Section/Title	Commentor	Functional Area
General	Taline Jaghasspanian	Quality
General	Jeremy Burlingame	Quality

Comment(s)

1. In support of adding web-based mode to HOS survey.
2. Need more clarity from CMS around the timeline from field test to full implementation and how transition years will be handled. We would not be able to compare prior years to new HOS survey given the proposed changes.
3. How will the results from the field test be reported back to us? How will vendor performance be evaluated and sampling be managed. Will plans be informed of changes well in advance after field testing is completed?
Will we receive the member data if they disenrolled or would we be notified if they disenrolled within the two-year follow up period?

Thank you for the opportunity to comment on *Form Number:* CMS-10861 (OMB control number: 0938-1464).

- Overall, we support CMS's efforts to shorten the survey and revise the questions to reduce respondent burden and improve cognitive understanding of the questions.
- The field test should consider the use of QR code on the prenotification letter and the web survey invitation letters. We have usually found that QR codes drive more people to the use of the web survey than web survey URL alone. QR code also makes the survey more accessible when the survey is offered in different languages. Starting with the 2025 survey, MA-PDP CAHPS made the use of QR code on prenotification and web invitation letters optional.
- The field test proposal includes two waves of web survey invitation mailings. This is in addition to the prenotification letter mailing, which will also include information on how to complete the survey online. We have found for the MA&PDP CAHPS survey that additional web invitation mailing(s) after the prenotification letter is not very productive considering the cost of mailing these letters to the members. We urge CMS to conduct a cost-benefit analysis of using the web survey invitation letters as part of this fielding test and consider the increased financial burden to the MAOs required to conduct this survey.
- It is not clear from the field test supporting statements whether the telephone outreach will follow the same guidelines that the survey vendors currently use regarding the number of attempts to the sample members. Currently the survey vendors are required to make five attempts per phone number for the sample member.
- Will there be any analysis done about the effect of removal of questions that are used as covariates in the case-mix adjustment model(s)? How will removal of the covariates affect the model(s) since some of the covariates may be correlated and therefore the coefficients on the covariates that continue to be part of the model may change as a result?

10/27/2025

Fallon Health (H9001) comments on CMS–10861 Medicare Health Outcomes Survey Field Test

- Our organization would like to comment on the limited variation in response choices for many of the questions on both proposed survey versions (A &B). We recommend that CMS change the surveys to a 5-point scale as this, in many cases, would allow a neutral response choice. As the surveys are currently formatted with 6-point scall, the differences between response choice 4 and 5 are most likely indiscernible for many respondents, which could be an issue across many proposed questions (example provided below):

    Current questions are written in the following format (example):
    How much of the time during the **past 4 weeks:**
    Have you felt downhearted and sad?
        1 All of the time
        2 Most of the time
        3 A good bit of the time
        4 Some of the time
        5 A little of the time
        6 None of the time

    If CMS instead settles on the 6-point scale, we recommend using a rating scale as this would be a better option. For a 6-point scale, we recommend making changes to the responses along the following lines:

    On a scale of 0 to 6, where 0 is none of the time and 6 is all of the time Please provide a number that describes the extent you have felt downhearted or sad over the past 4 weeks

- Our organization recommends that moderate activity choices in questions should be expanded to include a variety of activities that would qualify as moderate across income segments (not limited to just golf and bowling)

- We recommend that CMS add a question asking who is filling out the survey (member, member with assistance, a caregiver, etc.)

PUBLIC SUBMISSION

As of: 11/4/25, 1:53 PM
Received: November 03, 2025
Status: Draft
Category: Health Plan or Association
Tracking No. mhj-k9fy-di5q
Comments Due: November 04, 2025
Submission Type: Web

Docket: CMS-2025-0799
Medicare Health Outcomes Survey Field Test (CMS-10861)

Comment On: CMS-2025-0799-0001
Medicare Health Outcomes Survey Field Test (CMS-10861)

Document: CMS-2025-0799-DRAFT-0005
Comment on CMS-2025-0799-0001

Submitter Information

Email: Michael.A.Steele@HealthPartners.Com
Organization: HealthPartners

General Comment

The continuous evolution of the HOS surveys is indicative that improvement is needed to the survey instrument to provide accurate results and actionable insights. CMS has indeed acknowledged that survey responses will have an inherent bias with case mix adjustments attempting to reflect differences in respondents. These measures and the way they are derived from the survey instrument have significant limitations, including low sampling and low response rates. We recommend CMS stop investing time and resources in the HOS survey tool and remove the 5 HOS measures for Star Year 2027/Contract Year 2027, focusing on outcomes or experiences measures that are objective, representative and based upon clear clinical data with limited bias.

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Humana

November 4, 2025

Willaim N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via regulations.gov

RE: Medicare Health Outcomes Survey Field Test [CMS-10861]

Dear Mr. Parham:

This letter is in response to the "Medicare Health Outcomes Survey Field Test (CMS-10861)" notice as issued by the Centers for Medicare & Medicaid Services (CMS) on September 5, 2025.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 6.2 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.2 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in nine states.

Health Outcomes Survey (HOS) Field Test

CMS proposes a revised field test of the HOS with the goal of evaluating the measurement properties of new survey items, the effects of new content, and a web-based mode of survey on response patterns and measure scores as compared to existing HOS survey items and protocols.

> **Humana Comment:** Humana values the opportunity to provide feedback regarding the latest HOS Field Test. CMS proposes three new sets of survey content: Patient-Reported Outcomes Measurement Information System Physical Function and Mobility (PROMIS) items, Generalized Anxiety Disorder 2 (GAD-2) Items, and Behavioral Risk Factor Surveillance System (BRFSS). Humana supports these proposed additions to HOS as these questions may provide plans with valuable insights into the mental and physical health of MA enrollees. Humana believes the

results from these questions would be especially beneficial if plans had access to the baseline aggregate data closer to the survey completion date. Earlier access to this data would greatly aid plans in addressing specific populations with reported issues. We recommend that CMS provide plans with reports as soon as the agency has completed the aggregation process, ideally no longer than three months after the baseline surveys have been conducted.

Humana suggests that CMS provide clarification on two items related to the proposed survey content. First, we encourage CMS to clarify whether the PROMIS, GAD-2, and BRFSS questions will contribute to the Improving or Maintaining Physical Health (IMPH) and Improving or Maintaining Mental Health (IMMH) measures for measure year 2026 and beyond or if they are being considered in support of new, standalone measures. Second, with regard specifically to BRFSS, one version of the proposed question asks if a doctor "talked with" the member versus "provided advice" about diet and alcohol use. Humana urges CMS to clarify whether the intention of this question is to understand potential differences in perception about general health education and promotion as opposed to diagnosis and treatment.

In addition to the new survey, CMS proposes updates to existing questions including rewording some questions and removing others. Humana supports many of the proposed wording updates, as we believe they provide additional clarity and will help identify at risk populations. As it relates to Field Test Version B, the proposed survey tests a 5-question response option for Questions 6a, 6b, and 6c. Since these questions are tied to the Mental Component Summary score, we recommend that CMS share learnings with plans on how this shift could influence responses and scoring.

Additionally, while we support reducing the length of the survey, many of the questions that have been removed are related to member health conditions and labeled as "removal had a negligent impact on case-mix adjustment." Humana requests that CMS provide its definition of 'negligible' so that plans have a better understanding of the agency's reason for removing these questions. Can CMS provide any analysis on the effect of removal of questions that are used as covariates in the case-mix adjustment model(s)? How will removal of the covariates affect the model(s) since some of the covariates may be correlated and therefore the coefficients on the covariates that continue to be part of the model may change as a result?

With the recent addition of the CAHPS Web-based modality option, we agree it is logical to consider a similar structure for HOS. Regarding the proposed field test, Humana would appreciate clarification on the following:

1) Is there an outline for a number of channels/attempts across each arm of the test? For example, within the "traditional" arm, does execution follow official administration with two mail attempts followed by multiple phone attempts? Within the "Web" arm, should we expect it to mirror the official CAHPS administration?
2) It is not clear from the field test supporting statements whether the telephone outreach will follow the same guidelines that the survey vendors currently use regarding the number of attempts to the sample members. Currently the survey vendors are required to make five attempts per phone number for the sample member. Can CMS provide clarification on this?
3) The field test proposal includes two waves of web survey invitation mailings. This is in addition to the prenotification letter mailing, which will also include information on how to complete the survey online. We have found for the MA&PDP CAHPS survey that

additional web invitation mailing(s) after the prenotification letter is not very productive considering the cost of mailing these letters to the members. We urge CMS to conduct a cost-benefit analysis of using the web survey invitation letters as part of this fielding test and consider the increased financial burden on the MAOs required to conduct this survey.

4) Is CMS comparing the Web based-only response rates to the combined paper and telephone response rates per study group, or are only the total response rates compared between each study group?
    a. Given that participants in the web-mail-phone test could receive more opportunities or reminders to take the survey compared to the control group, it is possible that the group with more reminders will have a higher response rate, not due to the way in which the survey was received, but due to the additional opportunities and reminders that the survey should be completed. For this reason, reviewing the modality responses separately may be helpful in determining the results and we encourage CMS to study the responses in this way.
    b. Additionally, we seek clarification on whether case-mix adjustment will be applied to the Web arm of the field test results. If yes, Humana urges CMS to provide plans with more information about the nuances of that process such as whether it would work similarly to mail or be based on different variables.
c. The field test should also consider the use of QR code on the prenotification letter and the web survey invitation letters. We have usually found that QR codes drive more people to the use of the web survey than web survey URL alone. QR code also makes the survey more accessible when the survey is offered in different languages. Starting with the 2025 survey, MA-PDP CAHPS made the use of QR code on prenotification and web invitation letters optional.

Additionally, we understand the desire to increase response rates and believe the Web-based modality supports this effort. However, we suggest that CMS consider whether it is appropriate to adjust the minimum result threshold back down (e.g. from 100 back to 30 or a lower number) before or in tandem with the modality testing. This increased minimum result threshold can result in more HOS contracts being excluded from the final Star ratings, impacting the overall ratings of plans when high performing contracts are excluded because of the higher threshold. We urge CMS to consider reducing the threshold to previous levels as part of its evaluation of the results of this field test.

Further, the proposal states that "The Medicare HOS is administered annually to MA enrollees. CMS's contractor will use the remaining unused sample frame from the annual HOS administration to draw samples for this field test." Humana requests clarification on what "unused sample frame" mean. It appears that 50 contracts will be selected to participate in this field test, and we seek clarification on whether these participants will be selected across payors or if CMS is looking for Humana and other payors to provide recommendations on which contracts to include.

Humana also urges CMS to provide more information regarding when the field test planned to launch and how close to the official HOS survey will the test be issued. We recommend that the field test be conducted four to six months before the official HOS survey is conducted in order to

provide sufficient time for the field test survey results to be assessed for impacts before administering the official survey.

Finally, we recommend that CMS provide plans with the opportunity to review or see the HOS communication templates (digital and non-digital) before they are distributed to beneficiaries.

We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to beneficiaries, focused on improving their total health care experience. If you have any questions, please do not hesitate to reach out to me at mhoak@humana.com and 571-466-6673.

Sincerely,

Michael Hoak
Vice President, Public Policy

KAISER PERMANENTE®

Kaiser Permanente Comments on
Medicare Health Outcomes Survey Field Test

Attention: Document Identifier/OMB Control Number: CMS-10861
(OMB control number: 0938-1464)

November 4, 2025

Submitted electronically via regulations.gov

Kaiser Permanente[1] appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS) on the Medicare Health Outcomes Survey (HOS) Field Test, which may be used in the Medicare Part C Star Ratings in the future, as published in the *Federal Register* (90 FR 42969) on September 5, 2025 (Form CMS-10861, OMB control number: 0938-1464).

As CMS considers updating the HOS metrics used to assess the performance of Medicare Advantage and Part D plans, it is essential that the agency ensures the reliability of these measures, particularly as they will inform public reporting and stakeholder decision-making. Reliable estimation of changes in HOS scores at the contract level is critical to ensuring that comparisons are both meaningful and actionable. Reliability is inherently influenced by both the population included in the field test and the anticipated sample sizes within each contract, necessitating careful evaluation as the system is scaled.

To account for potential differences between the field test population and the full survey population, we recommend that CMS conduct sensitivity analyses to assess the robustness of the reliability estimates. Additionally, we urge caution when interpreting random effects estimates, as they may not fully capture variability associated with sample size fluctuations. To provide transparent and actionable data, we recommend reporting reliability using Spearman-Brown or similar calculations across a range of sample sizes, which will support more informed comparisons and quality improvement efforts.

Kaiser Permanente agrees with CMS that the introduction of a web survey modality is a positive step, as it is likely to increase response rates by providing greater accessibility and convenience for participants. Additionally, reducing the number of survey questions can help minimize respondent fatigue, which not only enhances participation but also improves the accuracy of the collected data.

Kaiser Permanente encourages CMS to share the anticipated timeline for completion of the field test and the subsequent release of results. We also recommend that the agency provide participating

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

One Kaiser Plaza
Oakland, CA 94612

contracts with the data and analyses specific to their respective members, which will ensure access to relevant information for internal review and quality improvement purposes.

CMS-10861 – Supporting Statement B

Statistical Methodology

2. Information Collection Procedures (p. 4)

CMS indicates, "The invitation will be sent by email to enrollees with email addresses, and via a letter to all sampled enrollees, including those with email addresses and for whom an email address is not available. A second invitation email will be sent five days after the initial invitation to enrollees with email addresses." We recommend specifying that a second invitation email will only be sent to non-respondents, as is specified with all other outreaches.

Attachment D. CMS HOS Crosswalk

Attachment D. Crosswalk of Item Differences by Questionnaire Version

*2. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? (p. 1)*

Field Test Version B proposes to add "walking at a brisk pace" as an example of moderate activity. To ensure clarity across varying literacy levels and potential language barriers, we recommend rewording this item to better define "brisk pace" – for example, by asking, "Can you walk one block (about the length of a street) without needing to stop?" or by replacing "brisk pace" with a more universally understood term such as "fast walk", "quick walk", or "walking quickly". We recommend that the clarified or simplified "brisk pace" language be applied consistently wherever the term appears throughout the field test to ensure comprehension across all respondents.

Items removed: Has a doctor ever told you that you had: congestive heart failure, A myocardial infarction or heart attack, Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat, A stroke, Crohn's disease, ulcerative colitis, or inflammatory bowel disease, or Osteoporosis, sometimes called thin or brittle bones? (p. 11)

We appreciate CMS's effort to streamline the survey and reduce respondent burden by removing select health condition items. However, we are concerned about the potential implications for case-mix adjustment, given the longitudinal nature of these questions and their established relationship with both physical and mental health outcomes. We respectfully request additional detail and definitions from CMS regarding the analysis supporting the conclusion that removal of these items will have little to no impact on case-mix adjustment calculations for all participating contracts.

While we recognize that many of these diagnoses can be captured through administrative data, such data may not fully align with members' self-reported conditions. These self-reported health conditions also provide valuable context for analyzing correlations and drivers of performance and identifying opportunities for improvement. For this reason, rather than completely removing

questions 18 through 21 and 23 and 24, we recommend CMS consider consolidating these items into one question with the following wording and testing this rewording in Field Test Version A or B:

> Have you ever been told by a doctor and/or are you currently under treatment for (please select all that apply):
>
> a. Congestive heart failure
> b. A myocardial infarction or heart attack
> c. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat
> d. A stroke
> e. Crohn's disease, ulcerative colitis, or inflammatory bowel disease
> f. Osteoporosis, sometimes called thin or brittle bones

*New Item Field Test Version A 38. In the **past 12 months**, has a doctor or other health professional talked with you about your diet or eating habits? Field Test Version B 38. In the **past 12 months**, has a doctor or other health professional provided advice about your diet or eating habits? (p. 19)*

We appreciate CMS's efforts to explore how providers engage patients around nutrition and healthy eating behaviors. However, we offer the following observations and recommendations for consideration:

- The questions in Versions A and B are not equivalent – Version A asks whether a provider "talked with you," while Version B asks whether a provider "provided advice." Clarification is needed regarding CMS's intended objective. Specifically, the goal should be to determine whether health plans, providers, and care teams are addressing healthy eating habits with patients.

- The use of the term "talk" in Version A may inadvertently exclude asynchronous or digital forms of communication (e.g., secure messaging, patient portal outreach, or educational resources). To reflect modern care delivery methods, CMS could consider alternatives such as "communicated with you," "reached out to you," or "discussed or shared information with you." These phrases would better encompass both in-person and virtual communication channels while maintaining the intent of provider engagement.

- We have concerns regarding the use of Behavioral Risk Factor Surveillance System (BRFSS)-style, patient recall-based data collection for this topic. Counseling and education information are more accurately captured through administrative or EMR-based data sources. For reference, the National Committee for Quality Assurance (NCQA) is retiring the Consumer Assessment of Healthcare Providers and Systems (CAHPS) smoking cessation counseling measure in favor of an administrative measure. While CMS may wish to collect this information through the survey for contextual understanding, we recommend it not be used for new measure development.

*New Item Field Test Version A 39. In the **past 12 months**, has a doctor or other health professional talked with you about your alcohol use? Field Test Version B 39. In the **past 12 months,** has a doctor or other health professional provided advice about your alcohol use?*

Question 39 also uses the phrasing “talked with you” and “provided advice” about alcohol use, and we offer the same feedback regarding the need for clarity of intent and more inclusive wording that reflects multiple forms of communication beyond direct conversation.

PUBLIC SUBMISSION

As of: 11/5/25, 7:32 AM
Received: November 04, 2025
Status: Draft
Category: Health Care Professional/Association - Physical Therapist
Tracking No. mhl-69p8-smfw
Comments Due: November 04, 2025
Submission Type: Web

Docket: CMS-2025-0799
Medicare Health Outcomes Survey Field Test (CMS-10861)

Comment On: CMS-2025-0799-0001
Medicare Health Outcomes Survey Field Test (CMS-10861)

Document: CMS-2025-0799-DRAFT-0009
Comment on CMS-2025-0799-0001

Submitter Information

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General Comment

I support this proposal. As more and more Medicare-eligible individuals are enrolling onto MA plans, and many are unfortunately experiencing declining levels of care as a result of poor coverage, restrictive prior authorizations, and restrictive coverage, I believe it is important to gather this information, including satisfaction, to rate these plans and hold insurers accountable. I am a physical therapist that works in geriatric care and I treat many older adults on MA plans, which are routinely limiting their therapy visits. We are seeing a large decline in our seniors and are ill equipped to provide them care when these MA plans are limiting their coverage so gravely.

Special Needs Plan Alliance

October 24, 2025

William N. Parham III
Director, Director of Information Collection and
Regulatory Impacts, Office of Strategic Operations
and Regulatory Affairs, CMS

Submitted electronically to Mr. William Parham www.reginfo.gov/public/do/PRAMain

Attention: Document Identifiers: CMS–10861
Federal Register / Vol. 90, No. 167 / Tuesday, September 2, 2025 / Notices

Dear Mr. Parham,

The Special Needs Plan Alliance (SNP Alliance) is a national, non-profit thought leadership organization addressing the needs of high-risk and high-cost complex care populations with chronic conditions through specialized managed care. The Alliance is the only organization exclusively representing Medicare Advantage Special Needs Plans – Dual SNPs (D-SNPs), Institutional SNPs (I-SNPs) and Chronic Condition SNPs (C-SNPs).

We represent approximately 65% of all SNPs. These plans have over 4 million beneficiaries enrolled across the country—totaling more than 55% of the national SNP and Medicare Medicaid Program demonstration enrollment. Our primary goals are to improve the quality of service and care outcomes for complex care populations with chronic conditions and to advance integration for those dually eligible for Medicare and Medicaid. The vast majority of all SNP enrollees, regardless of type of SNP, are dually eligible.

OVERVIEW

To prepare our response, we reviewed the Notice and supporting statements and related materials pertaining to proposed changes in the Health Outcomes Survey instrument for field testing. We also held discussions with subject matter experts from special needs health plans.

We appreciate CMS' commitment to ensuring that instruments and quality measures used in the Medicare program are valid, reliable, accurate, fair, and have utility to promote improvement. We are encouraged by the willingness of CMS to re-examine the Health Outcomes Survey. We agree with many of the proposed changes in Version B of the revised instrument. We appreciate the proposed use of items from PROMIS and the GAD-2 screen which could be used to replace

current questions around functional status assessment and could add to the understanding of anxiety within the Medicare population. We strongly support the addition of a web-based mode for collection.

However, the revised instrument and proposed field testing still falls short of what is needed in terms of revising and testing the Health Outcomes Survey.

The SNP Alliance and other organizations previously have reviewed, analyzed, and reported on information that indicates the HOS instrument needs a more major overhaul. Limitations discovered include:

- Diversity of Medicare Population not fully Considered
- Instrument Limitations as Applied to People with Special Needs
- Inadequate Methods and Administration
- Information Decay, Time Lag Impacting Utility of the Information
- Proxy Issues
- Results Affected by Underlying Characteristics of Enrollment which are Not Included in Case-Mix
- Attribution, Contextual Issues Not Considered
- Inadequate or Outdated Models and Adjustments
- Cautions Regarding Analysis, Interpretation, Comparisons and Reporting

For further information, see: HOS White Paper SNP Alliance, and our report and analysis conducted with ATI Advisory (HOS Report; ATI Advisory & SNP Alliance 2023).

RECOMMENDATIONS

We recommend the following to strengthen and augment the utility of the Health Outcomes Survey and the proposed field testing:

- ***RECOMMENDATION #1 - Use Version B, with additional further revisions to the Instrument*** - The SNP Alliance strongly recommends additional revisions to the Health Outcomes Survey beyond those which have been proposed. In regard to the two versions of the instrument, **Version B** is a better match for a special needs population as these individuals typically have multiple chronic conditions, use adaptive equipment to address functional limitations, and are low-income. The changes made from Version A to B are in line with previous recommendations of the SNP Alliance and its member health plans. Specifically these items in Version B align with our prior comments and analysis around special needs populations:
    - We sincerely appreciate CMS' recognition that *bowling and golf* were not inclusive activities in terms of use or access for this population.

- We also agree that a *five-item response scale* is superior to the current 6 item scale, particularly because many individuals have trouble discerning the difference between "a good bit of the time" and "some of the time."
- In previous letters, we strongly recommended revising item #10 which asked the person to discount their *use of special equipment*. We appreciate CMS's agreement that the revised item stem is more inclusive of those who use assistive devices and potentially enhance Physical Function Activities of Daily Living (PFADL) measure.
- We also appreciate that the PROMIS items are being tested as a potential replacement for existing *physical function items*, providing the opportunity to evaluate a wider range of impairment.
- We agree with the addition of two items in Question #31 allowing for focus on *anxiety and recognizing that mental health conditions* are important.
- We agree with the change in wording in Question #38 to clarify that question focuses on *advice of the physician*, not only conversation.

- ***RECOMMENDATION #2 - Retain and Add Conditions to Better Understand Case-Mix Impact*** – We do not agree with removal of some of the items proposed for deletion. Specifically, some of the condition questions, the living arrangement question, and the proxy response question. We provide further detail to explain our position:
  - ***Multiple conditions – Need to Review Impact on Case-mix stratification***. While we appreciate that the specific conditions listed in items #21, 22, 23, 24, 27, and 28 may have a limited impact on case mix adjustment, these diseases in combination with each other may disproportionately occur in special needs populations. Therefore, in combination, they may indicate heightened risk of health status decline. We recommend re-examining removal when 3 or more of these conditions are present. One approach would be to group all of these items into one question, so to limit the length/number of questions.
  - ***Add Progressive, Neuromuscular Degenerative Conditions*** -We request the addition of conditions which have empirically been associated with poorer health status outcomes, particularly over time. Progressive neuromuscular degenerative diseases are especially prevalent in a SNP population and should be included in case mix stratification. These include Alzheimer's Disease and Related Disorders, Parkinson's Disease, ALS, Lewy Body Disease, Muscular Sclerosis. We respectfully request that these be added to the instrument for case-mix adjustment. They could be grouped into one item, so that the length of the instrument is not unwieldy.
  - ***Living Arrangement*** – Regarding item #52, while we appreciate that there is sensitivity to a "living alone" response, research shows that persons who live alone and who also have functional impairment and multiple chronic conditions

are far more likely to experience a fall, depression, and functional decline. We believe it is very important to determine who lives alone when using a predictive algorithm for health status decline. This should be a variable in case mix adjustment. We recommend that the item could be reworded simply as: "Do you live with anyone else?" Yes/No.

- ***Proxy respondent*** – Regarding item #55, research shows that proxy respondents often have opinions and perspectives that differ from the individual. This is particularly important if the respondent was a paid professional caregiver. We strongly recommend adding this item back into the instrument.

- ***RECOMMENDATION #3 – Attend to Sampling of Contracts to Ensure Enough High Dual Contracts and Individuals are in the Final Field Test Sample –*** We have previously recommended oversampling among people who are dually-eligible to ensure that the field test has enough individuals for adequate statistical analysis. Otherwise, conclusions made using field test results may be inaccurate when applied to dually-eligible individuals. Likewise predictive modeling regarding expected decline over two years as is used for longitudinal measures could be inaccurate.

  We recommend selecting contracts that include a high proportion of diverse beneficiaries, for example where over 75% of enrollment within a H# contract plan is dually eligible, disabled or low-income. We also recommend selecting a set of contracts that predominately serve frail elderly, and a set of contracts that predominately serve people with high behavioral health needs and physical disabilities. This could be achieved by selecting contracts that are SNPs—FIDE-SNPs, HIDE-SNPs, I-SNPs, and C-SNPs. FIDE-SNPs and I-SNPs have a much older and more frail population. HIDE-SNPs have a higher proportion of people who became eligible for Medicare because of a physical disability and who have a higher rate of behavioral health and mental health conditions. C-SNPs have individuals with specific complex conditions such as HIV/AIDs and will provide important information from a population that has higher rates of functional and emotional health status challenges including anxiety.

  HOS-M and HOS – Please be sure that the field test sample is pulled from the unused sample frame from BOTH the HOS-M and the HOS. The HOS-M is used for calculating frailty adjusters for some FIDE-SNPs and it would be important to include these respondents as well as those who respond to the full-HOS.

- ***RECOMMENDATION #4 – Reconsider Use of HOS-derived data in Performance Evaluation and Comparison Across Health Plans -*** Due to limitations in the instrument, methods, and measure specifications of measures derived from HOS, the time lag in receiving data, and the other limitations outlined in previous reports, our analysis suggests

that HOS is not adequate to be used as the vehicle for performance evaluation or plan to plan comparison, particularly if a health plan membership composition includes a large proportion of dually eligible individuals. We recommend utilizing other Person-Reported Outcome Measures which could be more closely related to actions performed by a health plan.

- ***RECOMMENDATION #5 - Retest the Whole Instrument –*** If used in MA quality measurement, we recommend that re-testing the HOS instrument (all questions) should be performed with stratification of results by beneficiary sub-group, particularly for dually eligible individuals. We also recommend that the case-mix model includes functional status, complex chronic conditions including progressive neuro-muscular conditions and mental health conditions, social risk factors, and living arrangement status, in addition to age.

    - ***Obtain Substantive Input from Stakeholders with Complex Conditions and Special Needs –*** As indicated, the HOS instrument needs substantial revisions if it is to be used in a fair and equitable quality measurement, evaluation, and reporting system. The whole instrument needs additional review with more stakeholder input for comprehension, format, accuracy, validity, and utility. The proposed revisions are insufficient to address the issues we and others have raised. Please see our SNP Alliance White paper and analysis conducted with ATI Advisory (links provided earlier in this letter) for additional analysis and information. In addition to addressing the sample bias (discussed further within this letter), HOS could be improved by allowing the respondent to provide some kind of *contextual information* about what has happened to them over the past two years—particularly for longitudinal measures. It could have checkboxes or Likert scale questions to provide insight from the individual about what impacts their health status. This would retain anonymity but could help plans know what was driving the health status changes within the respondent sample that reported.

    - ***Format, Question Order, Response Scale -***A true test of a survey instrument involves the question order, format, length, and total duration to complete--not just each individual item posed separately. Response rate is important, but comprehension of each item and of the instrument as a whole (in the way that it is experienced by the respondent) is at least equally important. The response scales may not be equally understood by different sub-population groups. Examining the survey as a whole and the response scale comprehension among diverse population sub-groups should be included in the field testing—especially if CMS wishes to compare two versions of a revised instrument and wishes to understand how comprehension and response may differ based on characteristics of the person completing the survey.

- ***Conduct Sub-Group Analysis*** – The instrument must be adequately tested in special sub-populations, such as those with low literacy and people who are dually eligible, to ensure that the questions and scaled responses are understood and meaningful to these individuals. Analysis should separate out these sub-groups.

- ***RECOMMENDATION #6 – Reconsider Utility of the HOS Data -*** The data derived from HOS is insufficient for use in timely quality improvement. The SNP Alliance strongly supports obtaining information directly from the beneficiary on his/her/their status and experience of care. However, currently the HOS does not support performance evaluation nor comparison across plans and does not provide information to guide quality improvement.
    - *Blinded Respondent Sample Does Not Offer Actionable Information* - Unfortunately, blinded longitudinal data does not offer information that is actionable to a health plan or provider. It would be useful for an individual to discuss their self-report of status, compared to his/her/their self-report of status two years ago, with their provider as part of care conversations—but that is not how HOS is used. Providers are unaware and unable to see who or how their patients have responded to status questions.
    - *Biased Sample* - The composition of the respondent pool is inadequate to support the goals of accuracy, fairness, and utility. People who do not speak the few languages that are offered in the survey administration are left out of the sample.
    - *Long Time Lag/Delay* – The information is not received for years after data collection. Moreover, there is no contextual information to guide understanding of what is causing or impacting/affecting the response. This stymies practice or administrative root cause analysis and makes it impossible to tie responses to specific actions or use the information to set quality improvement goals.

- ***RECOMMENDATION #7 – Ensure Full Transparency and Complete Reporting of Results in a Timely Way –*** Despite these limitations, as long as a field test is being done, it is critical to provide full transparency and complete information to the field on the results. The field-testing methods, sample size, demographic characteristics including dual eligible status, language, age, geographic representation, and other characteristics of the sample must be reported so that these characteristics can be compared to the same characteristics of a plan's enrollment. This allows for appropriate benchmarking. Sub-group analysis should show the calculation of response averages and ranges by sub-group for each item and overall, most importantly separating out the dually eligible respondents from non-dual Medicare beneficiaries. We have also had a suggestion from one plan requesting that CMS incorporate information on the HOS respondents from other data sources, such as diagnoses or utilization to better understand beneficiary complexity.

CMS should request that the research contractors assess the impact of removing and lessening the robustness of the case-mix variables and report on this. What is the net effect of deleting these conditions and losing these covariates? Might other covariates be considered that would have a larger effect, such as progressive neuromuscular degenerative conditions as we have proposed? Complete and comprehensive reporting on methods, analysis, discussion, and implications is crucial. This information is vital to inform stakeholders and guide future quality measurement system improvement. It will be useful beyond the initial purpose of modifying the instrument. The information should be distributed as soon as possible after analysis. We appreciate CMS' commitment to informing the general public as well as health organizations, and other researchers, and to providing in-depth information.

SUMMARY

In summary, while we are encouraged by CMS' interest in reworking items within the HOS and field-testing alternative items in HOS, we strongly support revisions to HOS beyond what has been proposed. We have attempted to offer solutions to address the observed limitations. We support field testing a revised instrument among a substantial group of beneficiaries with complex chronic conditions and functional limitations.

Thank you for the opportunity to comment. We appreciate your attention. Please let us know if you would like to discuss any of this further. We would be happy to do so.

Sincerely,

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SNP Alliance

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November 4, 2025

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB control number: 0938–1464
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Submitted Electronically:

Re: Federal Comment Opportunity: Medicare Health Outcomes Survey Field Test

Dear Sir/Madam:

UnitedHealthcare (UHC) is responding to the Information Collection Request (ICR) for the Centers for Medicare & Medicaid Services (CMS) Medicare Health Outcomes Survey Field Test. The ICR was published by CMS in the Federal Register (90 FR 42969) on September 5, 2025.

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UHC is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

UHC appreciates the opportunity to provide several Medicare Health Outcomes Survey Field test suggestions outlined below.

We support CMS's re-evaluation of the Health Outcomes Survey and many of the proposed updates in Version B, including the use of Patient-Reported Outcomes Measurement Information System (PROMIS) items to better assess functional status and anxiety in the Medicare population. UHC recommends that Medicare Advantage Organizations be provided with results from the HOS Field Test to evaluate how these changes may impact the Health Outcomes Survey.

In the past, UHC has recommended replacing the Improving or Maintaining Physical Health (PCS) measure with the Physical Functioning Activities of Daily Living (PFADL) measure, and we believe this field test may provide further data to support this position.

Recommendations Regarding Physical Component Summary (PCS) and Mental Component Summary (MCS) Scoring

We remain concerned about the PCS and Mental Health Score (MCS) scoring methodology, particularly the use of regression-based coefficients, which can produce results that are counterintuitive and difficult to interpret. Specifically:

- The PCS score incorporates five mental health-related items, where better self-reported mental health can paradoxically result in a lower PCS score.
- The MCS score includes six physical health-related items with negative coefficients, meaning that improved physical health responses can result in a lower MCS score.

This scoring structure can lead to confounding outcomes between baseline and follow-up surveys. For example, a respondent may report that they improved mental health over a two-year period, yet their PCS score may decline—even when there is no reported deterioration in the physical health domains of the survey.

In addition, we recommend that CMS select PROMIS items that are more appropriate for the Medicare population. For example, a question about moving heavy furniture may not reflect the typical experiences of Medicare beneficiaries, whereas a question about carrying groceries or other common activities of daily living would be more relevant and meaningful.

We believe these aspects undermine the utility of the PCS and MCS scores and reinforce the need to explore alternative measures such as PFADL.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

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