

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

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Background

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 150 million people across the Medicare, Medicaid, CHIP, and Health Insurance Marketplace populations¹. 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 of its programs. CMS also aims to empower patients by giving them greater control over their health care information and improve 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 other CMS operations. For example, 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. In addition, information on beneficiary insurance coverage and payments from non-Medicare sources (including beneficiary out-of-pocket spending) are collected by surveying beneficiaries because these data are not available to CMS from administrative sources. 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 is a multimode survey. 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.

The MCBS has been continuously fielded since 1991, encompassing over 1.2 million interviews with more than 140,000 sampled beneficiaries. 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.

¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights>

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, charges, insurance coverage, and payments over time. 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:

- 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 has been at the forefront of in-person (and now multimode) 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;
- develop and implement more efficient, cost-effective, accurate, and innovative sampling and data collection strategies;
- increase response rates, understand and address non-response bias, and minimize burden;
- 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 for revision to the MCBS's current OMB clearance (OMB No. 0938-0568, Expiration Date 8/31/2027). The purpose of this revision is to seek approval for CMS to add new items on sleep apnea, thyroid disease, and bowel disease, remove content that is no longer relevant to the goals of the survey, and update existing content to better meet the policy needs of CMS and stakeholders. To ensure the sustainability of the survey and to maintain a reasonable level of respondent burden, it is necessary to routinely review MCBS survey content and remove items that are no longer as relevant to the policy landscape or which are no longer performing well. The requested deletions are a result of a content reduction process that CMS developed in 2024 and is currently using to review MCBS survey content in the Community and Facility instruments. The goals of this process are three-fold: 1) to promote efficiency by streamlining the questionnaire and reducing respondent burden; 2) to continuously assess utility of information collected by the MCBS and remove questions that are no longer relevant, and 3) to maintain the production of high-quality data by removing content that is no longer performing well. For this full clearance revision, CMS has used the content reduction process to identify items that a) are low performing due to difficulty of administration or data quality issues, b) are no longer needed at the same frequency of administration, c) require updated question text or response options, or d) no longer match the existing healthcare landscape or require further evaluation.

The three new items will be added to the Health Status and Functioning Questionnaire (HFQ) to measure the prevalence of sleep apnea, thyroid disease, and bowel disease, respectively.

The requested deletions and revisions include:

- Streamlining the four-item arthritis series to two items, removing three items related to knowledge of colorectal cancer screening tests, and streamlining the collection of information about activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the Health Status and Functioning Questionnaire (HFQ).
- Removing eleven items that collect follow-up detail about different types of health insurance plans in the Health Insurance Questionnaire (HIQ) to reduce respondent burden.
- Removing nine items about Medicare program knowledge, internet use, comparison of Medicare plans, and knowledge of the Inflation Reduction Act (IRA) of 2022 in the Beneficiary Knowledge and Information Needs Questionnaire (KNQ) that are either redundant with other survey content, do not perform well, or are no longer relevant.
- Removing the Physical Measures Questionnaire (PXQ) to reduce respondent burden.
- Streamlining the Satisfaction with Care Questionnaire (SCQ) by removing three redundant items and changing the administration schedule for 14 items to reduce respondent burden.
- Removing 72 items from the Usual Source of Care Questionnaire (USQ) due to difficulty of administration, low number of affirmative responses, and decreased relevance.

CMS has also identified operational updates that will improve efficiency, including:

- Consolidating all immunization measures into one section of the Community questionnaire, the Immunization Questionnaire (IMQ), and deleting immunization site and select COVID-19 items.
- Grouping all immunization measures into the Health Status (HS) section of the Facility instrument, aligning immunization measures with the Long-Term Care Minimum Data Set (MDS), and deleting select COVID-19 items.

CMS plans to continue to review additional questionnaire sections and identify items for removal or improvement in future revision requests.

In addition to survey content changes and in response to requests from CMS and non-CMS stakeholders, CMS plans to update sampling plans for the MCBS. Without increasing survey costs or reducing sample, CMS will implement a national design in Fall 2026 Round 106 that for the first time expands MCBS data collection to all 50 states and the District of Columbia, enabling production of state-level estimates and expanding analytic utility of MCBS data. Each Fall Incoming Panel will be selected using the redesigned approach, taking four years (through 2029) until all panel members have been selected under the new design. Telephone interviewing will continue to be the primary data collection method supplemented with limited video interviewing or in-person visits. This change is described in detail in Supporting Statement B.

CMS also continues to align the MCBS with federal standards and guidelines that impact survey data collection as well as executive orders that impact federally funded research. A non-substantive change request, approved on April 17, 2025, updated the MCBS Community Questionnaire to align with Executive Order (EO) 14168 *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*. In Fall 2027 Round 109, CMS plans to update measures of race and ethnicity in the Community and Facility instruments to align with the updated Statistical Policy Directive No. 15 released by OMB on March 28, 2024². Agency action plans due in September 2025 will inform CMS' plans for implementing this revision on the MCBS in Fall 2027 Round 109.

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.

² <https://spd15revision.gov/>

c. Section 1875 of the Social Security Act (42 United States Code 1395ll³).

The MCBS supports CMS' program evaluation and legislative mandate compliance by providing data to determine expenditures and sources of payment for all services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to trace processes over time, such as changes in health status and "spending down" to Medicaid eligibility and the impacts of program changes, satisfaction with care, and usual source of care. These unique design features of the MCBS enable it to support a variety of CMS functional areas. For example, the MCBS is used by CMS to assess the potential number of beneficiaries eligible for proposed new care and payment models, their utilization and patterns of usual care, and the factors that help determine when and where beneficiaries seek care. In addition, the MCBS panel design provides essential longitudinal data to measure change over time. Last, a unique feature of the MCBS – the capacity to follow individuals from the community into and out of nursing facilities and hospitals – provides critical data including information on characteristics of the institutionalized population, total cost of episodes of illness, level and type of system interventions including home health care, as well as the care transitions that occur across the various care providers.

A2. Purpose and Use of Information Collection

The MCBS continues to provide unique insight into the Medicare program and helps both CMS and external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. MCBS data are used to assess potential changes to the Medicare program. For example, MCBS data were instrumental in supporting the initial implementation of the Medicare prescription drug benefit and continue providing a means to evaluate prescription drug costs and out-of-pocket burden to Medicare beneficiaries.

Moving forward, the MCBS will continue to play a critical role in aiding policymakers in administering, monitoring and evaluating the Medicare program, with an emphasis on supporting CMS efforts to test innovative payment and service delivery models' ability to reduce costs and improve quality. For example, the longitudinal and comprehensive nature of the MCBS provides the opportunity for both pre/post and observational studies (with a control and comparison group) for beneficiaries involved with CMS models or other CMS programs. Other areas that can only be captured by using survey data along with the CMS administrative data include changes to beneficiaries' financial well-being in relation to Medicaid eligibility requirements, changes to cost sharing and premiums, and the use and knowledge of existing and new Medicare-covered preventive services.

MCBS data will continue to be used by CMS to assess the impact of major policy innovations and health care reform on Medicare beneficiaries (pre- and post-implementation). MCBS data users continue to monitor delivery of services, sources of payment for Medicare covered and non-covered services, beneficiary cost sharing and financial protection, satisfaction with and access to health care services, and integration of patient care. Researchers can relate the dynamics of future aging patterns to age-specific rates of use of health care services. MCBS data also allow accurate measurement of total health care expenditures for beneficiaries and changes

³ <https://www.hhs.gov/foia/privacy/sorns/09700519/index.html>

in private health insurance benefits (including long-term care insurance). The capacity to follow individuals into and out of nursing facilities and hospitals provides researchers the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care.

Researchers can assess the aggregate cost of short stays and long stays in nursing homes, and of combined hospital/nursing home stays. In addition, the MCBS data can be used to forecast the need and settings for selected chronic condition care and long-term care services by examining trends in the use of health care services, linked with morbidity, disability, and mortality data.

The comprehensive nature of the MCBS makes its data appealing to a broad spectrum of users. In addition to CMS use, the MCBS consistently provides value and unique data to external users, as demonstrated by more than 4,500 research articles and citations using the MCBS to date, over 250 MCBS Limited Data Set (LDS) files purchased and shipped to researchers each year, and over 150 MCBS Microdata Public Use File (PUF) downloads per month. MCBS survey data are also vital in the production of highly regarded publications, including CMS' Annual Trustees Report, the Medicare Payment Advisory Commission'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."

- **Within CMS.** Survey results have been and will continue to be used by various components within CMS. CMS has frequently used the data collected by the MCBS for a variety of purposes, including 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 also uses the MCBS to benchmark to other federal surveys, where appropriate, and uses the information to produce estimates of health care utilization, costs, and well-being for various populations.

The MCBS is used by the CMS Office of the Actuary to track trends in out-of-pocket spending and monitor Medicare supplemental insurance (Medigap). It is also a major source of information for the annual Trustees' Report.

MCBS data are also used by the CMS Office of Communications to track beneficiary's knowledge and sources of information 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.

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. The bibliography is available at [CMS MCBS Bibliography](#).

- **Other Governmental / quasi-governmental, outside CMS.** Data from the MCBS support multiple important functions across government and research organizations. The Congressional Budget Office uses MCBS data to develop budget options and estimate how many beneficiaries may be affected by policy changes. The Medicare Payment Advisory Commission (MedPAC) relies heavily on the MCBS as a primary information source to monitor healthcare 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 healthcare innovation and analysis utilize MCBS data in their research and policy development efforts.

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. Topics of other research found in bibliographies of MCBS data 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](#).

Requested Revisions to Currently Approved Collection:

This is a request to revise the existing MCBS clearance beginning in 2026, which will extend the collection for an additional three years as a result. This revised clearance request includes net burden deletions to the Community and Facility instruments stemming from CMS' review of MCBS survey content via a content reduction process. Changes to the MCBS sample design described in Supporting Statement, Part B will not impact respondent burden.

When implemented, the revision to this OMB package will result in a **net decrease** in respondent burden as compared to the current clearance. While the planned content additions are expected to **add 0.8 minutes to the Community questionnaire** each year starting in Fall 2026, the planned content removals and revisions are expected to **reduce the Community questionnaire by 19.4 minutes** annually. This includes a decrease of 5.7 minutes from the Fall round⁴, 12.2 minutes from the Winter round, and 1.2 minutes in the Summer round due to item deletions and revisions. The planned changes will also **reduce the Facility instrument by 0.25 minutes each year** starting in Winter 2027; this change is comprised of a decrease of 0.25 minutes from the Winter round due to content deletions.

The current OMB clearance projects an annual respondent burden of 35,206 hours. This revision to the clearance **reduces the annual respondent burden by 2,948 hours**, bringing the total annual respondent burden to 32,258 hours. The changes in estimated annual respondent burden

⁴ This represents the amount reduced in the Continuing Fall round survey. The net decrease for the Baseline interview will be 2.7 minutes.

are summarized in Table B-12 (under section A12 below). All these changes are described below and are referred to in Supporting Statement, Part B as well.

Changes that will **increase** respondent burden are summarized in Table A-1 below by questionnaire section and administration schedule.

Table A-1: Summary of New Items by Questionnaire Section and Administration Schedule

| Content Area | # of Items Added | Questionnaire Section | Administration Schedule |
|-----------------|------------------|-------------------------------------|-------------------------|
| Sleep Apnea | 1 | Health Status and Functioning (HFQ) | Annually, Fall Round |
| Thyroid Disease | 1 | Health Status and Functioning (HFQ) | Annually, Fall Round |
| Bowel Disease | 1 | Health Status and Functioning (HFQ) | Annually, Fall Round |

These changes include:

- **Adding three new items on sleep apnea, thyroid disease, and bowel disease in the Health Status and Functioning Questionnaire (HFQ).** The MCBS collects extensive information on the prevalence of chronic conditions to provide a comprehensive view of Medicare beneficiary health status. Unlike administrative data, which only capture conditions when beneficiaries have healthcare contact, the MCBS is administered to beneficiaries regardless of care-seeking behavior, thereby providing robust self-report measures. This information is then used to derive a '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. To enhance this measure's completeness and policy relevance, MCBS is adding three items to measure high-impact chronic conditions that disproportionately affect Medicare beneficiaries:
 - ***One item on the prevalence of sleep apnea***, as most Americans over the age of 40 experience some degree of sleep apnea, and the risk of developing sleep apnea increases with age.⁵
 - ***One item on the prevalence of thyroid disease***, which affects 5-10% of US adults, and the prevalence increases with age.⁶

⁵ [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(16\)00006-0/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(16)00006-0/fulltext)

⁶ <https://www.sciencedirect.com/science/article/pii/S1530891X23005281>

- **One item on the prevalence of bowel disease**, which affects a substantial percentage of older Americans, with Irritable Bowel Syndrome (IBS) alone affecting 10-20% of older Americans.⁷

The addition of these three items will provide a more accurate health status assessment and better inform coverage decisions, as demonstrated by recent CBO analysis of anti-obesity medication coverage⁸ that relied heavily on MCBS chronic conditions data. As CMS continues to expand coverage for chronic disease management and preventive services, comprehensive data on these conditions will inform evidence-based policy decisions. These changes will add a total of 0.8 minutes to the Fall round Baseline and Continuing interviews.

Changes that will **decrease** respondent burden are summarized in Table A-2 below by questionnaire section and administration schedule. 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 item administration schedule.

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

| Content Area | # of Items Removed | # of Items Revised | Questionnaire Section | Administration Schedule |
|---|--------------------|--------------------|--|---|
| Revise Arthritis Series, Reduce Colorectal Cancer, IADLs and ADLs | 66 | 16 | Health Status and Functioning (HFQ) | Annually, Fall Round |
| Streamline and Reduce Satisfaction with Care Items | 3 | 14 | Satisfaction with Care Questionnaire (SCQ) | Annually, Fall Round |
| Reduce Health Insurance Plan Details | 11 | - | Health Insurance Questionnaire (HQ) | Annually, Winter, Summer, and Fall Rounds |

⁷ <https://www.tandfonline.com/doi/full/10.2147/CLEP.S40245>

⁸ <https://www.cbo.gov/publication/60816>

| Content Area | # of Items Removed | # of Items Revised | Questionnaire Section | Administration Schedule |
|---|--------------------|--------------------|---|-------------------------|
| Reduce Medicare Program and Internet Use and Remove Inflation Reduction Act Knowledge | 9 | - | Beneficiary Knowledge and Information Needs Questionnaire (KNQ) | Annually, Winter Round |
| Reduce Usual Source of Care Items | 72 | 16 | Usual Source of Care Questionnaire (USQ) | Annually, Winter Round |
| Remove Physical Measures Collection | 48 | - | Physical Measures Questionnaire (PXQ) | Annually, Summer Round |

These changes include:

- **Streamlining three series in the Health Status and Functioning Questionnaire (HFQ).**
As part of the content reduction process, CMS identified three series within the HFQ that will be streamlined to reduce respondent burden while maintaining policy relevance:
 - ***Revise the arthritis series in the Health Status and Functioning Questionnaire (HFQ):*** Currently, the arthritis series asks beneficiaries to identify specific arthritis types (rheumatoid, osteoarthritis, and other arthritis) in separate questions, which creates difficulties for beneficiaries who have been diagnosed with arthritis but are uncertain about the specific type. The revised question structure employs a two-step approach: first asking beneficiaries if they have been diagnosed with arthritis (any type), then asking about the specific type. This modification provides several critical data quality improvements, including reducing misclassification between rheumatoid and osteoarthritis, providing more accurate overall arthritis prevalence estimates by capturing all diagnosed cases regardless of beneficiary knowledge about subtypes, and enhancing analytical utility by distinguishing between "unknown arthritis type" and "no arthritis diagnosis."

Accurate prevalence data are essential for CMS policy development and will inform coverage decisions for arthritis treatments, physical therapy services, and disease management programs. Additionally, this revision reduces respondent burden by minimizing the need for beneficiaries to make uncertain distinctions between arthritis types while still capturing valuable diagnostic information when known, ultimately improving the accuracy and utility of MCBS arthritis data for policy analysis and program planning.

- ***Remove three knowledge items in the colorectal cancer series:*** To reduce burden, three separate questions asking if the respondent has ever heard of 1) colorectal or colon cancer, 2) the fecal occult blood test, or 3) sigmoidoscopy or colonoscopy, will be removed and, as a result, two additional items will be revised to include new introductory text.
- ***Streamline collection of information related to instrumental activities of daily living (IADL) and activities of daily living (ADL):*** Currently, if a respondent indicates that they require help completing IADLs (such as using the telephone or doing housework) or ADLs (such as bathing, dressing, or using the toilet), the Community questionnaire collects the first and last name of this helper and their specific relationship to the respondent (e.g., child, spouse, etc.). CMS has determined that collection of helper information at this level of detail is burdensome to respondents and has limited analytic utility. Collecting the basic category of relationship to the respondent provides valuable information for use in analytic products while balancing the need to provide a more streamlined questionnaire for respondents. Starting in Fall 2026 Round 106, 12 items in the HFQ will be revised such that rather than collecting the detailed information for each individual who provides help with IADLs and ADLs, the questionnaire will ask for respondents to select whether the helper(s) fits into one of six categories: 1) Spouse, 2) Child, 3) Other Family member, 4) Friend, 5) Home health aide or home care worker, or 6) Homemaker or house cleaner. This results in deletion of 49 items that previously captured helpers' first and last names and specific relationship to the respondent.

In addition, 12 detailed follow up questions with a low number of affirmative responses, and therefore limited analytic utility, will be removed from the ADLs series to reduce respondent burden. The questionnaire will no longer ask 1) if someone stands close by while the respondent is performing the activity or 2) for how long they have needed help with the activity. Together, these changes will result in a reduction of 1.5 minutes for the Fall round Baseline and Continuing interviews.

- ***Streamlining the Satisfaction with Care Questionnaire (SCQ).*** The Satisfaction with Care Questionnaire (SCQ) is administered annually during the Fall round Baseline and Continuing interviews and collects important information on the quality of patient experience, health seeking behaviors, and patient activation. During CMS' review of this section, CMS identified several items either to remove or collect on a less frequent administration schedule:
 - ***Remove three redundant items:*** One item regarding satisfaction with information about health issues and two items regarding health care avoidance will be removed as they are duplicative with other questions asked in this section.
 - ***Change administration schedule for 14 items to reduce respondent burden:*** To reduce burden, 14 items that were previously asked once a year will now be asked only once, in the Fall round Baseline interview. These items collect important information on respondent attitudes and behavior but do not require annual fielding.

Together, these changes will result in a reduction of 1 minute to the Fall round Baseline interview and 4 minutes to the Fall round Continuing interview.

- **Removing items that are no longer relevant in the Health Insurance Questionnaire (HIQ).** In Winter 2023, CMS made several updates to improve the Health Insurance Questionnaire (HIQ), including aligning the collection of health insurance information across six different plan types and reducing respondent burden by discontinuing collection of detailed information about exact start and end dates for health insurance coverage. While reviewing the recently improved HIQ, CMS identified several additional items that are no longer relevant. In the 2026 survey year, the following detailed items will be removed from the Community questionnaire:
 - One item asking respondents with Medicaid if their plan covers prescribed medicines.
 - Two items for three different health insurance plan pathways, capturing the reason why a beneficiary disenrolled from their health insurance plans.
 - One item capturing whether a plan is offered through a Health Insurance Marketplace.
 - Two items capturing where beneficiaries enrolled in Tricare obtain medications.
 - One item capturing whether beneficiaries receive health care, health services, or prescribed medicines at a TRICARE Military Treatment Facility (MTF).

Together, these changes will result in a reduction of 0.3 minutes in the Winter, Summer, and Fall round Continuing interviews, respectively. Changes to the Fall round Baseline interview are expected to be negligible given the small number of respondents who receive these detailed items.

- **Removing items that are no longer relevant in the Beneficiary Knowledge and Information Needs Questionnaire (KNQ).** The KNQ is an important topical section in the Community questionnaire, which provides the CMS Office of Communications and other stakeholders with information about beneficiary knowledge of the Medicare program and beneficiary access to Medicare program resources and reference materials. Through a recent review of the KNQ, CMS identified several items that are either redundant or no longer relevant. Starting in Winter 2027, the following items will be removed from the Community questionnaire:
 - Two redundant items related to interest in receiving information about the Medicare program and satisfaction with availability of information about the Medicare program.
 - One redundant item related to use of the internet.
 - One item about the types of Medicare plans compared during the most recent Open Enrollment period. Field interviewers regularly flagged this item as difficult to administer and frustrating to respondents.
 - Five items about beneficiary knowledge of provisions from the Inflation Reduction Act (IRA) of 2022.

Other important items related to Medicare program knowledge, access to and use of the internet for obtaining health information, experiences with open enrollment and cost

transparency will be retained for use by CMS and key stakeholders. Together, these changes will result in a reduction of 3 minutes to the Winter round interview.

- **Removing items with low analytic utility from the Usual Source of Care Questionnaire (USQ).** The Usual Source of Care Questionnaire (USQ) 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. Respondents without a usual provider or clinic receive a short series of follow-up questions to determine reasons for not having a usual source of care. Respondents who report having a usual source of care receive follow-up questions related to travel time and distance from their usual provider, whether they are accompanied to appointments and if so by whom, experiences with care from their usual provider, visits to specialists and hospitalizations, care coordination, and availability of test results. CMS reviewed the USQ and identified a total of 72 items that could be removed starting in Winter 2027 Round 107, due to low item utility. These include the removal of:
 - Six items related to details about the usual source of care, including provider name and sex, which are no longer needed for operational purposes.
 - Five items related to health care experiences and health care communication of beneficiaries with limited English proficiency due to limited affirmative response and concerns about low analytic utility.
 - Two items about transportation methods to the beneficiary's usual source of care due to limited response variation and concerns about low analytic utility.
 - Five items that collect detailed information about companions accompanying the beneficiary to health care appointments. Detailed information including first and last name and relationship to the beneficiary were removed and replaced with a categorical item.
 - Fifty-four items related to experiences with care, specialists, hospitalization, availability of test results, and electronic health records. Field interviewers regularly flagged these items as being difficult to administer and frustrating to respondents who found them repetitive and often asked the questions to be read multiple times.

In addition, response options for two items will be revised to collect less detailed information about provider specialty and accompaniment to appointments and text fills for 14 items will be revised to refer to the beneficiary's usual source of care more generally as opposed to by name. Together, these changes will result in a reduction of 7.5 minutes from the Winter round interview.

- **Removing the Physical Measures Questionnaire (PXQ).** In early 2022, CMS began the collection of four physical measures to assess physical functioning and frailty, including gait speed, balance test, chair stand, and grip strength. Due to in-person interviewing restrictions because of the COVID-19 pandemic, collection of these physical measures was limited. Now that the majority of MCBS interviews are conducted via phone, there is limited opportunity to continue physical measures collection. Further, for the small number of cases completed in-person, these measures pose a high level of respondent burden. CMS plans to remove this section from the Community questionnaire permanently as of Summer 2027 Round 108. While the PXQ typically took 10 minutes to administer, given that it was fielded to only

about 10% of cases, this change will result in a net reduction of 1 minute in the summer round interview.

Changes that will **improve operational efficiency** include:

- **Consolidating and streamlining immunization items in the Immunization Questionnaire (IMQ).** In Winter 2025, CMS introduced the IMQ to standardize the collection of most vaccine data in the MCBS Community questionnaire. In Winter 2027, the migration of remaining immunization items into IMQ will be complete such that vaccine collection is consolidated into a single MCBS survey section. Further, some vaccine details will be removed as they are no longer relevant. The changes are described below.
 - *Migrate the existing flu and COVID-19 vaccination items from the Preventive Care Questionnaire (PVQ) and COVID-19 Questionnaire (CVQ), respectively, into the IMQ.* To consolidate the collection of vaccination data, all relevant items found in PVQ and CVQ will be placed in one section, IMQ. This section will be administered in the Winter round (and for some measures, in the Summer round, only to Winter non-respondents). These changes will result in a reduction of 1 minute to the Winter round Community interview.
 - *Remove vaccination site follow up questions.* Beneficiaries were asked where they received their vaccination (pharmacy, doctor's office, etc.). This information is no longer needed and these items will be removed from the MCBS beginning in Winter 2027. This change will result in a reduction of 0.5 minutes to the IMQ administration time in the Winter round.
- **Consolidating and streamlining immunization items in the Health Status (HS) section of the Facility Instrument.** CMS will remove the COVID-19 Beneficiary (CV) section in Winter 2027. One item on COVID-19 vaccination will be retained and migrated to the HS section to be administered alongside existing items about flu and pneumonia vaccination. To promote further efficiency, this remaining item will be revised to align with the Long-Term Care Minimum Data Set's (MDS) item on COVID-19 vaccination status⁹. This revised item will only be administered to approximately 50% of Facility cases where the beneficiary is residing a non-CMS-certified facility. For the remaining approximately 50% of cases where the beneficiary is residing in a CMS-certified facility, and for which a valid CMS Certification Number (CCN) is reported, this item will be skipped altogether along with other eligible items in the HS section. This change will result in a reduction of 0.25 minutes in the Winter round Facility interview.

Table A-3 summarizes the new content requested to be added to the Community instrument and their associated effect on burden (minutes).

⁹ <https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>

Table A-3: Increased Burden Associated with New Content Revisions to the Community Instrument

| Community | Section | Fall 2026 Round 106 | Winter 2027 Round 107 | Summer 2027 Round 108 | Total |
|---------------------------------|---------|---------------------|-----------------------|-----------------------|--------------------|
| Add New Item on Sleep Apnea | HFQ | 0.2 minutes | 0 minutes | 0 minutes | 0.2 minutes |
| Add New Item on Thyroid Disease | HFQ | 0.3 minutes | 0 minutes | 0 minutes | 0.3 minutes |
| Add New Item on Bowel Disease | HFQ | 0.3 minutes | 0 minutes | 0 minutes | 0.3 minutes |
| Total Minutes Added | | 0.8 minutes | 0 minutes | 0 minutes | 0.8 minutes |

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-5 summarizes the decrease in burden associated with consolidating and streamlining content in the Facility instrument.

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

| Community | Section | Fall 2026 Round 106 | Winter 2027 Round 107 | Summer 2027 Round 108 | Total |
|---|----------|----------------------|-----------------------|-----------------------|---------------------|
| Revise Arthritis Series, Remove Colorectal Cancer Screening Knowledge Items and Streamline IADL/ADL Items | HFQ | 1.5 minutes | 0 minutes | 0 minutes | 1.5 minutes |
| Streamline and Reduce Satisfaction with Care Items | SCQ | 4 minutes* | 0 minutes | 0 minutes | 4 minutes |
| Remove Health Insurance Plan Details | HIQ | 0.3 minutes | 0.3 minutes | 0.3 minutes | 0.9 minutes |
| Remove Medicare Knowledge, IRA Knowledge, and Internet Use Items | KNQ | 0 minutes | 3 minutes | 0 minutes | 3 minutes |
| Consolidate and Streamline Immunization Items | IMQ, CVQ | 0 minutes | 1.5 minutes | 0 minutes | 1.5 minutes |
| Remove Usual Source of Care Items | USQ | 0 minutes | 7.5 minutes | 0 minutes | 7.5 minutes |
| Remove Physical Measures Collection | PXQ | 0 minutes | 0 minutes | 1 minute | 1 minute |
| Total Minutes Deleted | | 5.8 minutes** | 12.3 minutes | 1.3 minutes | 19.4 minutes |

*The revised administration schedule for 14 items in the SCQ will yield a reduction of 1 minute for the Fall round Baseline interview and 4 minutes for the Fall round Continuing interview.

**This represents the amount reduced in the Continuing Fall round survey. The net decrease for the Baseline interview will be 2.7 minutes.

Table A-5: Decreased Burden Associated with Changes in the Facility Instrument

| Facility | Section | Fall 2026 Round 106 | Winter 2027 Round 107 | Winter 2028 Round 108 | Total |
|--|-----------|------------------------|--------------------------|--------------------------|---------------------|
| Remove and streamline COVID-19 Items | CV, HS | 0 minutes | 0.25 minutes | 0 minutes | 0.25 minutes |
| Net Annual Effect Decrease in Facility Burden | | 0 minutes | 0.25 minutes | 0 minutes | 0.25 minutes |

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 reexamined 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 survey¹⁰. 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

¹⁰ HHS Data Council Co-Chairs memorandum to the Secretary of the Department of Health and Human Services, May 11, 2016

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.

A6. Consequences of Collecting the Information Less Frequently

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.

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).

In addition, the MCBS administers some sections only once per panel or once a year which allows for 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 July 14, 2025 (90 FR 31207). Three comments were received opposing the removal of questions on gender identity and perceived discrimination by health care providers. CMS appreciates the concerns of the commentors. The items were approved for removal from the survey in April 2025, in anticipation of the Fall 2025 data collection round. These changes were made to comply with Executive Order (E.O.) 14168 *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*.

CMS also values the commentors' analysis of items regarding perceived discrimination by health care providers. CMS agrees that information on self-reported topics, such as perceived discrimination, can provide an opportunity to monitor important health care experiences. Where possible, CMS adds self-reported items to the MCBS Community questionnaire to align with relevant areas or emerging topics of growing interest. CMS routinely reviews MCBS survey content and removes items to ensure the survey's sustainability and to maintain a reasonable level of respondent burden. In reviewing responses to perceived discrimination items which were administered for the first time in Fall 2023 and subsequently included in Fall 2024, CMS noted low levels of endorsement of perceived discrimination (3% or less for any category) and minimal variation across survey years. These results suggest that a longitudinal general health survey may not be the most effective method for obtaining information on such a nuanced topic. Retaining these items in the survey long-term would not be cost-effective given the low variation in response observed across survey rounds. For these reasons, CMS plans to uphold the removal of these items at this time, with a plan to conduct further evaluation in the future to determine if alternative item versions or an alternative item cadence may be more effective.

One of the three commentors, Justice in Aging, also opposed the proposal to 1) remove a subset of items related to instrumental activities of daily living (IADL) and activities of daily living (ADL), and 2) remove items with low analytic utility from the Usual Source of Care Questionnaire (USQ), including items on limited English proficiency (LEP) and transportation. Of the items highlighted by the commentor, several were proposed for removal from the survey due to limited response variation. Items about transportation to healthcare visits and LEP from the USQ as well as items about perceived discrimination by health care providers had limited affirmative responses, raising concerns about the analytic utility of these data as well as the burden and cost associated with administering them annually via a longitudinal survey. In reviewing the commentor's thoughtful justification on the importance of questions about IADLs and ADLs, CMS agrees that it would be helpful to retain additional detail about the type of family member providing help. CMS has updated the helper code list at ADL and IADL items in HFQ in this package to delineate between potential caregivers, including: 1) Spouse, 2) Child, 3) Other Family Member, 4) Friend, 5) Home Health Aide or Home Care Worker, or 6) Homemaker or House Cleaner.

Finally, one of the three commentors provided support for state-level data. CMS appreciates the commentor's support and plans to implement a national design in Fall 2026 Round 106 that for the first time expands MCBS data collection to all 50 states and the District of Columbia, enabling production of state-level estimates and expanding analytic utility of MCBS data. As described in Supporting Statement B, each Fall Incoming Panel will be selected using the redesigned approach, taking four years (through 2029) until all panel members have been selected under the new design.

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](https://www.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 November XX, 2025 (XX FR XXXXX).

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. In fielding the Community questionnaire Income and Assets module, an additional handout (Attachment 1) is provided explaining its purpose and restating the Privacy Act.

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.”

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 Fall 2026

| Community Rounds 106-114 | Time Per Response | Number of Interviews | Expected Number of Completed Interviews Per Round | Burden Hours |
|--|--------------------------|-----------------------------|--|---------------------|
| Fall 2026 Round 106 Baseline Interview | 64.1 minutes | 1 | 5,766 | 6,160 |
| Fall 2026 Round 106 Continuing Interview | 70.2 minutes | 1 | 6,852 | 8,017 |
| Winter 2027 Round 107 Continuing Interview | 50.5 minutes | 1 | 10,619 | 8,938 |
| Summer 2027 Round 108 Continuing Interview | 60.3 minutes | 1 | 7,880 | 7,915 |
| FM Follow-up with 5% of Completed Interviews | 5 minutes | 1 | 1556 | 130 |

| Facility Rounds 106-114 | Time Per Response | Number of Interviews | Expected Number of Completed Interviews Per Round | Burden Hours |
|---|--------------------------|-----------------------------|--|---------------------|
| Fall 2026 Round 106 Baseline Interview | 42.0 | 1 | 209 | 146 |
| Fall 2026 Round 106 Continuing Interview | 40.5 | 1 | 249 | 168 |
| Fall 2026 Round 106 Baseline Interview—Admin Data | 30.2 | 1 | 225 | 113 |
| Fall 2026 Round 106 Continuing Interview—Admin Data | 38.0 | 1 | 267 | 169 |
| Winter 2027 Round 107 Continuing Interview | 21.6 | 1 | 799 | 288 |
| Summer 2027 Round 108 Continuing Interview | 21.7 | 1 | 593 | 214 |

| Rounds 106-114 | Expected Number of Completed Interviews Per Round | Burden Hours |
|--|--|---------------------|
| Total Expected Number of Completed Interviews Annually | 35,015 | |
| Total Annual Burden Hours | | 32,258 |
| Total Estimated Burden Hours – Rounds 106-114 (3 Years) | | 96,775 |

Below provides a summary of the annual burden change from the current clearance, reflecting the net decreased burden of removing 209 items and revising 46 items.

| | |
|--|--------------|
| Total annual burden hours – current 2025 clearance | 35,206 |
| Total annual burden hours – revised 2026 clearance | 32,258 |
| Total annual burden hours – difference | 2,948 |

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 2025¹¹) and multiplied it to the Total Annual Hours for Rounds 106-108 (32,258), for a Total Annual Cost Burden in terms of dollars of \$233,870.50

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 4 (May 1, 2025-April 30, 2026): Survey development, operations, processing and analysis: \$22,000,000.¹²

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

CMS personnel involved in MCBS include approximately 9 FTEs broken out by paygrade or paygrade range in Table B-14.

¹¹ <https://www.dol.gov/general/topic/wages/minimumwage>

¹² Future awards are based on execution of option years and funding availability.

Table B-14: CMS Personnel

| Grade | FTE | 2025 Annual Salary | Cost to Government ¹³ |
|-------------|-----|--------------------|----------------------------------|
| GS13 step 5 | 4.0 | \$136,658 | \$546,632 |
| GS14 step 5 | 4.0 | \$161,486 | \$645,944 |
| GS15 step 5 | 1.0 | \$189,950 | \$189,950 |
| | | | Total: \$1,382,526 |

CMS staff costs are approximately \$1,382,526. The MCBS releases its documentation as downloadable files on its public website thus eliminating its printing budget. Thus, in-house CMS cost will be \$1,382,526.

A15. Explanation for Burden Changes (Program Adjustments)

This revision includes the addition of three items that result in a burden increase of 0.8 minutes annually. However, the deletion of 209 items and the revision of 46 items result in a burden decrease of 19.4 minutes from the Community questionnaire each year and 0.25 minutes from the Facility instrument each year, thereby offsetting the content additions. Specifically, as noted earlier, the following changes are requested:

Changes that will **increase** respondent burden in the Community questionnaire:

- 0.8 minutes of burden will be added each Fall round beginning in Fall 2026 due to the addition of three items related to prevalence of sleep apnea, thyroid disease, and bowel disease.

Changes that will **decrease** respondent burden in the Community questionnaire:

- 5.8 minutes of burden will be removed each Fall round beginning in Fall 2026 due to the removal of items related to colorectal cancer screening knowledge and streamlining of items about arthritis and IADLs/ADLs in the HFQ, streamlining of satisfaction with care items in the SCQ, and removal of health insurance plan details in the HIQ¹⁴.
- 12.3 minutes of burden will be removed each Winter round starting in Winter 2027 due to the removal of health insurance plan details from the HIQ, removal of Medicare and IRA knowledge items and internet use items from the KNQ, consolidation and streamlining of immunization content, and removal of usual source of care items from the USQ.
- 1.3 minutes of burden will be removed each Summer round starting in Summer 2027 due to the removal of health insurance plan details and removal of physical measures data collection.

Changes that will **decrease** respondent burden in the Facility instrument:

¹³ <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf>

¹⁴ A total of 2.7 minutes of burden will be removed from the Baseline interview each Fall round beginning in Fall 2026 due to differences in administration schedule of some revised SCQ items.

- 0.25 minutes of burden will be removed from the Facility instrument each Winter round starting in Winter 2027 due to the reduction of COVID-19 content and consolidation of immunization items.

Net impact to respondent burden:

- As a result, the total burden has decreased from 35,206 in the currently approved clearance to 32,258. This is a net decrease of 2,948 burden hours annually.

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 106 (Fall 2026) through Round 114 (Summer 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.

Table B-16a: Annual schedule for information collection and dissemination, July 2026 – January 2031.

Data collection schedule

| | |
|------------|--|
| 07/20/2026 | Data collection starts for Fall 2026 Round 106 |
| 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 |
| 07/19/2028 | 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 |

Data dissemination schedule

| | |
|------------|--|
| 07/15/2026 | Limited Data Set available for 2024 Survey File. |
| 09/15/2026 | Limited Data Set available for 2025 Survey File - Early Release. |
| 10/15/2026 | Limited Data Set available for 2024 Cost Supplement File. |
| 10/15/2026 | Survey File Microdata Public Use File for 2024 data. |
| 01/15/2027 | Cost Supplement File Microdata Public Use File for 2024 data. |
| 07/15/2027 | 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. |
| 01/15/2028 | Cost Supplement File Microdata Public Use File for 2025 data. |
| 07/15/2028 | 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. |
| 01/15/2029 | Cost Supplement File Microdata Public Use File for 2026 data. |
| 07/15/2029 | 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. |
| 01/15/2030 | Cost Supplement File Microdata Public Use File for 2027 data. |
| 07/15/2030 | 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. |
| 01/15/2031 | Cost Supplement File Microdata Public Use File for 2028 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, while the Survey File - Early Release contains timely data on a subset of key topics released on the Survey File primarily collected from respondents 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](#).

The MCBS Chartbook provides the public with a collection of charts and tables presenting estimates from both the Survey File and Cost Supplement File. The charts and tables in the Chartbook are cross-sectional and describe the Medicare population in terms of its demographic and socioeconomic characteristics, use of and expenditures on health care, perceived health and

functional status, and access to and satisfaction with health care within a given year. The Chartbook is intended as a reference for persons interested in using MCBS data to analyze the health and health care of the Medicare population. Beginning with the release of 2021 MCBS data, the <https://chartbook.mcbs.org> website replaced the PDF version of the MCBS Chartbook. MCBS estimates from 2015 through 2020 can be found in both the current online version of the MCBS Chartbook at <https://chartbook.mcbs.org> and the previous MCBS Chartbook PDFs at [CMS MCBS Data Tables](#).

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, and oral 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](#).

Researchers can also use interactive tools developed with MCBS data to explore trends for variety of topics on the Medicare population, including beneficiary health and well-being, health care access and expenditures, and COVID-19 impact. These tools can be found at [MCBS Interactives](#) and [MCBS Chartbook](#).

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.