HEDIS® Medicare Health Outcomes Survey Use Application

Overview

The following Medicare HOS and HOS-M Instruments (Surveys) are available for use outside the official CMS-sponsored HOS Program with permission from NCQA:

- Medicare Health Outcomes Survey Instrument Version 3.0 – English, Spanish, Chinese, and Russian
- Medicare Health Outcomes Survey Instrument Version 2.5 – English
- Medicare Health Outcomes Survey Instrument Version 2.0 – English
- Medicare Health Outcomes Survey Instrument Version 1.0 – English
- Medicare Health Outcomes Survey-Modified Instrument – English, Spanish, Chinese, and Russian

Please see the instructions below to request use of the Surveys.

Instructions to Request Use of a Survey

1. **Survey Use Application:** Complete and sign this Survey Use Application to request to use all or a subset of Survey items. You must provide a detailed description of the project. Incomplete applications will be returned to the requester for additional information and will delay review of your organization's request.

2. **Terms of Use:** Read and sign the Terms of Use for the Surveys. If you do not agree to the Terms of Use, you may not use the Surveys or the HEDIS® technical specifications for the Surveys outside the official CMS-sponsored HOS Program.

   Survey vendors, health plans, or their agents are prohibited from administering any HOS and HOS-M survey questions to Medicare beneficiaries during the eight week period prior to HOS and HOS-M administration and during HOS and HOS-M administration.

3. **Survey Materials:** The organization administering the survey is required to submit all necessary documentation and survey materials in accordance with the Terms of Use before NCQA can issue approval of the Survey Use Application.

   The survey materials required for submission are determined by the protocol specified by the organization in the Survey Use Application. All applications must provide a sample copy of the proposed *questionnaire*, including the appropriate copyright language, for the HOS or HOS-M as indicated in the Terms of Use, and sample copies of any *outreach materials.* Outreach materials include any notification sent to sampled members regarding the survey, including but not limited to, pre-notification mailings or reminder emails. If the questions will be administered verbally (in-person or over the phone), the

applicant must provide a copy of the proposed *script*. If the survey will be administered electronically through a web link or computer assisted telephone interviewing system, programming *specifications* must be included either in the questionnaire or submitted via screenshots or live links to the specifications.

Table 1. Required Survey Materials by Administered Mode

Protocol	Required Survey Materials
Mail	Sample Questionnaire and Sample Outreach Materials
Telephone	Sample Questionnaire, Sample Script, Sample Interviewing Specifications, and Sample Outreach Materials
Web	Sample Questionnaire, Sample Programming Specifications, and Sample Outreach Materials
In Person	Sample Questionnaire, Sample Script, and Sample Outreach Materials

4. **Submit Survey Use Application, Terms of Use, and the proposed survey materials must be typed and sent electronically to hos@ncqa.org.**

   All requests must be reviewed and approved by NCQA. Additional information may be requested if an application lacks sufficient detail. Applications will not be considered complete until all additional information is received. Requesting organizations will receive a written decision within 10 business days of submitting a complete request. Approval expires one year after the approval date. Organizations may reapply, annually to continue to use the Surveys.

1. ORGANIZATION/CONTACT INFORMATION
1a. ORGANIZATION NAME:
1b. MEDICARE CONTRACT NUMBER (If Applicable):
1c. PRIMARY CONTACT PERSON: FIRST NAME MIDDLE INITIAL LAST NAME
1d. TITLE:
1e. MAILING ADDRESS 1:
1f. MAILING ADDRESS 2:
1g. CITY STATE ZIP CODE
1h. TELEPHONE (Area Code, Number, and Extension):
1i. E-MAIL ADDRESS:
1j. ORGANIZATION TYPE: ☐ Health Plan ☐ Health Care Provider • Academia ☐ Researcher ☐ Student ☐ Government (Specify Agency) _____ ☐ Other (Specify) _____

2. PROJECT INFORMATION
2a. PROJECT TITLE:
2b. PROJECT TYPE: ☐ Quality Improvement ☐ Research ☐ Other (Specify) _____
2c. PROJECT TIMING (Project Start & End Date):
3. PROJECT DESCRIPTION
3a. Describe purpose of project:
3b. Describe the population to be surveyed:
3c. What is the sample size for your project? The sample size should be a maximum of 1,200 members for each contract to align with the official HOS survey size (500-1,200).[1] If fielding multiple surveys, list the sample size for each:
3d. Describe the sampling methodology (i.e., how will the survey sample be selected?). If fielding multiple surveys, describe the sampling methodology for each sample:

[1] Surveys of Medicare beneficiaries that use the same or similar questions as official CMS surveys could have a negative effect on how beneficiaries respond to non-CMS and CMS surveys. Medicare beneficiaries who receive requests to participate in multiple off-cycle surveys are likely to ignore one or more of those requests, putting all survey response rates at risk.

3. PROJECT DESCRIPTION (Continued)
3e. When will the proposed survey be fielded? List month(s) and year:
3f. Check all administration modes that apply: ☐ Mail ☐ Telephone ☐ Web ☐ In Person
3g. Describe your data collection method(s) and mode(s).
3h. Describe the analyses that will be conducted. Attach additional sheets, if necessary:
4. QUESTIONNAIRE INFORMATION (Include Sample Questionnaire with Form)
4a. Version of HOS or HOS-M Requested:
4b. Items Used in Questionnaire: ☐ Complete Questionnaire ☐ Subset of Questionnaire (Specify Survey Questions) _____
5. SURVEY VENDOR INFORMATION (If Applicable)
SURVEY VENDOR ORGANIZATION NAME:
PRIMARY CONTACT PERSON (First Name, Last Name, Title):
PRIMARY CONTACT TELEPHONE NUMBER:
PRIMARY CONTACT EMAIL ADDRESS:

6. APPLICANT ORGANIZATION SUBMISSION
Please complete and date the form. I hereby attest that the information contained in this application is accurate to the best of my knowledge, and I agree that the Medicare Health Outcomes Survey or Medicare Health Outcomes Survey-Modified will be used solely for the purpose specified in this Survey Use Application.
Name:
Title:
Organization:
Date:
TO BE COMPLETED BY NCQA HOS STAFF
Documentation Provided: ☐ Survey Use Application ☐ Terms of Use Agreement Check all that apply (based on administered mode, see Table 1): ☐ Sample Questionnaire ☐ Sample Script ☐ Sample Specifications ☐ Sample Outreach Materials Request approved for one year: ☐ Yes ☐ No
Comments:
Reviewer Name:
Title:
Date:
Approval Expiration Date:

