	130

Facility Rounds 107-115	Time Per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Winter 2027 Round 107 Continuing Interview	21.1	1	799	281
Summer 2027 Round 108 Continuing Interview	21.2	1	593	210
Fall 2027 Round 109 Baseline Interview	39.1	1	209	136
Fall 2027 Round 109 Continuing Interview	37.6	1	249	156
Fall 2027 Round 109 Baseline Interview—Admin Data	27.3	1	225	102
Fall 2027 Round 109 Continuing Interview—Admin Data	35.1	1	267	156

Rounds 107-115	Expected Number of Completed Interviews	Burden Hours
Total Expected Number of Completed Interviews Annually	35,015	
Total Annual Burden Hours		31,917
Total Estimated Burden Hours – Rounds 107-115 (3 Years)		**95,752**

Below provides a summary of the annual burden change from the current clearance, reflecting the net decreased burden of adding 67 items and removing 76 items.

Total annual burden hours – revised 2027 clearance	31,917
Total annual burden hours – current 2026 clearance	32,258
Total annual burden hours – difference	**-341**

To provide an estimate of the cost of participating in this survey, CMS must select an hourly rate to use which is then multiplied by the burden hours of the respondent. CMS selected the U.S. minimum wage ($7.25 for 2026[7]) and multiplied it to the Total Annual Hours for Rounds 107-109 (31,917), for a Total Annual Cost Burden in terms of dollars of $231,400.87.

[7] https://www.dol.gov/general/topic/wages/minimumwage

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

All costs associated with this effort are reported in Items 12 and 14.

A14. Annualized Costs to the Federal Government

The estimated cost to the government for collecting these data includes the NORC data collection contract, and direct CMS expenses for labor and travel.

The estimated cost for the annual planning, sampling, data collection and analysis for the MCBS is below.

Option Year 5 (May 1, 2026-April 30, 2027): Survey development, operations, processing and analysis: $22,300,000.[8]

These costs include all labor hours, materials and supplies, reproduction, postage, telephone charges and indirect costs.

CMS personnel involved in MCBS include approximately 14 FTEs broken out by paygrade or paygrade range in Table B-14.

Table B-14: CMS Personnel

Grade	FTE	2026 Annual Salary	Cost to Government[23]
GS13 step 5	8.0	$138,024	$1,104,192
GS14 step 5	4.0	$163,104	$652,416
GS15 step 5	2.0	$191,850	$383,700
			Total: $1,258,338

CMS staff costs are approximately $2,140,308. The MCBS releases its documentation as downloadable files on its public website thus eliminating its printing budget. Thus, in-house CMS cost will be $2,140,308.

A15. Explanation for Burden Changes (Program Adjustments)

This is a request to revise the existing MCBS clearance beginning in Winter 2027. When implemented, the revision to this OMB package will result in a **net decrease** in respondent burden as compared to the current clearance. The planned content removals and revisions are expected to **reduce the Community questionnaire by 9.2 minutes** each year starting in Winter 2027 while the planned content additions are expected to **add 8 minutes to the Community questionnaire** annually, resulting in a net decrease of 1.2 minutes[9]. This includes a decrease of 5.9 minutes from the Fall round and 3.3 minutes from the Winter round due to item deletions and

[8] Future awards are based on execution of option years and funding availability.

[9] This represents the amount reduced in the Fall Baseline survey. The net change to the Fall round Continuing survey is a reduction of 0.1 minutes. In other words, 8 minutes will be added to the Continuing Community survey and 8.1 minutes will be deleted.

revisions[10]. The requested deletions will reduce the **Facility instrument** by **2.9 minutes** each year starting in Winter 2027. This includes a decrease of 0.5 minutes from the Winter and Summer round interviews, respectively, as well as a reduction in 1.9 minutes from the Fall round survey.

The current OMB clearance projects an annual respondent burden of 32,258 hours. This revision **reduces the annual respondent burden by 341 hours**, bringing the total annual respondent burden to 31,917 hours. The changes in estimated annual respondent burden are summarized in Table B-12 (under section A12 above). This reduction in burden will help to maintain the overall sustainability of the MCBS and will ensure that CMS creates dedicated capacity for future MCBS Pulse requests fielded under CMS' forthcoming new generic clearance testing vehicle.

Changes that will **decrease** respondent burden are summarized below. These changes include the removal and revision of existing survey items. Some of the item revisions are burden neutral, such as simplification of item text and response options, while others will reduce interview length, such as changing the item administration schedule.

These changes include:

- **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. These changes will result in a reduction of 2.2 minutes annually from the Winter round interview.
- **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. This change will result in a reduction of 0.7 minutes annually from the Winter round interview.
- **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. This change will result in a reduction of 0.4 minutes annually from the Winter round interview.
- **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.

[10] A total of 5.2 minutes will be removed from the Fall round Baseline interview. A total of 4.1 minutes will be removed from the Fall round Continuing interview.

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. These revisions are burden neutral.

- **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.[11] These revisions are consistent with the structure of the three proposed RXQ additions (see below for more detail) and are burden neutral.

- **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. This change will result in a reduction of 0.2 minutes from the Fall round Baseline interview.

- **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. This change will result in a reduction of 0.2 minutes from the Fall round Baseline and Continuing interviews.

- **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

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

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 (ASCVD).[12] Following 2019 guideline changes related to aspirin use among those with ASCVD[13], the use of aspirin has decreased, thereby making this item less relevant.[14]
- 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

[12] https://diabetesjournals.org/care/article-pdf/20/11/1772/583603/20-11-1772.pdf
[13] https://www-ahajournals-org.proxy.uchicago.edu/doi/10.1161/cir.0000000000000678
[14] https://pubmed.ncbi.nlm.nih.gov/40243986/

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.

Together, these changes will result in a decrease of 3.1 minutes in the Fall Baseline and Continuing interviews.

- **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:
  - ***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[15]. 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

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

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.[16]

Together, these changes will result in a decrease of 1.2 minutes for the Fall round Baseline interview and 0.3 minutes for the Fall round Continuing interview.

- **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.

Together, these changes will result in a decrease of 1.2 minutes annually in the Fall Baseline and Continuing interviews.

In addition to the changes summarized above, there are several changes to the Facility instrument content that will decrease respondent burden. These changes include the removal and revision of existing survey items. Some of the item revisions are burden neutral, such as aligning the flow of questions across the Community and Facility instruments, while others will reduce interview length through the removal of items with limited analytic utility or redundant content.

These changes include:

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

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

- **Removing items from the Residence History (RH) section in Web 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 Web 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 Web 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 Web 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.

Together these changes will remove 0.5 minutes from the Winter round Facility instrument, 0.5 minutes from the Summer round Facility instrument, and 1.9 minutes from the Fall round Baseline and Continuing Facility instruments. Changes that will **increase** respondent burden are summarized below. These questions are being added to the survey as they are highly relevant to the current healthcare landscape, and will increase CMS's capacity for monitoring and evaluating important topics related to experiences with care and chronic conditions. In line with CMS's standard content review practices, the added items will be routinely evaluated and removed if they stop performing well or are no longer policy relevant.

These changes include:

- **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)[17]; other items in this category were adapted from existing MCBS content.

- ***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[18]. 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

[17] https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/emergency-department-cahps
[18] https://pmc.ncbi.nlm.nih.gov/articles/PMC1262715/

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.

Together, these changes will add a total of 6.7 minutes to the Winter round interview.

- **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. 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.[19] 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

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

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.[20]

- ***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 population. Certain demographic groups may be less aware of the various provisions and may benefit from tailored outreach and education efforts.

Together, these changes will add 0.6 minutes to the Summer round interview.

- **Adding one new item about hypertension management in the Health Status and Functioning Questionnaire (HFQ).** The HFQ collects information on the prevalence of chronic 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.[21] Hypertension puts individuals at risk of heart disease, which is a leading cause of mortality among older adults.[22] Medications to treat hypertension are also among the most frequently prescribed in Medicare.[23]

  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.[24] 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.

[20] https://investors.goodrx.com/news-releases/news-release-details/goodrx-reports-fourth-quarter-and-full-year-2025-results
[21] https://www.cms.gov/files/document/data-snapshot-hypertension-jan-2023.pdf
[22] https://www.cdc.gov/nchs/fastats/older-american-health.htm
[23] https://aspe.hhs.gov/sites/default/files/documents/920ec8349c53a362b27e3b10669dafd4/generic-drug-landscape-ib.pdf
[24] https://www-ahajournals-org.proxy.uchicago.edu/doi/10.1161/CIR.0000000000001356

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)[25], where they were easily understood.

Together, these changes will add 0.7 minutes to the Fall round Baseline and Continuing interviews.

Finally, **burden neutral operational changes** are summarized below. These changes include the addition of a web-based mode for the Facility instrument beginning in Summer 2027 to supplement telephone interviewing and updates to respondent materials for the Facility and Community instruments.

- **Addition of 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-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.

[25] OMB Control Number 0938-1434

- **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.

With the addition of the self-administered mode, CMS expects some efficiencies in survey administration over time, which may result in reduced respondent burden. CMS plans to evaluate these efficiencies and will reflect any reductions in respondent burden in future packages.

- **Update 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
- **Update 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.

Table A-4 summarizes the decrease in burden associated with the removal and revision of content in the Community questionnaire as well as operational efficiencies.

Table A-4: Decreased Burden Associated with the Removal and Revision of Items from the Community Instrument

Community	Section	Winter 2027 Round 107	Summer 2027 Round 108	Fall 2027 Round 109	Total
Access to Care	ACQ	2.2 minutes	0 minutes	0 minutes	2.2 minutes
Cost of Vaccines	IMQ	0.7 minutes	0 minutes	0 minutes	0.7 minutes
Right to File an Appeal	KNQ	0.4 minutes	0 minutes	0 minutes	0.4 minutes
LIS and MSP Use	IAQ	0 minutes	0 minutes	0 minutes	0 minutes*
Prescription Drug Purchasing Behavior	RXQ	0 minutes	0 minutes	0 minutes	0 minutes*
Religious Affiliation	DIQ	0 minutes	0 minutes	0.2 minutes	0.2 minutes
Household Members	ENS	0 minutes	0 minutes	0.2 minutes	0.2 minutes
Diabetes Management, Hypertension, Urinary and Bowel Incontinence	HFQ	0 minutes	0 minutes	3.1 minutes	3.1 minutes
Health Care Screening	PVQ	0 minutes	0 minutes	1.2 minutes	1.2 minutes**
Satisfaction with Health Care Services	SCQ	0 minutes	0 minutes	1.2 minutes	1.2 minutes

Community	Section	Winter 2027 Round 107	Summer 2027 Round 108	Fall 2027 Round 109	Total
Total Minutes Deleted		**3.3 minutes**	**0 minutes**	**5.9 minutes**	**9.2 minutes**

*This is a burden neutral change.
**This represents the amount reduced in the Baseline Fall round survey. The net decrease for the Continuing interview will be 0.5 minutes.

Table A-5 summarizes the decrease in burden associated with the removal and revision of content in the Facility instrument as well as operational efficiencies.

Table A-5: Decreased Burden Associated with the Removal and Revision of Items from the Facility Instrument

Facility	Survey/ Section	Winter 2027 Round 107	Summer 2027 Round 108	Fall 2027 Round 109	Total
Facility Contact and Facility Structure	1/FQ and RH	0.2 minutes	0.2 minutes	0.2 minutes	0.6 minutes
Billing Confirmation	2/EX	0.3 minutes	0.3 minutes	0.3 minutes	0.9 minutes
Health Status Items	3/HS	0 minutes	0 minutes	1.4 minutes	1.4 minutes*
Total Minutes Deleted		**0.5 minutes**	**0.3 minutes**	**1.9 minutes**	**2.9 minutes**

Table A-6 summarizes the new content requested to be added to the Community instrument and their associated effect on burden (minutes).

Table A-6: Increased Burden Associated with New Content Revisions to the Community Instrument

Community	Section	Winter 2027 Round 107	Summer 2027 Round 108	Fall 2027 Round 109	Total
Care Coordination	CCQ	2.2 minutes	0 minutes	0 minutes	2.2 minutes
Trust in Health Care Providers	CCQ	2.5 minutes	0 minutes	0 minutes	2.5 minutes
Pre-Authorization of Health Care Services	CCQ	2.0 minutes	0 minutes	0 minutes	2.0 minutes
Prescription Drug Discount Programs	RXQ	0 minutes	0.6 minutes	0 minutes	0.6 minutes
Nutrition	HFQ	0 minutes	0 minutes	0.4 minutes	0.4 minutes
Hypertension Management	HFQ	0 minutes	0 minutes	0.3 minutes	0.3 minutes
Total Minutes Added		**6.7 minutes**	**0.6 minutes**	**0.7 minutes**	**8 minutes**

A16. Plans for Tabulation and Publication and Project Time Schedule

Data files will continue to be prepared over the course of the survey. This clearance request covers data collection beginning in Round 107 (Winter 2027) through Round 115 (Fall 2029). See Table B-16a for data collection rounds and plans for data dissemination. CMS is

continuously evaluating ways to compress the schedule for data dissemination (making the data available faster). This schedule may be revised as innovative plans for data dissemination and delivery are developed and implemented. CMS will continue to produce and release tabulations based on MCBS data.

Table B-16a: Annual schedule for information collection and dissemination, January 2027 – January 2032.

Data collection schedule

01/06/2027	Data collection starts for Winter 2027 Round 107
05/05/2027	Data collection starts for Summer 2027 Round 108
07/19/2027	Data collection starts for Fall 2027 Round 109
01/05/2028	Data collection starts for Winter 2028 Round 110
05/03/2028	Data collection starts for Summer 2028 Round 111
07/18/2028	Data collection starts for Fall 2028 Round 112
01/10/2029	Data collection starts for Winter 2029 Round 113
05/03/2029	Data collection starts for Summer 2029 Round 114
07/23/2029	Data collection starts for Fall 2029 Round 115

Data dissemination schedule

01/31/2027	Cost Supplement File Microdata Public Use File for 2024 data.
06/30/2027	Limited Data Set available for 2025 Survey File.
09/15/2027	Limited Data Set available for 2026 Survey File - Early Release.
10/15/2027	Limited Data Set available for 2025 Cost Supplement File.
10/15/2027	Survey File Microdata Public Use File for 2025 data.
01/31/2028	Cost Supplement File Microdata Public Use File for 2025 data.
06/30/2028	Limited Data Set available for 2026 Survey File.
09/15/2028	Limited Data Set available for 2027 Survey File - Early Release.
10/15/2028	Limited Data Set available for 2026 Cost Supplement File.
10/15/2028	Survey File Microdata Public Use File for 2026 data.
01/31/2029	Cost Supplement File Microdata Public Use File for 2026 data.
06/30/2029	Limited Data Set available for 2027 Survey File.
09/15/2029	Limited Data Set available for 2028 Survey File - Early Release.
10/15/2029	Limited Data Set available for 2027 Cost Supplement File.
10/15/2029	Survey File Microdata Public Use File for 2027 data.
01/31/2030	Cost Supplement File Microdata Public Use File for 2027 data.

06/30/2030	Limited Data Set available for 2028 Survey File.
09/15/2030	Limited Data Set available for 2029 Survey File - Early Release.
10/15/2030	Limited Data Set available for 2028 Cost Supplement File.
10/15/2030	Survey File Microdata Public Use File for 2028 data.
01/31/2031	Cost Supplement File Microdata Public Use File for 2028 data.
06/30/2031	Limited Data Set available for 2029 Survey File.
09/15/2031	Limited Data Set available for 2030 Survey File - Early Release.
10/15/2031	Limited Data Set available for 2029 Cost Supplement File.
10/15/2031	Survey File Microdata Public Use File for 2029 data.
01/31/2032	Cost Supplement File Microdata Public Use File for 2029 data.

The Survey File contains data collected directly from respondents and supplemented by administrative items plus facility (non-cost) information and Medicare Fee-for-Service claims. The Survey File - Early Release contains timely data on a subset of key topics released on the Survey File collected from respondents living in the community during the fall round. The Cost Supplement File contains both individual event and summary files and can be linked to the Survey File to conduct analyses on health care cost and utilization. The Survey File Microdata Public Use File (PUF) includes data on topics such as Medicare beneficiaries' access to care, health status, other information regarding beneficiaries' knowledge of, attitudes toward, and satisfaction with their health care, as well as demographic data and information on all types of health insurance coverage. The Cost Supplement File Microdata PUF includes data that links Medicare claims to survey-reported health care events and provides summarized expenditure and source of payment data on all health care services, including those not covered by Medicare. Disclosure protections have been applied to the Microdata PUFs, including de-identification and other methods. CMS posts the Microdata PUFs online at CMS MCBS Public Use File.

A series of policy-relevant MCBS PUF table packages and early PUF table packages are issued using MCBS Limited Data Set data by CMS each year. These products present estimates on various topics of interest, such as beneficiaries' financial well-being, telemedicine, usual source of care, internet access, diabetes prevalence and self-management, preventive care, oral health, chronic pain, and mental health as well as for key subpopulations, such as dually eligible beneficiaries, beneficiaries living in metropolitan versus non-metropolitan areas, and differences across beneficiaries by age and sex. CMS posts these products online at CMS MCBS Data Tables as well as accompanying infographics at CMS MCBS Data Briefs.

A17. Display of OMB Expiration Date

The OMB expiration date is displayed on the hardcopy respondent materials, including advance mail materials. It is also displayed on the MCBS website. When conducting in person interviews, the OMB expiration date is displayed in the CAPI instrument on the first screen (introductory script and consent) and on the last screen (thank you script), as displayed in Attachment 6. There is no hard copy questionnaire or document to display the OMB expiration date.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to this certification statement.