

# **Medicare Health Outcomes Survey**

## **Supporting Statement A**

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## Supporting Statement A

### Paperwork Reduction Act Clearance Request

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

CMS received its previous OMB clearance (OMB 0938-0701) in May 2022, expiring May 31, 2025. CMS requests a renewed three-year clearance to continue annual fielding of the HOS.

To increase the efficiency of the survey, CMS seeks to remove five questions from the HOS questionnaire. (See **Attachment A** for a crosswalk of the survey changes from the last OMB package submission.) This includes the Instrumental Activities of Daily Living (IADL) question, three Healthy Days questions, and the numeric pain scale. Removing these items do not significantly affect the time for Medicare beneficiaries to complete the HOS survey, but additional items are being considered for removal pending the results of the planned field test approved under a separate OMB control number, 0938-1464. The requirements and burden for MA contracts remain unchanged.

### Background

The HOS is a longitudinal patient-reported outcome measure (PROM) that assesses self-reported beneficiary quality of life and daily functioning. As a PROM, the HOS measures the impact of services provided by MAOs, whereas process and patient experience measures only provide a snapshot of activities or experiences at a specific point in time.<sup>1</sup> PROM data collected by the HOS allow CMS to continue to assess the health of the Medicare Advantage population. This older population is at increased risk of adverse health outcomes, including chronic diseases and mobility impairments that may significantly hamper quality of life.<sup>2</sup> The HOS supports

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<sup>1</sup> Martha Hostetter and Sarah Klein, "Using Patient-Reported Outcomes to Improve Health Care Quality," The Commonwealth Fund, Accessed September 17, 2024, <https://www.commonwealthfund.org/publications/newsletter-article/using-patient-reported-outcomes-improve-health-care-quality>

<sup>2</sup> Office of Disease Prevention and Health Promotion, "Older Adults", Healthy People 2030, September 5, 2024, <https://health.gov/healthypeople/objectives-and-data/browse-objectives/older-adults>.

CMS’s commitment to improve health outcomes for beneficiaries. CMS accomplishes this by focusing on high-priority areas for quality measurement and improvement established in the agency’s Meaningful Measures 2.0 Framework.<sup>3</sup> The HOS uses quality measures that ask beneficiaries about health outcomes related to specific mental and physical conditions. Consistent collection of HOS PROM data for the Medicare population has allowed CMS, MAOs, and researchers to understand trends in the Medicare population’s health outcomes over time, as well as beneficiary perspectives on their own health status.

Each year, the HOS is administered to a random sample of MAO beneficiaries from participating MAOs that have a minimum of 500 enrollees (Baseline). Two years later, the Baseline respondents are surveyed again (Follow-Up). For each member who completes the Follow-Up Survey, a two-year change score is calculated and the member’s physical and mental health status is categorized as “better than expected,” “as expected,” or “worse than expected,” with incorporation of risk-adjustment factors. Summary HOS results are calculated for each MAO based on aggregated beneficiary outcomes. CMS includes multiple measures from HOS in the Medicare Part C Star Ratings program to help consumers choose health plans.<sup>4</sup> Star Ratings serve as the basis for quality bonus payments (QBPs) for Medicare Advantage plans that were implemented in 2012.

Refer to **Attachment B** for the HOS instrument. The HOS-M is a shorter version of the HOS that is administered to beneficiaries enrolled in Programs of All-Inclusive Care for the Elderly (PACE). Refer to **Attachment C** for the HOS-M instrument.

## **Justification**

### ***1. Collection Necessity and Legal Requirements***

The HOS meets the requirements for collecting and publicly reporting quality and performance indicators as required by the Balanced Budget Act of 1997, which established a new Part C of the Medicare program, then known as the Medicare+Choice (M+C) program, and mandated collection of Medicare+Choice and PACE quality and performance indicators and the provision of

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<sup>3</sup> Centers for Medicare & Medicaid Services, “Meaningful Measures 2.0: Moving to Measure Prioritization and Modernization,” CMS National Quality Strategy, Accessed September 5, 2024, <https://www.cms.gov/medicare/quality/cms-national-quality-strategy/meaningful-measures-20-moving-measure-reduction-modernization>.

<sup>4</sup> Centers for Medicare & Medicaid Services, “Fact Sheet – 2021 Part C and D Star Ratings,” Part C and D Performance Data, Accessed September 17, 2024, <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-star-ratings>

this information to beneficiaries.<sup>5</sup> The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 continued the collection and reporting requirements under Section 1860D-4 (Information to Facilitate Enrollment) and renamed the program “Medicare Advantage” (MA). Under the MMA, beneficiaries may choose from additional plan options, including special needs plans (SNPs). The MMA also required CMS to provide quality and performance results to Medicare beneficiaries prior to the annual enrollment period.<sup>6</sup>

Two longitudinal measures, Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health and three cross-sectional measures (Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control) are derived from the HOS and used in Medicare Star Ratings. CMS continues to consider how new longitudinal PROMs may be developed from the HOS. One new longitudinal measure, Physical Functioning Activities of Daily Living (PFADL), complements the current measurement of physical health status by measuring change in physical functioning of beneficiaries enrolled in MAOs over a two-year period. PFADL was introduced as a display measure for 2021 (display measures are publicly reported for informational purposes only and are not included in the Star Ratings or used for QBP calculations). CMS will field test potential enhancements to the measure and other new HOS items for plans to potentially use as a focus of their quality improvement efforts, as approved under OMB control number 0938-1464.

## ***2. Information Users***

Multiple stakeholders use HOS data. Information obtained from the HOS provides data to assist consumers in choosing a plan that best meets their needs via the Medicare Plan Finder website ([www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan)), a site where people can compare plan performance. CMS continues to utilize the survey as an avenue for quality oversight and MAO accountability. MAOs use the data generated from the HOS in conjunction with Medicare Part C and D Star Ratings scores to support quality improvement (QI) activities.<sup>7</sup> HOS survey results, with detailed reports, support the quality improvement efforts of

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<sup>5</sup> United States Congress, “H.R.2015 - Balanced Budget Act of 1997,” Congress.gov, August 5, 1997, <https://www.congress.gov/bill/105th-congress/house-bill/2015/text/enr>.

<sup>6</sup> United States Congress, “Medicare Prescription Drug Improvement Act,” Congress.gov, December 8, 2003, <https://www.congress.gov/108/plaws/publ173/PLAW-108publ173.pdf>.

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

individual plans. Researchers continue to use data from the HOS to advance the science of care for older adults and functional health outcomes measurement (see Table 1 for research topic areas).

CMS uses the HOS to support its quality oversight role of MAOs and to establish QBPs for MA organizations that incentivize quality improvement. Current areas of focus include increasing physical activity, reducing the risk of falling, and managing urinary incontinence. These themes continue to remain areas of high priority for the elderly population and are therefore incorporated into Medicare Star Ratings. Medicare Part C and D Star Ratings are publicly reported and translated into consumer-facing information for beneficiaries to provide transparency, hold MAOs accountable, and highlight high performing MAOs.

MAOs use HOS data and the Part C and D Star Ratings scores to improve the care they provide to Medicare beneficiaries. MAOs are responsible for providing access to services that help to maintain and improve beneficiary health and function. HOS results assist MAOs in establishing QI initiatives and developing systems to track progress toward improving patient outcomes. HOS reports are designed to maximize the ability of MAOs to apply their HOS results to health promotion, quality improvement, and care management interventions and activities. Results help MAOs track the overall self-reported health outcomes of their beneficiary group longitudinally, identify the demographic profile of their beneficiaries and health status for each population, assess the functional health status of their population, and evaluate the impact of interventions geared toward maintaining and improving the health of their older adult beneficiaries.

The HOS is also used extensively by researchers to advance the science of health outcomes, cancer research, care for older adults, and end-of-life care (see Table 1). Researchers continue to use de-identified survey data to publish studies on caring for beneficiaries with and without cancer, developing survey measures, identifying and tracking areas for health plan improvement, and differentiating health plan performance. CMS, in partnership with the National Cancer Institute (NCI), established the Surveillance, Epidemiology, and End Results Medicare Health Outcomes Survey (SEER-MHOS) Linked Data Resource to better understand the health-related quality of life of cancer patients and survivors enrolled in Medicare health plans.<sup>8</sup> This

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

database links patient-reported quality of life, activities of daily living, and effectiveness of care derived from the HOS. SEER-MHOS data have been used in over 80 studies published in the last 10 years and over a dozen more studies are currently in review prior to potential publication. SEER-MHOS data inform manuscripts on topics such as trends in disparities of health-related quality of life for beneficiaries with cancer, a study of patient-reported geriatric assessment domains for patients with cancer, and patterns of patient-reported outcomes associated with pain and depression for patients with cancer. Without the HOS, this database would not include beneficiary self-reports of health-related quality, which providers and researchers consistently rely upon to target interventions to improve the quality of life of older cancer patients. Table 1 summarizes the topic areas in which HOS data have informed research.

**Table 1. Research Topic Areas Published Using the HOS**

Category	Topic Areas
Beneficiary health	<ul style="list-style-type: none"> <li>• Health-related quality of life for beneficiaries with and without cancer</li> <li>• Treatment, survivorship, and health outcomes of beneficiaries with cancer</li> <li>• Racial and ethnic disparities in beneficiaries with and without cancer</li> <li>• Falls among cancer survivors</li> <li>• Depression and chronic conditions in beneficiaries with and without cancer</li> <li>• Physical activity</li> <li>• Smoking cessation in beneficiaries with and without cancer</li> </ul>
HOS performance	<ul style="list-style-type: none"> <li>• Differentiating MAO plan performance</li> <li>• Identifying and tracking areas for MAO improvement</li> </ul>
Survey and measure Development	<ul style="list-style-type: none"> <li>• Adapting health status measures and indices</li> <li>• Developing and validating health status measures</li> </ul>

### ***3. Use of Improved Information Technology***

The HOS uses a mixed-mode protocol to maximize response rates.<sup>9</sup> The current mixed-mode survey protocol uses mail with telephone follow-up for non-respondents, and CMS is preparing to field test a new protocol that includes a web-based mode of data collection with mail and telephone follow-up for non-respondents under a separately approved package (OMB control number 0938-1464). Under the current protocol, CMS-approved survey vendors administer the mail and telephone survey on behalf of MAOs. Each questionnaire mailing includes a barcode or unique alphanumeric identifier associated with the sampled beneficiary. Survey vendors use electronic telephone interviewing systems to administer the telephone

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

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

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

#### ***4. Duplication of Efforts***

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

#### ***5. Small Businesses***

Small MAOs, with fewer than 500 beneficiaries, are excused from Baseline requirements to reduce the burden on these MAOs. Small MAOs that fielded the HOS survey two years prior are still required to report the Follow-Up survey. This enables CMS to calculate the longitudinal PCS (Physical Component Summary) and MCS (Mental Component Summary) scores, providing valuable insight into their health status. Administration of the Follow-Up survey is limited to beneficiaries who completed the survey two years prior. The surveys are administered by CMS-approved survey vendors on behalf of MAOs. The survey instruments and procedures for completing the instruments are designed to minimize burden on all respondents and will not

have a significant impact on small businesses or other small entities.

#### **6. *Less Frequent Data Collection***

CMS relies on the annual collection of HOS data to provide up-to-date information to beneficiaries to assist them in making informed decisions when choosing a Medicare plan. The HOS is a longitudinal survey which measures beneficiary health at two points in time. Data derived from the HOS are used in Medicare Star Ratings. Three cross-sectional HEDIS measures (Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control) are calculated using the combined Baseline and Follow-Up data from a single measurement year. In addition, two longitudinal HOS measures, Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, allow CMS to assess the health of beneficiaries over time. Although the two outcomes measures were moved to display due to the COVID pandemic and more recently due to substantive methodological changes, the measures will be reintroduced in the 2026 Medicare Star Ratings. Less frequent data collection would result in gaps in information in Medicare Star Ratings and jeopardize CMS's ability to measure differences in outcomes attributable to MAOs.

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

#### **7. *Special Circumstances***

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

#### **8. *Federal Register and Outside Consultation***

The 60-day Federal Register Notice published in the *Federal Register* on October 9, 2024 (89 FR).

#### **9. *Payments or Gifts to Respondents***

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

#### **10. *Confidentiality***

Individuals contacted are assured confidentiality under 42 U.S.C. 1306, 20 CFR 401 and

422, 5 U.S.C.552 (Freedom of Information Act), 5 U.S.C.552a (Privacy Act of 1974), and OMB Circular No. A-130. The Systems of Records is the Health Plan Management System (HPMS) (SORN 09-70-0500) and the Enrollment Database (EDB) (SORN 09-70-0502).

### ***11. Sensitive Questions***

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

### ***12. Burden Estimates (Hours & Wages)***

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

Table 2 shows the estimated annualized burden for respondents' time to participate in this data collection. Tests have shown the average time to complete the HOS is about 19 minutes. Despite the removal of five items, we do not anticipate significant change to the annualized burden as these were brief questions.

**Table 2. Estimated Annualized Burden (Hours and Cost) – HOS and HOS-M Based on 2024 Response Estimates**

HOS Survey	Number of Participating Plans <sup>a</sup>	Number of Respondents per Plan <sup>b</sup>	Number of Responses	Average Burden per Response (hours)	Hourly Wage Rate	Total Annual Burden (hours)	Total Annual Respondent Cost <sup>d</sup>
HOS Baseline	638	600	382,800	0.32	\$23.11	122,496	\$2,830,882.56
HOS Follow-Up	550	450	247,500	0.32	\$23.11	79,200	\$1,830,312.00
HOS-M	146	225	32,850	0.32	\$23.11	10,512	\$242,932.32
<b>Total:</b>						<b>212,208</b>	<b>\$4,904,126.88</b>

<sup>a</sup>. The number of participating plans is based on the 2024 participating plan list.

<sup>b</sup>. The number of respondents per plan is calculated as follows: Baseline – average number of members sampled per plan (1,200) with an expected 50% response rate (600); Follow-Up – average number of members responding to Baseline survey two years prior (600) at a 75% response rate at Follow-Up (450); HOS-M – average number of sampled members per plan (300) at a 75% response rate (225).

<sup>c</sup>. The hourly wage rate is based on national wage data for all occupations in 2023 from the U.S. Bureau of Labor Statistics.<sup>10</sup>

<sup>d</sup>. The total annual respondent cost = the number of responses multiplied by the cost per response (\$23.11 x .32 = \$7.40).

### **13. Capital Costs**

There are no capital costs associated with HOS administration.

### **14. Costs to Federal Government**

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

### **15. Burden Changes and Adjustments**

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

<sup>10</sup> *Occupational Employment and Wage Statistics* [Review of *Occupational Employment and Wage Statistics*]. United States Bureau of Labor Statistics. Retrieved September 4, 2024, from [https://www.bls.gov/oes/current/oes\\_nat.htm#00-0000](https://www.bls.gov/oes/current/oes_nat.htm#00-0000).

MAOs required to administer the HOS and the number of PACE plans required to administer the HOS-M, as well as a lower average Baseline response rate. The total number of MAOs required to report HOS Baseline and Follow-Up increased by 129 and 115 MAOs, respectively, since the previous OMB submission. The increase in the number of contracts required to report HOS Baseline and Follow-Up in 2020 was largely due to changes in the number of MA contracts since the last submission. The burden adjustments on PACE plans are a result of changes in the number of PACE plans required to report HOS-M. The number of PACE plans required to administer the HOS-M increased by 22 since the last OMB package.

CMS is seeking to further reduce the burden on respondents by eliminating five questions, none of which are used for the Medicare Star Ratings, reporting, or other purposes:

- The Instrumental Activities of Daily Living (IADL) item (Q11a-c). CMS is seeking to remove this item because it is no longer being considered as a quality measure for Star Ratings.
- Three Healthy Days items (Q12-Q14). CMS seeks to remove these items because they have proven challenging for older adults to complete.
- The Numeric Pain Scale (Q35). CMS seeks to remove this item given other work in this area to measure pain.

This package retains U.S. Department of Health and Human Services (HHS) data collection standards for race, ethnicity, sex, primary language, and disability as required under Section 4302 of the Affordable Care Act (ACA). Due to the timing of this package, CMS is unable to implement OMB's recent revisions to Statistical Policy Directive No. 15 (Directive No. 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity but will develop a plan for future implementation.

Based on the proposed deletion of five items, the time required to administer the HOS remains at 0.32 of an hour, as shown in Table 2. Estimated Annualized Burden (Hours and Cost) – HOS and HOS-M Based on 2024 Response Estimates. Note also that the HOS mailing materials, formerly submitted as attachments E and F, are not included in this PRA package.

### ***16. Publication and Tabulation Dates***

HOS data are used for descriptive, explanatory, and predictive analyses. A number of analyses have already been conducted on HOS data; these analyses (complete with data files and

reports) continue to be prepared over the course of the survey program. HOS Baseline Reports, Follow-Up Reports, and Performance Measurement Data are created for each cohort. CMS continues to work to deliver data to plans as soon as possible to ensure that the data are relevant, actionable, and timely. Table 3 displays the project schedule and the availability of the data.

**Table 3. HOS Results Report and Data Availability**

HOS Cohort	Data Collection Dates	Baseline Report Available	Follow-Up Performance Measurement Report Available	Performance Measurement Data Available
24	<b>Baseline:</b> Summer 2021 <b>Follow-Up:</b> Summer 2023	November 4, 2022	August 1, 2024	August 1, 2024
25	<b>Baseline:</b> Summer 2022 <b>Follow-Up:</b> Summer 2024	October 27, 2023	<i>Expected 2025</i>	<i>Expected 2025</i>
26	<b>Baseline:</b> Summer 2023 <b>Follow-Up:</b> Summer 2025	<i>Expected 2024</i>	<i>Expected 2026</i>	<i>Expected 2026</i>

Additionally, several types of HOS data files are available for research purposes. HOS data files are available as Public Use Files (PUFs), Limited Data Sets (LDSs), and Research Identifiable Files (RIFs). HOS PUFs contain most of the survey items collected from the HOS instrument (excluding beneficiary identifying information) and select additional administrative variables. HOS PUFs are constructed in a manner that prevents the identification of any single beneficiary or plan. Only respondent data are included in the PUFs (non-respondent data are removed). HOS PUFs are available at no cost and can be downloaded directly from the CMS website.

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

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

characteristics). A signed DUA with CMS is required to obtain the RIF data.

***17. Expiration Date***

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

***18. Exceptions to Certification Statement***

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

**List of Attachments**

**Attachment A:** Crosswalk of Changes

**Attachment B:** HOS Questionnaire

**Attachment C:** HOS-M Questionnaire

**Attachment D:** Response Rates