

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

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October 7, 2025

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## B. Statistical Methods

The revision to this OMB package includes the following modifications to the Community and Facility instrument sections to reduce survey costs and increase efficiencies by content reductions and revisions, operational improvements, sample redesign, and expanded multimode data collection methods to include computer assisted video interviewing.

The requested content additions, deletions, and revisions include:

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

In addition to survey content changes, CMS plans to:

- Implement a national design that expands MCBS data collection to all 50 states and the District of Columbia, without increasing survey costs or reducing sample. Each Fall Incoming Panel beginning in 2026 would 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 be the primary data collection method supplemented with limited video interviewing or in-person visits.

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, 2024<sup>1</sup>. Agency action plans due in September 2025 will inform CMS' plans for implementing this revision on the MCBS in Fall 2027 Round 109.

### ***B1. Universe and Respondent Selection***

The target universe is current Medicare beneficiaries entitled to hospital and/or supplementary medical insurance and living in the 50 states or the District of Columbia. Both institutionalized and non-institutionalized beneficiaries are represented. Table B.1 summarizes the number of beneficiaries in the target universe based on CMS administrative records through 2024. The seven age groups shown in the table correspond to the primary sampling strata from which the samples for the MCBS are drawn. The age groups are defined by the beneficiaries' age as of December 31 of the given year for 2018 and later.

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

Age Interval	2018	2019	2020	2021	2022	2023	2024
<b>Disabled &lt;45</b>	1,791.78	1,771.52	1,744.56	1,715.78	1,646.76	1,585.22	1,541.14
<b>45 to 64</b>	6,903.46	6,773.12	6,641.56	6,411.54	6,153.78	5,897.58	5,645.22
<b>65 to 69</b>	15,978.62	16,368.74	16,895.90	16,975.40	17,149.42	17,538.10	17,742.46
<b>70-74</b>	13,647.66	14,322.88	14,967.58	15,115.86	15,278.12	15,631.94	15,976.76
<b>75-79</b>	9,463.14	9,820.30	10,117.54	10,576.94	11,296.14	11,789.56	12,453.50
<b>80-84</b>	6,301.04	6,441.96	6,610.14	6,737.94	7,098.58	7,447.08	7,767.44
<b>85+</b>	7,001.80	7,052.58	7,099.28	6,902.06	6,966.30	7,062.08	7,204.38
<b>Total (64 and under)</b>	8,695.24	8,544.64	8,386.12	8,127.32	7,800.54	7,482.80	7,186.36
<b>Total (65 and over)</b>	52,392.26	54,006.46	55,690.44	56,308.20	57,788.56	59,468.76	61,144.54
<b>Total (All)</b>	61,087.50	62,551.10	64,076.56	64,435.52	65,589.10	66,951.56	68,330.90

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

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

Totals do not necessarily equal the sum of rounded components.

Regardless of design, the target sample size of the MCBS varies slightly each year. Most recently, it has been designed to yield 8,200-8,500 completed cases providing Cost Supplement data per year (approximately 17-18 percent of these being disabled enrollees under the age of 65, approximately 48-49 percent being age 65 to 79, and approximately 33-34 percent being

<sup>1</sup> <https://spd15revision.gov/>

enrollees 80 years of age and older) from 2023 onwards. The redesigned sample from 2026 onward will maintain approximately the same overall targets.

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

Each year, an analysis of non-response and attrition is conducted to determine the optimal sample size for the Fall round Incoming Panel. Through 2009, approximately 6,500 beneficiaries were added to the sample in the Fall (September – December) round each year to replace the exiting panel and to offset sample losses due to non-response and attrition. Beginning in the Fall round of 2010 and continuing through the decade, the number of beneficiaries included in the Incoming Panel sample release was gradually increased to compensate for declining response rates. Beginning in 2020 when interviewing shifted from in-person to telephone due to the COVID-19 pandemic, the Incoming Panel sample size was approximately 15,100. This increase is a reflection of the continued decline in response rates and the additional difficulty of locating respondents via telephone<sup>2</sup>. The sample size results in over 34,000 interviews completed per year.

The methodology for drawing the samples is described later in this document. The number of cases to be selected each year for the Incoming Panel (designated sample sizes) are larger than the targeted number of completes to compensate for non-response, ineligibility, and attrition. Beginning in 2020 and through 2022, more sample was necessary to compensate for a switch from in-person interviewing to telephone interviewing and the expected lower response rates associated with that mode. With the reintroduction of some in-person interviewing in late 2021, and the shift to multimode data collection, these additional increases have no longer been needed.

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

**Cross-sectional sample sizes for other domains.** There are multiple domains of interest in the MCBS (for example, respondents with end-stage renal disease, persons residing in nursing homes, managed care enrollees, Medicaid recipients, and beneficiaries aligned to a provider participating in accountable care organizations). Under the Fall 2026 redesign of the MCBS sampling, the MCBS will continue to maintain a minimum target of 8,200 to 8,500 completed

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

responses in the annual Cost Supplement file to ensure that analysis can be performed on MCBS data for many domains of interest.

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

Table B.3 (in section B2 below) presents the round-by-round conditional and unconditional response rates as of Round 97 (Fall round of 2023) for the samples (referred to in the table as “panels”) selected in 2015 through 2023. For example, from the bottom part of the table, it can be seen that by the 10th round of data collection for the 2020 panel, 12.3 percent of the 2020 panel were still in a formal responding status (that is, either the sampled beneficiary was alive and still participating in the study or had died but a cooperative proxy was found for the collection of data on the last months of life) or had participated in the survey until death, leaving enough data to estimate the last months of life. For the 2021 and 2022 panels, the unconditional response rates as of Round 97 were 14.6 percent (through the 7th round of data collection) and 20.4 percent (through the 4th round of data collection), respectively. The 2023 panel (the new panel selected in Round 97) had an initial response rate of 45.2 percent in its first round of data collection.

Round 97 (Fall 2023) is the latest round for which MCBS data have been fully processed. There were 1,896 interviews successfully completed at Round 97 with still-living members of the 2020 panel. For brevity, we refer to these 1,896 interviews as “live completes.” For the 2021 and 2022 panels there were 2,190 and 3,259 live Round 97 completes, respectively. For the first round of data collection for the 2023 panel, there were 6,523 completes at Round 98.

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

## ***B2. Procedures for Collecting Information***

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

### **a. Statistical Methodology for Stratification and Sample Selection**

This section opens with a comparison of the current MCBS sample design to the 2026 redesign. This is followed by a general discussion of the selection of the incoming samples under the current design and 2026 redesign, and the use of Medicare administrative enrollment data each year to reduce problems associated with duplication of samples across the years.

1. *Current three-stage clustered design compared to the 2026 State-stratified national redesign.* The MCBS currently employs a complex multistage probability sample design.

At the first stage of selection, the sample consists of 104<sup>3</sup> primary sampling units (PSUs<sup>4</sup>) defined to be metropolitan areas and clusters of nonmetropolitan counties. At the second stage, a sample of 703 secondary sampling units consisting of Census tracts or groups of tracts (SSUs<sup>5</sup>) is selected within the sampled PSUs. At the third and final stage of selection, stratified samples of beneficiaries within the selected Census tracts are sampled annually at rates that depend on age group and Hispanic or non-Hispanic ethnicity. The geographically-clustered nature of the current design was developed to support in-person interviewing by ensuring that sampled beneficiaries are clustered into relatively small areas. Under this design, the sampled beneficiaries within each state are not representative of their state as a whole, and 14 states contain no PSUs (and thus no beneficiaries selected for data collection), resulting in a design which supports only national-level estimation. It is not possible to produce representative estimates for states or other sub-national regions.

The 2026 redesign will employ a national frame, which covers all 50 states and the District of Columbia. The sample will be stratified by state<sup>6</sup> to provide approximately equal numbers of beneficiary interviews within each state. The redesigned approach will no longer rely on PSUs or SSUs, and all beneficiaries in the United States will be eligible for sampling and recruitment. In place of the PSUs and SSUs, the national frame will be partitioned by state, and within each state, beneficiaries will be selected at rates designed to preserve adequate representation of the under-65 disabled population, beneficiaries 65-79 years of age, and beneficiaries 80 years of age and older. There will no longer be additional stratification based on ethnicity.

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

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

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

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

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

<sup>6</sup> A total of 51 strata that include the 50 states and the District of Columbia.



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

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

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

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

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

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

\* Cells reflect rounds that included intentional NIRs.

2. *Selection of beneficiaries.* An annual Incoming Panel sample of beneficiaries is selected from the Medicare administrative enrollment data. The 2026 redesign national sample will be stratified by state and by three age groups (beneficiaries under-65, 65-79, and 80 or older). Beneficiaries will be selected from within each state to achieve a minimum of 278 completed interviews, a target developed to achieve the desired level of precision in state-level estimates. Beneficiaries residing in the same state and who are in the same age-group strata will have equal probabilities of selection and equal design-based weights. Since 2015, and continuing under the redesign, beneficiaries eligible *anytime* during the sampling year are also included in the Medicare administrative enrollment sampling frame (referred to as current-year enrollees). Nursing home residents will continue to be drawn into the sample in exactly the same manner as other beneficiaries residing in the community.

## **b. Estimation Procedure**

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

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

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

A broad range of statistics are produced from the MCBS. There is no single attribute of beneficiaries and their medical expenses that stands out as the primary goal of the survey. Thus, there has been no simple criterion for the degree of reliability that statistics for each analytic domain should satisfy. Even with a larger sample size, there are many small domains of interest for which it would be necessary to use modeling techniques or to wait several years for sufficient data to accumulate.

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<sup>7</sup> Events and costs incurred after enrollment in Medicare but prior to the first interview.

The 2026 MCBS redesign will employ a national, rather than clustered, approach to the selection of the sample. The sample will be stratified by state (50 states plus DC) and will also continue to be stratified by age domain, though it will use only three age strata (under-65, 65-79, and 80 or older) compared to the seven age groups under the current design. While the overall national number of completed interviews per year will be similar under the new design, state-level precision targets were established. These targets were designed to achieve a maximum coefficient of variation of 7 percentage points on a hypothetical 50 percent top-line state-level estimate. This was done to eventually support state-level estimation after the redesign is fully implemented in 2029, with approximately 280-300 beneficiaries per state.

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

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

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

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

##### *1. Content and timing of instrument sections.*

The primary variables of interest for the MCBS are the use and cost of health care services and associated sources and amounts of payment. While Medicare claims files supply information on billed amounts and Medicare payments for covered services, the survey provides important self-reported information on use of services not covered by Medicare and on payment sources and amounts for costs not reimbursed by Medicare. For both the Community and Facility components, the primary focus of the data

collection is on use of services (dental, hearing and vision care, hospital, physician, medical providers, prescription medication and other medical services), sources and amounts of payment, and health insurance coverage. The MCBS interview collects continuous information on these items through thrice-yearly interviews; that is, once a new respondent completes their Baseline interview, they are asked utilization and cost questions each round.

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

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

The literature (initially reported by Neter and Waksberg in 1964<sup>8</sup> and confirmed in subsequent research by other analysts) indicates that collection of behavioral information in an unbounded recall period can result in large recall errors. The Incoming Panel interviews covered in this clearance request - Fall 2026 (Round 106), Fall 2027 (Round 109), and Fall 2028 (Round 112) - prepares the respondent for the collection of utilization and expenditure information in subsequent rounds, thus “bounding” the recall period for the next interview. During the Baseline interview, the respondent is provided with a calendar and interviewers emphasize the importance of this tool for use in future interviews. This calendar marks the recall period for the respondent and serves as the means to record utilization as well as a prompt to retain statements and bills.

## *2. Content of the instruments, Rounds 106-114.*

Nearly all of the instrument sections as currently approved by OMB are unchanged. Table B.3 presents the core and topical sections that comprise the MCBS Community instrument. As shown in the table, the content and order of administration varies based on season of data collection (Fall, Winter, Summer) and the type of interview (Baseline, Continuing). Those sections with an asterisk (\*) include a revision contained in this clearance request (either adding or deleting questions). Occasionally an item may be moved from one questionnaire section to another to improve the flow and use of the data, or for other operational or analytic purposes.

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

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

<b>Section</b> Listed in the order in which the section is administered.	<b>Type of Section</b> (Core or Topical)	<b>Season of Administration</b> (Rounds Administered)	<b>Interview Type</b> (Baseline, Continuing, Both)
Introduction (INQ)	Core	All (Round 106-114)	Both
Enumeration (ENS)	Core	All (Round 106-114)	Both
Housing Characteristics (HAQ)	Topical	Fall (Rounds 106, 109, 112)	Both
Health Insurance (HIQ)*	Core	All (Round 106-114)	Both
Mobility of Beneficiaries (MBQ)	Topical	Fall (Rounds 106, 109, 112)	Both
Preventive Care (PVQ)*	Topical	Fall (Rounds 106, 109, 112)	Both
Health Status and Functioning (HFQ)*	Core	Fall (Rounds 106, 109, 112)	Both
Nicotine and Alcohol Use (NAQ)	Topical	Fall (Rounds 106, 109, 112)	Both
Satisfaction with Care (SCQ)*	Core	Fall (Rounds 106, 109, 112)	Both
Cognitive Measures (CMQ)	Core	Fall (Rounds 106, 109, 112)	Both
Demographics and Income (DIQ)	Core	Fall (Rounds 106, 109, 112)	Baseline
Immunization (IMQ)*	Topical	Winter (Round 107, 110, 113)	Continuing
Beneficiary Knowledge and Information Needs (KNQ)*	Topical	Winter (Round 107, 110, 113)	Continuing
Usual Source of Care (USQ)*	Core	Winter (Round 107, 110, 113)	Continuing
Telemedicine (TLQ)	Topical	Winter (Round 107, 110, 113)	Continuing
Chronic Pain (CPQ)	Topical	Summer (Rounds 108, 111, 114)	Continuing
Income and Assets (IAQ)	Core	Summer (Rounds 108, 111, 114)	Continuing
Debt (DBQ)	Core	Summer (Rounds 108, 111, 114)	Continuing
Drug Coverage (RXQ)	Topical	Summer (Rounds 108, 111, 114)	Continuing
Dental, Vision, and Hearing Care Utilization (DVH)	Core	All (Round 106-114)	Continuing
Emergency Room Utilization (ERQ)	Core	All (Round 106-114)	Continuing
Inpatient Utilization (IPQ)	Core	All (Round 106-114)	Continuing
Outpatient Utilization (OPQ)	Core	All (Round 106-114)	Continuing
Institutional Utilization (IUQ)	Core	All (Round 106-114)	Continuing
Home Health Utilization (HHQ)	Core	All (Round 106-114)	Continuing
Medical Provider Utilization (MPQ)	Core	All (Round 106-114)	Continuing
Access to Care (ACQ)	Core	Winter (Rounds 107, 110, 113)	Continuing
Prescribed Medicine Utilization (PMQ)	Core	All (Round 106-114)	Continuing
Other Medical Expenses (OMQ)	Core	All (Round 106-114)	Continuing
Statement Cost Series (STQ)	Core	All (Round 106-114)	Continuing
Post-Statement Cost (PSQ)	Core	All (Round 106-114)	Continuing
No Statement Cost Series (NSQ)	Core	All (Round 106-114)	Continuing
Cost Payment Summary (CPS)	Core	All (Round 106-114)	Continuing
End Section (END)	Core	All (Round 106-114)	Both

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

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

<b>Section</b>	<b>Type of Section</b> (Core or Topical)	<b>Season of Administration</b> (Rounds Administered)	<b>Interview Type</b> (Baseline, Continuing, Both)
Facility Questionnaire (FQ)	Core	All (Round 106-114)	Both
Residence History (RH)	Core	All (Round 106-114)	Both
Background Questionnaire (BQ)	Core	Fall (Rounds 106, 109, 112)	Baseline
Health Insurance (IN)	Core	Fall (Rounds 106, 109, 112)	Both
Use of Health Services (US)	Core	All (Round 106-114)	Continuing
Expenditures (EX)	Core	All (Round 106-114)	Continuing
Health Status (HS)*	Core	Fall (Rounds 106, 109, 112)	Both
Facility Questionnaire Missing Data^	Core	All (Round 106-114)	Both
Residence History Missing Data^	Core	All (Round 106-114)	Both
Background Questionnaire Missing Data^	Core	Fall (Rounds 106, 109, 112)	Baseline

^Section only activated and available for administration when critical data points from the FQ, RH, or BQ sections are marked as missing, Don't Know, or Refused.

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

**Summary of instrument changes beginning in Fall 2026 Round 106 through Summer 2029 Round 114:**

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

**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 captures 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.<sup>9</sup>
- ***One item on the prevalence of thyroid disease***, which affects 5-10% of US adults, and the prevalence increases with age.<sup>10</sup>
- ***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.<sup>11</sup>

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 coverage<sup>12</sup> 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.

**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

<sup>9</sup> [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)

<sup>10</sup> <https://www.sciencedirect.com/science/article/pii/S1530891X23005281>

<sup>11</sup> <https://www.tandfonline.com/doi/full/10.2147/CLEP.S40245>

<sup>12</sup> <https://www.cbo.gov/publication/60816>



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.

**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.

### **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).

### **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.

**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 were revised to collect less detailed information about provider specialty and accompaniment to appointments and text fills for 14 items were revised to refer to the beneficiary's usual source of care more generally as opposed to by name.

**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.

CMS has also included two changes in this revision request that will **improve operational efficiency**:

- **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).
- *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.
- **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 status<sup>13</sup>. 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.

## **Rounds 106 through 114 Data Collection Procedures**

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

***Outreach to Incoming Panel sample persons in the community.*** In the Fall rounds (Round 106, 109, 112), all newly selected beneficiaries will be mailed a **Community Advance Letter** from the Centers for Medicare and Medicaid Services. This letter serves to provide notification to the beneficiary that an interviewer will contact them to request an interview. It also includes a copy of the **MCBS Community Brochure**. The letter is printed in both English and Spanish to all beneficiaries and a Language Insert is included to provide an explanation of the survey for respondents who do not speak English or Spanish. Following this letter, outreach is made by telephone to locate the beneficiary and begin the interview.

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

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<sup>13</sup> <https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>

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

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

Regardless of mode of administration, Community interviews (Rounds 106-114) will be administered to the respondent or a designated proxy using a CAI program on a laptop computer. Attachment 2 includes a copy of all questionnaire sections administered in the Baseline interview, the Continuing interview, and the Showcards used by the interviewer to assist in the interviewing process<sup>14</sup>.

***Interviews with sample persons in institutions.*** For all facility residents, the Facility Eligibility Screener is administered each time a respondent is found to have entered a facility, or in the case of Baseline respondents, is currently in a facility (Attachment 3). The Facility instrument to be used in Rounds 106-114 is shown in Attachment 4.

An advance letter is sent to all facilities prior to an interviewer contacting the facility for an interview (Attachment 5). CMS has also developed additional materials to gain cooperation including providing information on how to prepare for the interview, introducing the study to staff at third-party billing offices who may provide additional survey responses, and thanking the facility staff for participation.

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

#### **e. Proxy rules.**

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

Upon screening a facility where a sampled beneficiary is determined to be living, the interviewers identify the appropriate staff at the facility best able to respond. MCBS interviewers do not interview residents in a facility. Instead, interviewers are trained to determine and seek out the appropriate staff for the interview. If a respondent is incarcerated, we do not seek response.

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

The sample for the MCBS is a heterogeneous population that presents a unique challenge for maximizing response rates. The survey selects respondents from two Medicare groups – those

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<sup>14</sup> Showcards are available to respondents to download in order to follow along during phone interviews.

age 65 and over and those younger than 65 who have disabilities. Advancing age, poor health or poor health of a family member are common reasons for refusal. On the other hand, older persons are the least mobile segment of the population and thus, for a longitudinal survey, there is generally a low instance of failing to locate respondents.

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

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

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

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

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

- g. Interviewers are encouraged to use personal touches such as thank you notes and birthday cards to maintain contact with respondents.

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

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

A non-response bias analysis for the MCBS is conducted approximately every three years. The most recent non-response bias analysis for the MCBS was conducted based on the 2021 Panel and was released in the final 2021 Methodology Report<sup>15</sup>. This analysis also included beneficiaries who participated in COVID-19 surveys. While non-response is carefully monitored every year, a complete non-response bias analysis is updated every three years to ascertain trends both annually and for subpopulations. The next non-response bias analysis for the MCBS will be conducted based on the 2024 Panel and released with the forthcoming 2024 documentation.

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

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<sup>15</sup> <https://www.cms.gov/files/document/2021-mcbs-methodology-report.pdf>

conditions than were respondents. While many differences were found, most were not large in a practical sense. Furthermore, across most of these measures, weighted respondent distributions were closer to benchmarks than unweighted respondent distributions, suggesting that the potential bias identified via these analyses is expected to be minimized by the weighting procedures.

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

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

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

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

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

### **Multimode Survey Administration**

NORC interviewers conduct phone interviewing, supplemented by in-person outreach where feasible within the budget constraints. Phone interviews may also be enhanced with video calling



when respondents are interested and can access this technology. CMS also assumes a majority of Facility interviews will take place over the phone with a small proportion conducted in-person, based on location. Results of several in-depth analyses along with feedback from field staff have shown that phone data collection works well for a majority of interviews, maintaining stability in representativeness and data quality. The phone mode also offers a cost-effective option for both contacting and interviewing. Limited in-person interviews are generally used for locating respondents where phone outreach has failed, non-response follow-up, and to administer the interview to beneficiaries with high levels of utilization or difficulty using the phone.

#### ***B4. Tests of Procedures or Methods***

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

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

In February and March 2024, CMS conducted a small number of usability tests (nine) with respondents using video calling capabilities to enhance the interview. Interviewers and respondents gave positive feedback to the experience, indicating that for telephone interviews, using video technology may be helpful for rapport-building and long-term participation.

#### ***B5. Individuals Consulted on Statistical Aspects of Design***

The person responsible for statistical aspects of design is:

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