U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

DATA COLLECTION FOR ADMINISTERING THE MEDICARE HEALTH IMPROVEMENT SURVEY

OFFICE OF MANAGEMENT AND BUDGET CLEARANCE PACKAGE SUPPORTING STATEMENT

July 10, 2006

CONTENTS

CONTENTS

LIST OF TABLES

Page

CONTENTS

APPENDICES

A. Background

The Centers for Medicare & Medicaid Services (CMS), a division of the U.S. Department of Health & Human Services (DHHS), seek approval for survey data collection for an evaluation project entitled Evaluation of the Medicare Care Management for High Cost Beneficiaries Demonstration. This evaluation will assess the impact of care management programs upon the behavior, health status, and health care costs of high-cost Medicare beneficiaries. Through this submission, CMS is requesting OMB approval for the implementation and analysis of the **Medicare Health Improvement Survey.**

Appendix A contains a copy of the appropriate Statutes and Code of Federal Regulations, and Appendix B contains the survey instrument.

A.1 Purpose

The purpose of this beneficiary survey is to obtain information about beneficiary behavior, physical functioning and satisfaction with the care management programs—data required to evaluate the Medicare Care Management for High Cost Beneficiaries demonstration (CMHCB). This demonstration provides an opportunity to test new models of care for Medicare beneficiaries who are high-cost and who have complex chronic conditions with the goals of reducing future costs, improving quality of care and quality of life, and improving beneficiary and provider satisfaction.

CMS has awarded a contract to RTI, International (RTI) to conduct the Medicare Health Improvement Survey. This cross-sectional beneficiary survey is designed to measure changes in beneficiary behaviors and physical functioning and satisfaction with the CMHCB programs during the period approximately 18 months following the launch of each program. The impact of the CMHCB programs will be assessed by comparing survey results from intervention group members and members of corresponding comparison groups.

A.2 General Background

Overview of the CMHCB

The CMHCB is one of several programs conducted by the Department of Health and Human Services to develop and test strategies to improve the coordination of Medicare services for beneficiaries with high-cost conditions. The goal of the CMHCB demonstration is to examine different models of intensive management for high-cost beneficiaries with various medical conditions to reduce cost as well as improve quality of care and quality of life for those beneficiaries. The Centers for Medicare and Medicaid Services (CMS) have awarded contracts to six organizations to operate programs in the CMHCB demonstration. These include:

- ACCENT, a consortium of clinics in Oregon and Washington state;
- Care Level Management (CLM), a physician home visiting program that will operate in California, Texas, and Florida;
- Massachusetts General Hospital and Physicians Organization operating in Boston;

- Montefiore Medical Center, an integrated delivery system (IDS) operating in the Bronx;
- RMS DM, a renal disease management company focusing upon chronic kidney disease among beneficiaries in New York; and
- Texas Senior trails, an IDS operating in the panhandle of Texas

Beneficiary participation in the CMHCB program will be voluntary and will not change the scope, duration or amount of Medicare FFS benefits currently received by Medicare FFS participants. All Medicare FFS benefits will continue to be covered, administered, and paid for by the traditional Medicare FFS program. Beneficiaries will not pay any charge to receive CMHCB program services. In addition, no Medicare FFS beneficiaries will be subjected to utilization reviews that restrict them to doctors in a given network as a result of this project.

CMS will pay awarded programs with a monthly administrative fee per participant. Payments will be made contingent upon savings to the Medicare program (based on comparisons of the intervention versus comparison groups in a given geographic area).

The care management organization (CMO) programs are designed to incorporate relevant features from private sector programs but also be sufficiently flexible to adapt to the unique needs of the highest cost Medicare populations. For example, organizations will be given the latitude to stratify targeted individuals according to risk and to tailor their interventions to the unique needs of FFS Medicare beneficiaries, including self-care and caregiver support, care coordination, education, and use of in-home monitoring devices, as deemed appropriate. Each organization will be expected to assume financial risk in the event of failure to meet agreed-upon performance standards for savings targeted (discussed more in the Section on Adjustment of Fees below). CMS has developed the CMHCB program with considerable administrative risk as an incentive to reach targeted beneficiaries and their providers on a continuing basis to help them improve chronic care management.

Concerns/Rationale for the Proposed Intervention

This program was designed to address current failings of the health care system with regard to chronically ill Medicare FFS beneficiaries. The current health care system has been structured and financed to help older persons to manage acute, rather than long-term health problems. Providers of care typically are organized and paid for in discrete settings (for example hospitals, physician offices, home health care, preventive services, long-term care, etc). In addition, some literature has suggested that current provider incentives favor focusing on each patient while he/she is within the provider's care setting, rather than on treating him/her in a more holistic fashion. Similarly, patient care can be fragmented and poorly coordinated, with patient information difficult to integrate among settings as patients move from one provider to another. Providers also may lack timely and complete clinical information needed to fully assess their patients' needs and to prevent complications. Ongoing care for managing chronic conditions to support beneficiaries is rare. Because Medicare beneficiaries have multiple conditions, see a variety of providers, and often receive conflicting advice from different providers, there is concern that there is a significant gap between what is appropriate care for patients with chronic conditions and the care they actually receive.

Medicare beneficiaries with multiple progressive chronic diseases are a large and costly subgroup of the Medicare population. The Congressional Budget Office (CBO) recently estimated that in 2001 high-cost beneficiaries, i.e., those in the top 25% of spending, accounted for 85% of annual Medicare expenditures.[1] Three categories of high-cost users, beneficiaries with multiple chronic conditions, those who were hospitalized, or those who had high total costs, had expenditures that were twice as high as expenditures for a reference group. Subsequent years of costs remained higher than the reference group; however, total expenditures declined the most for those beneficiaries who were identified as high-cost due to a hospitalization. Subsequent costs were virtually unchanged for beneficiaries with multiple chronic conditions.

Further, these beneficiaries must navigate a health care system that has been structured and financed currently to manage their acute, rather than long-term, health problems. When older patients seek medical care, their problems are typically treated in discrete settings rather than being managed in a holistic fashion.[2,3] Because Medicare beneficiaries have multiple conditions, see a variety of providers, and often receive conflicting advice from them, there is concern that there is a significant gap between what is appropriate care for these patients and the care they actually receive.[4,5] The CMHCB demonstration has been designed to address current failings of the health care system for chronically ill Medicare FFS beneficiaries.

The program interventions implemented by physician groups, hospitals, and integrated delivery systems are intended to improve outcomes and manage care in a cost-effective manner that will raise the quality of care delivered. Examples of strategies to be employed by CMOs include: telemonitoring, telephonic care management, electronic medical records, and home visits. This program has been proposed to test the success of programs that offer ongoing guidance and support beyond that typically provided in individual provider settings.

Data Collection Materials

RTI will use the following materials to gain response from sample members:

- Pre-notification letter—will be sent to all sample members to alert them to the questionnaire packet we will be sending to them the following week.

- 1st questionnaire packet—will be sent to all sample members and will include the beneficiary questionnaire and a prepaid envelope to return the completed questionnaire

- Thank you/reminder postcard—will be sent to all sample members the week after the first questionnaire is mailed

- 2nd questionnaire packet—will be sent to sample members who have not returned the first questionnaire. It will also include a prepaid envelope.

- 3rd overnight questionnaire packet—will be send to sample members who have not returned a questionnaire and to those for whom we cannot locate a telephone number.

- CATI follow-up—phone numbers will be obtained for sample members who have not responded to any of the mailings. They will be called and persuaded to complete the interview over the phone

B. Justification

B.1 Need and Legal Basis

The authority for this demonstration and data collection is given under the provisions of Section 1110 of the Social Security Act *[42 U.S.C. 1310]* and Section 402 of the Social Security Amendments of 1972 *[42 U.S.C.1395b-1]*. The former legislation establishes the authority for making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto. The latter legislation authorizes the Secretary of Health and Human Services to use grants and contracts to develop and engage in experiments and demonstration projects to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of health services for which payment may be made under such program.

See Appendix A for the text of the cited Public Law.

B.2 Information Users

The data from this beneficiary survey will be used to evaluate the Medicare Care Management for High Cost Beneficiaries demonstration (CMHCB). CMS demonstration and evaluation project staff and the RTI, International (RTI) evaluation contractor team will be analyzing the collected data. Analysis will consist of the development of descriptive and test statistics that will answer questions regarding changes in beneficiary behaviors and physical functioning and satisfaction with the CMHCB programs during the period approximately 18 months following the launch of each program. The impact of the CMHCB programs will be assessed by comparing survey results from intervention group members and members of corresponding comparison groups.

B.3 Improved Technology and Burden Reduction

CMS has awarded a contract to RTI, International (RTI) to conduct the Medicare Health Improvement Survey. There are no barriers or obstacles that prohibit the use of improved technology for this information collection activity. Both surveys will employ a mail methodology with a computer-assisted telephone (CATI) follow-up of mail non-respondents with telephone numbers. Receipt of the questionnaire in the mail will give respondents more flexibility in deciding when and where to complete the questionnaire, which will reduce burden.

RTI will key the data into an electronic database, and aggregate the data electronically. However, beneficiaries will complete the survey manually, as this is still the most cost-effective way of reaching the vast majority of beneficiaries. The telephone follow-up is planned to increase the overall response rate on the survey, and the use of CATI technology will improve the quality of the data collection. This CATI technology will also be used when sample members call in to our

call center in response the questionnaire they received. The respondents will then also have the option of completing the questionnaire.

B.4 Efforts to Identify Duplication of Similar Information

There is no other entity, public or private, that uses a widely-accepted, standardized survey with a uniform mode of administration to collect information on Fee-for-Service (or Original) Medicare beneficiaries' health and chronic care. Information about chronic care is collected through the RAND Improving Chronic Illness Care (ICIC) survey, a Robert Wood Johnson-funded evaluation of the effectiveness of the Chronic Care Model and the IHI Breakthrough Series Collaborative in improving clinical outcomes and patient satisfaction with care.

There are two federally-funded ongoing evaluations of disease management programs that involve surveys of beneficiaries. However, one of these programs targets beneficiaries enrolled in the Medicare Advantage program while this survey targets beneficiaries enrolled in Original Medicare. The second program targets Medicare beneficiaries eligible for the Medicare Health Support (previously named Chronic Care Improvement) which are excluded from the CMHCB demonstration.

B.5 Impact on Small Businesses or Other Small Entities

There is no burden on any business, including small businesses. RTI will assume all burden for drawing the sample and administering the survey on behalf of CMS. CMS reports the results to Medicare beneficiaries and the general public.

B.6 Consequences of Collecting the Information Less Frequently

In order for Medicare beneficiaries to receive the best possible chronic care, CMS needs to receive up-to-date information from this population to help determine the successes of the program. This is a one time study and will involve a single cross-section survey. There are no legal obstacles to reduce the burden.

B.7 Special Circumstances

CMS has sought the proper approval under the Privacy Act for data that are identifiable by individual beneficiary. Publicly reported data will not identify beneficiaries in any way. CMS will be providing data at the aggregate level. Responding to the surveys will be completely optional. Beneficiaries will be given the opportunity to respond whenever it is convenient for them during the data collection period. Confidentiality promises will be consistent with the Privacy Act of 1974 and the standards of the IRB. Beneficiaries included in the survey samples will be informed that their participation or lack of participation in the survey will in no way affect their health care benefits.

B.8 Federal Register Notice

The 60-day federal register notice, was published on July 28, 2006.

1-800-Medicare will be informed of the data collection effort and will be provided with suitable information with which to field any inquiries.

Individuals outside the United States Department of Health and Human Services who have been consulted about the survey include:

- Nancy McCall, RTI International
- Shula Bernard, RTI International
- Kevin Smith, RTI International

B.9 Explanation of Any Payment or Gift to Respondents

Participation in this survey will be voluntary, and no incentives or remuneration of any kind will be given to sample members.

B.10 Confidentiality

All respondents will be informed that participation in the survey is voluntary and that the data provided will be kept confidential by RTI and CMS. In addition, RTI's Institutional Review Board (IRB) will review all instruments and informed consent materials and procedures to insure that sample members' rights are safeguarded. Only authorized project staff at each survey organization will have access to respondents' data, and the telephone interviewers in the CATI follow-up portion of the study will each sign a statement of confidentiality. Paper copies of completed questionnaires will be kept in storage areas of locked buildings. To protect the confidentiality of the respondent, the subject's name will not be linked to his/her individual data. For identification purposes, a unique ID number will be assigned to each sample member.

All patient-level data are protected from public dissemination in accordance with the Privacy Act of 1974, as amended. The information collected from these beneficiaries and proxies is protected and held confidential in accordance with 20 CFR 401.3. Data will be treated in a confidential manner, unless otherwise compelled by law.

B.11 Sensitive Questions

The questions from the CMHCB survey are drawn from the Health Outcomes Survey, Medicare Health Survey, the Medicare CAHPS-FFS survey, the RAND ICICE the Robert Wood Johnson Foundation survey of Diabetic patients, and the Healthcare System Hassles Survey. These questions have been utilized extensively in both clinical practice and research in previous surveys and are not considered sensitive.

B.12 Respondent Burden

CMS estimates the average time to complete the baseline Medicare Health Improvement Survey is 15 minutes. This estimate is based on assessment by survey research experts at RTI, however, additional assessment will be made by cognitive testing planned for June-July 2006. Thus, as shown in ***Table B-1*** below, the burden on the beneficiary is 0.25 hours X approximately 3,600 respondents = 900 hours (assuming approximately 75% response rate on an estimated sample of 4,890 beneficiaries) for the survey.

Table B-1.
Average Respondent Burden

Number in total sample	Estimated number of respondents	Number of forms per respondent	Estimated time to complete	Total estimated time burden
4890	3633	1	1/4th hour	908 hours

B.13 Annualized Cost for Respondents (Non-hour burden)

There are no fixed or variable non-hour costs incurred by respondents for participating in the survey. Respondents are not asked to keep records. Respondents in the survey will be given a toll-free number call if they have questions about the study or about their rights as a study participant. Respondents will be provided a postage-paid envelope in which to return their completed questionnaires and so will not incur costs for postage.

B.14 Annualized Cost to the Federal Government

The cost to the government to conduct this evaluation is $1,226,140 of which $288,501 is devoted to the task of developing and administering the survey and reporting of the results.

B.15 Program Changes

There are no program changes or adjustments.

B.16 Publication and Tabulation Schedule

The data collection will take place in 2007 and 2008 (see ***Table B-2***). The survey process will begin in August 2007 and will be conducted in two phases to accommodate the lagged start dates of the 6 programs:

All information will be tabulated at the aggregate level. Information that is published will not identify individual beneficiaries.

Table B-2.
Medicare Health Improvement Survey Data Collection Schedule

Medicare Health Improvement Survey Activity	Date

Wave 1 – RMS, CLM, Accent	
Sample Selection	June 2007
Advance letter mailing	August 13, 2007
Initial survey to all sample members (1 week following advance letter)	August 20, 2007
Thank you/reminder post card (10 days following initial survey)	August 30, 2007
2nd survey to non-respondents (1 month following initial survey)	September 20, 2007
3rd survey via overnight mail to those respondents for whom we could not locate a telephone number (2 months following the initial survey)	October 17, 2007
Telephone follow-up w/ non-respondents (2 months following initial survey)	October 19, 2007
Wave 2 – Texas Tech, Montefiore, MGH	
Sample Selection	August 2007
Advance letter mailing	October 16, 2007
Initial survey to all sample members (1 week following advance letter)	October 23, 2007
Thank you/reminder post card (10 days following initial survey)	November 2, 2007
2nd survey to non-respondents (1 month following initial survey)	November 20, 2007
3rd survey via overnight mail to those respondents for whom we could not locate a telephone number (2 months following the initial survey)	December 18, 2007
Telephone follow-up w/ non-respondents (2 months following initial survey)	December 20, 2007

A series of statistical analyses will be performed to explore CMHCB intervention effects.

Descriptive and Scaling Analyses. We will begin our analyses by computing site specific descriptive statistics (means, standard deviations, and frequency distributions) for all survey variables. Some of the survey outcomes, such as the SF-12 physical and mental component scores, have established procedures for scoring. Multi-item scales may also be constructed for some of the constructs in our conceptual model, such as the health care satisfaction measures which have been adapted from CAHPS surveys. We will evaluate the unidimensionality of these scales using confirmatory factor analysis, and summarize the reliability of the scales by computing Cronbach's alpha. We will then conduct statistical tests comparing intervention vs. control group values for key study outcomes. At baseline, however, we do not expect to find any group differences.

$$Y= a + b_1X_1 +b_2X_2 + b_kX_k + e$$

where:

Y = outcome measure,
X_1 = intervention status (1=intervention, 0=comparison),
X_2 = months in intervention group (= 0 for comparison and those refusing participation),
X_k = a vector of k covariates,
b_1, b_2, and b_k = regression coefficients to be estimated,
a = an intercept term, and -
e = an error term.

In this model, coefficient b_1 estimates the overall effect of the intervention in an intent-to-treat analysis, and coefficient b_2 estimates the added effect of program intensity. Models will be estimated separately for each CMO to test the impact of the program in each site.

The regression results will be summarized in tables showing the point estimates, standard errors, and associated p-values for each coefficient, as well as summary statistics of model fit. The statistical results will be incorporated into the third annual analysis report for the project and the final evaluation report.

B.17 Expiration Date

CMS will display the date for OMB approval on the questionnaire.

B.18 Certification Statement

There are no exceptions to this certification statement.

C. Collection of Information Employing Statistical Methods

C.1 Respondent Universe and Response Rates

The target population for the Medicare Health Improvement Survey is Medicare beneficiaries who have high health care costs (i.e., greater than or equal to $5,000) and/or high disease severity measured by the Hierarchical Conditions Categories (HCC) (i.e., greater than or equal to 1.7) who have been assigned to either the intervention or comparison groups for this program. Those beneficiaries who are deceased will not be included in our sample.

Project statisticians will use CMS' Enrollment Database (EDB) file in order to obtain current addresses as well as other demographic variables that will be used in the analysis. The data elements from these files that will be used for sampling, data collection and/or analysis will include name (given name, middle name and surname), county of residence and zip code, current mailing address, demographic information including birth date, gender, race and ethnicity, health insurance claim number and social security number.

C.2 Procedures for the Collection of Information

Statistical Methodology for Stratification and Sample Selection

Among the six CMO programs, intervention and comparison populations are identified in two distinct ways. CMS analyzed 2004 claims data to identify Medicare beneficiaries eligible for each program based upon costs, disease severity, and diagnostic criteria, unique to each site. For two programs, CMS was able to randomly assign beneficiaries to intervention and control groups. Eligibility for the remaining four programs was related to beneficiary geographic location as well as receipt of services, or loyalty to, the sponsoring organization. Therefore CMS randomly selected a group of intervention beneficiaries for each of these CMOs from an identified population and then selected a group of similar beneficiaries to serve as a matched comparison group. We employed HCC risk score and cost criteria (varies in detail by site) as the basis for matching populations, and comparisons between the two populations across demographic categories and utilization patterns i.e., using BETOS categories applied to claims, were made to insure similarity and avoid biases.

Care Management Organization	Intervention	Comparison
Randomized comparison group		
RMS	5,057	2,024
CLM	15,194	6,084
Matched comparison group		
Accent	1,600	1623
MGH	2,500	2,500
Montefiore	2,989	1875
Texas Tech	5,063	5106

Statistical Power

The sample size for the beneficiary survey is designed to be large enough to allow us to reliably detect substantively important differences between the CMHCB intervention and comparison groups in each program. To make these sample size assessments, we focus on the prevalence of a particular outcome in the intervention group and its associated comparison group. These percentages can be created by dichotomizing any of the variables in our survey, such as the percentage of respondents who report they have discussed their care plan recently, the percentage who take their medication as prescribed, or the percentage who rate their experience with their health care team as "very good" or "excellent."

Table C-1 below shows the estimates which account for survey design effects and anticipated response rates at each mailing. The estimates show that we will initially need to send questionnaires to 815 respondents (2,280 in the CMHCB intervention group and 2,610 in the control group) in each program site to detect a 5% difference.

Table C-1.
Sample sizes for each site and a total for all sites

	Per Site			Total		
	Intervention	**Control**	**Total**	**Intervention**	**Control**	**Total**
Surveys in initial mailing	380	435	815	2,280	2,610	4,890
Response Rate	80%	70%		80%	70%	74.7%
Projected surveys	305	305	608	~1,830	~1,830	~3,650

*For power=.80, alpha = .05, one-sided test

Survey Eligibility

Medicare beneficiaries who live in institutions, such as jails and prisons, will be ineligible to participate in the sample, because Medicare is the secondary payor for health care services used by this population.

Survey Type

The Medicare Health Improvement Survey is a cross-sectional design. As described earlier, the survey process will consist of a pre-notification letter on CMS letterhead sent out prior to the first questionnaire mailing, the first questionnaire mailing, a thank you/reminder postcard, and a second questionnaire mailing. We will conduct telephone follow up of non-respondents, and an overnight package will be sent to those non-respondents for whom we can not find a telephone number.

C.3 Maximizing Response Rates

To maximize the response rate on the Medicare Health Improvement Survey, we plan to use "best mail survey practices" which have been proven in methodological research to improve response rates, as well as our experience fielding of other Medicare surveys. Research on mail survey design suggests that the following factors usually increase response rates[4]:

- pre-notification letters,
- number of follow-up contacts,
- survey sponsorship,
- saliency of the survey topics to the target population,
- personalization of the correspondence with sample members, and
- postage-paid return envelopes.

The most important of these factors is the number of contacts, including the pre-notification and cover letters, thank you/reminder letters and other follow-up mailings that include a replacement questionnaire. Our data collection approach will employ nearly all of these features, creating a multi-pronged, comprehensive strategy that avoids the weaknesses of reliance upon mail or telephone contact alone.

The Medicare Health Improvement Survey is designed as a mail survey with phone follow-up of non-respondents. The mail survey component of each project will consist of mailing a pre-notification letter to all sample members, followed by an initial questionnaire package seven days later. A Thank You/Reminder Letter designed to thank sample members who have already responded, and to remind others who have not to do so, will be sent ten days after the initial questionnaire is mailed. A second questionnaire mailing will be sent to sample members who do not return a completed questionnaire within four weeks after the pre-notification letter is mailed. All cases that do not return a completed questionnaire during mail survey data collection period will be transferred to the telephone survey unit, where interviewers will attempt to contact the sample member and complete the interview by phone.

All of the materials that we design for use in the mail surveys will employ best mail survey practices suggested by Jenkins and Dillman (1997)[5] and lessons learned from other surveys of Medicare beneficiaries to ensure high rates of cooperation. These include:

- that all materials sent to the sample members will be written at no higher than the fifth- or sixth-grade level, if possible, in order to minimize the burden
- the correspondence will briefly describe the survey and emphasize its importance to the sample member; each subsequent letter will address these aspects in stronger language than in the previous mailing
- the correspondence will also describe the confidential nature of the survey and that participation is voluntary. Breach of confidentiality by project staff might be seen as a risk and therefore as a potential burden
- the print style of the letters and questionnaires will be kept simple, with limited mixtures of fonts
- we will use questionnaire boxes to help respondents determine where to mark their answers and to navigate through the instrument
- the questionnaires will be printed in large typeface (font size of 13 pt) to facilitate participation among sample members with poor vision
- the cover of each questionnaire will include an attractive graphic that will appeal to older Americans
- all correspondence will include the name and telephone number of a survey contact person that sample members can call toll-free for information about the survey.

Proxy responses will be accepted from spouses or adult children of sampled respondents. Those who are too cognitively or physically impaired to complete the survey, or whose primary language is not English or Spanish (and who have no acceptable proxy relative), will still be considered eligible, although we will remove them from the mail and calling sample if no proxy is available.

We will attempt to complete an interview with all mail survey non-respondents. Following up by telephone with mail survey non-respondents, as well as using best practices for questionnaire design and data collection, are intended to increase the response. Analysis weights will be created to adjust for non-response. These site specific weights will enable design-consistent estimation of population parameters by scaling the disproportionalities between the sample and the underlying population. These weights may be viewed as inflation factors that account for the number of beneficiaries in the target population that a sample member represents. The initial component of an analysis weight is the inverse of the selection probability that is specified by the sample design. Typically, adjustments are then made to the weights to compensate for potential biases attributable to differential response and coverage among sample members based on relevant characteristics of the sample members.

Response Propensity Analysis. Once data collection has been completed, we will conduct an analysis of response rates to determine whether survey participation was influenced by intervention status or other background characteristics. This response propensity analysis is based on a logistic regression model in which the binary outcome is coded 1 if the sampled beneficiary completed the survey and 0 if the beneficiary did not return a survey. The explanatory variables in the model will consist of factors that are available for all beneficiaries from the CMHCB programs and secondary sources, such as demographic characteristics, HCC scores, chronic disease diagnoses, and intervention status. Factors contributing to differential participation will be incorporated in the sample weights for the study.

C.4 Contacts

David Bott, Project Officer
CMS/ORDI/REG/DBR
Phone: 410 / 786-0249
Fax: 410 / 786-5515
Email: david.bott@cms.hhs.gov

Shula Bernard,
Survey Development & Implementation
RTI International
Phone: 919/485-2790
Fax: 919/990-8454
Email: sbernard@rti.org

Nancy McCall, Project Director
RTI International
Phone: 202/728-1968
Fax: 202/728-2095
Email: nmcall@rti.org

Kevin Smith, Statistician
RTI International
Phone: 781/434-1748
Fax: 781/434-1701
Email: kevinsmith@rti.org

References

1. Congressional Budget Office (2005). *High-Cost Medicare Beneficiaries.* Washington, DC.

2. Todd, W., and Nash, T., eds. (2001). Disease Management, A Systems Approach to Improving Patient Outcomes. New York: Jossey-Bass Publishers.

3. Anderson, G. (December 2002). *Chronic conditions: Making the Case for Ongoing Care.* Partnership for Solutions, Johns Hopkins University and the Robert Wood Johnson Foundation. Baltimore, MD: Johns Hopkins University

4. Herberlein, T.A., & Baumgartner, R. (1978). Factors Affecting Response Rates to Mailed Questionnaires: A Quantitative Analysis of the Published Literature. *American Sociological Review*, 43, pp 447-62.

5. Jenkins, C.R., and D.A. Dillman (1997). Towards a Theory of Self-administered Questionnaire Design. In L. Lyberg , P. Biemer, M. Collins, et al. (Eds.), Survey Measurement and Process Quality (Chapter 7, pp. 165-196). New York. Wiley.

Appendix A
Appropriate Statutes and Code of Federal Regulations

The authority for this system is given under the provisions of Section 1110 of the Social Security Act *[42 U.S.C. 1310]* and Section 402 of the Social Security Amendments of 1972 *[42 U.S.C.1395b-1]*.

Section 1110 of the Social Security Act

SEC. 1110. *[42 U.S.C. 1310]* (a)(1) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, $5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (A) making grants to States and public and other organizations and agencies for paying part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto, and (B) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters.

> (2) No contract or jointly financed cooperative arrangement shall be entered into, and no grant shall be made, under paragraph (1), until the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning titles II or XVI) obtains the advice and recommendations of specialists who are competent to evaluate the proposed projects as to soundness of their design, the possibilities of securing productive results, the adequacy of resources to conduct the proposed research or demonstrations, and their relationship to other similar research or demonstrations already completed or in process.
> (3) Grants and payments under contracts or cooperative arrangements under paragraph (1) may be made either in advance or by way of reimbursement, as may be determined by the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title II or XVI); and shall be made in such installments and on such conditions as the Secretary (or the Commissioner, as applicable) finds necessary to carry out the purposes of this subsection.

(b)(1) The Commissioner is authorized to waive any of the requirements, conditions, or limitations of title XVI (or to waive them only for specified purposes, or to impose additional requirements, conditions, or limitations) to such extent and for such period as the Commissioner finds necessary to carry out one or more experimental, pilot, or demonstration projects which, in the Commissioner's judgment, are likely to assist in promoting the objectives or facilitate the administration of such title. Any costs for benefits under or administration of any such project (including planning for the project and the review and evaluation of the project and its results), in excess of those that would have been incurred without regard to the project, shall be met by the Commissioner from amounts available to the Commissioner for this purpose from appropriations made to carry out such title. The costs of any such project which is carried out in coordination with one or more related projects under other titles of this Act shall be allocated among the appropriations available for such projects and any Trust Funds involved, in a manner determined by the Commissioner with respect to the old-age, survivors, and disability insurance programs under title II and the supplemental security income program under title XVI, and by the Secretary with respect to other titles of this Act, taking into consideration the programs (or types of benefit) to which the project (or part of a project) is most closely related or which the project (or part of a

project) is intended to benefit. If, in order to carry out a project under this subsection, the Commissioner requests a State to make supplementary payments (or the Commissioner makes them pursuant to an agreement under section 1616) to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments, the Commissioner shall reimburse such State for the non-Federal share of such payments from amounts appropriated to carry out title XVI. If, in order to carry out a project under this subsection, the Secretary requests a State to provide medical assistance under its plan approved under title XIX to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such assistance from amounts appropriated to carry out title XVI, which shall be provided by the Commissioner to the Secretary for this purpose.

(2) With respect to the participation of recipients of supplemental security income benefits in experimental, pilot, or demonstration projects under this subsection—
(A) the Commissioner is not authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project;
(B) the Commissioner may not require any individual to participate in a project; and the Commissioner shall assure (i) that the voluntary participation of individuals in any project is obtained through informed written consent which satisfies the requirements for informed consent established by the Commissioner for use in any experimental, pilot, or demonstration project in which human subjects are at risk, and (ii) that any individual's voluntary agreement to participate in any project may be revoked by such individual at any time;
(C) the Commissioner shall, to the extent feasible and appropriate, include recipients who are under age 18 as well as adult recipients; and
(D) the Commissioner shall include in the projects carried out under this section such experimental, pilot, or demonstration projects as may be necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability, including programs in residential care treatment centers.

(c) (1) In addition to the amount otherwise appropriated in any other law to carry out subsection (a) for fiscal year 2004, up to $8,500,000 is authorized and appropriated and shall be used by the Commissioner of Social Security under this subsection for purposes of conducting a statistically valid survey to determine how payments made to individuals, organizations, and State or local government agencies that are representative payees for benefits paid under title II or XVI are being managed and used on behalf of the beneficiaries for whom such benefits are paid.

(2) Not later than 18 months after the date of enactment of this subsection, the Commissioner of Social Security shall submit a report on the survey conducted in accordance with paragraph (1) to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

Section 402 of the Social Security Amendments of 1972 (Public Law 90-248)

Section 1395b-1. *[42 U.S.C.1395b-1]* **Incentives for economy while maintaining or improving quality in provision of health services**

(a) Grants and contracts to develop and engage in experiments and demonstration projects

(1) The Secretary of Health and Human Services is authorized, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

(B) to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing –

(i) comprehensive health care services,

(ii) mental health care services (as defined by section 2691(c))1(! of this title),

Appendix B
Survey Instrument

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

NAME
ADDRESS
CITY, STATE ZIP

Dear NAME:

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency that administers the Medicare program. Our responsibility is to make sure that you get high quality care. One of the ways we can do that is to find out directly from you about how the care you are currently receiving under the Medicare program affects your health.

CMS is conducting a survey of people with Medicare called the **Medicare Health Survey**. Your name was selected at random from a list of people currently enrolled in Medicare. We hope that you will participate in this important survey.

Within the next few days, you will receive a questionnaire asking about the state of your health. We hope that you will take a few minutes to complete the questionnaire and return it in the postage-paid envelope to RTI, the organization assisting us with this survey. If you have any questions about your involvement in this study, please call us toll-free at X-XXX-XXX-XXXX.

Your help is voluntary and your decision to participate or not to participate will have no effect on your Medicare benefits. All information you provide will be held in confidence by CMS and is protected by the Privacy Act. While you do not have to participate in this survey, we hope that you will choose to help us. Learning about the state of your health is very important to us.

If you have any questions about the survey or would like to find out how to complete the survey by phone, please call XX toll-free at X-XXX-XXX-XXXX, Monday through Friday, between 8:15 a.m. and 5:00 p.m. Eastern time.

Thank you in advance for your help with this important survey.

Sincerely,

Walter D Stone

Walter Stone
Privacy Officer

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

NAME
ADDRESS
CITY, STATE ZIP

Dear NAME:

Recently, we sent you a letter asking for your help with a research survey that the Centers for Medicare & Medicaid Services (CMS) is conducting, called the **Medicare Health Survey**. A copy of the survey is enclosed with this letter.

Your name was selected at random from a list of people who are currently enrolled in Medicare. Please take a few moments to complete the questionnaire and return it in the enclosed postage-paid envelope to RTI, the organization helping us with this survey.

All information you give in this survey will be held in confidence and is protected by the Privacy Act. The information you provide will not be shared with anyone other than authorized persons at RTI and CMS. You do not have to participate in this survey. **Your help is voluntary and your decision to participate or not to participate will not affect your Medicare benefits in any way.** However, by completing this survey you are providing us with valuable information about the state of your health.

If you have any questions about the survey or would like to find out how to complete the survey by phone, please call XX toll-free at 1-800-XXX-XXXX, Monday through Friday, between 8:15 a.m. and 5:00 p.m. Eastern time.

Thank you in advance for your participation.

Sincerely,

Walter Stone
CMS Privacy Officer

Dear Medicare Beneficiary,

The Centers for Medicare & Medicaid Services (CMS) is conducting the Medicare Health Survey. We sent you a questionnaire for this survey about a week ago.

If you have completed & returned your survey, thank you very much for your help. If not please take a few minutes to complete and return it today!

If you have any questions or would like to do the survey by telephone, please call toll-free:

1-800-XXX-XXXX

Thank you again for your help.

The Survey Project Team

Medicare Health Improvement Survey

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- . The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Survey Instructions

This survey asks about you and your health. Answer each question thinking about yourself. Please take the time to complete this survey. Your answers are very important to us. If you are unable to complete this survey, a family member or friend can fill out the survey about you. If a family member is NOT available, please ask someone who knows you and your care for help.

Please return the survey with your answers in the enclosed postage-paid envelope.

- Answer the questions by putting an "X" in the box next to the appropriate answer category like this:

  Are you male or female?

  ☐ Male
  ☒ Female

- Be sure to read all the answer choices given before marking a box with an 'X.'

- It is important that you answer EVERY question on this survey. If you are unsure of the answer to a question or that a question applies to you, please answer the question anyway, choosing the BEST possible answer.

All information that would permit identification of any person who completes this survey will be kept strictly confidential. This information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without your permission.

If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].

About Your Health

These questions ask for your views about your health, about how you feel and how well you are able to do your usual activities.

1. In general, would you say your health is

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

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?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. *Moderate activities*, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing *several* flights of stairs	☐	☐	☐

3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities as a *result of your physical health*?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. *Accomplished less* than you would like	☐	☐	☐	☐	☐
b. Were limited in the *kind* of work or other activities	☐	☐	☐	☐	☐

About Your Health

4. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. *Accomplished less* than you would like	☐	☐	☐	☐	☐
b. Didn't do work or other activities as *carefully* as usual	☐	☐	☐	☐	☐

5. During the <u>past 4 weeks</u>, how much did *pain* interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

6. These questions are about how you feel and how things have been with you. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past 4 weeks</u>

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt *calm and peaceful*?	☐	☐	☐	☐	☐	☐
b. Did you have *a lot of energy*?	☐	☐	☐	☐	☐	☐
c. Have you felt *downhearted and blue*?	☐	☐	☐	☐	☐	☐

About Your Health

7. During the <u>past 4 weeks</u>, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

8. In the <u>past 2 weeks</u> have you been bothered by little interest or pleasure in doing things?

Not at all	Several days	More than half of the days	Nearly every day
☐	☐	☐	☐

9. In the <u>past 2 weeks</u> have you been bothered by feeling down, depressed, or hopeless?

Not at all	Several days	More than half of the days	Nearly every day
☐	☐	☐	☐

About Your Health

10. Because of a health or physical problem, do you have any difficulty doing the following activities? (Please mark one response for each activity.)

	I am not able to do this activity	Yes, I have difficulty	No, I do not have difficulty
a. Bathing	☐	☐	☐
b. Dressing	☐	☐	☐
c. Eating	☐	☐	☐
d. Getting in or out of chairs	☐	☐	☐
e. Walking	☐	☐	☐
f. Using the toilet	☐	☐	☐

11. Do you receive help from another person with any of these activities?

	Yes, I receive help	No, I do not receive help
a. Bathing	☐	☐
b. Dressing	☐	☐
c. Eating	☐	☐
d. Getting in or out of chairs	☐	☐
e. Walking	☐	☐
f. Using the toilet	☐	☐

Your Health Care

A health care team consists of a variety of people who help you take care of your health condition. For some people, this team may include nurses, case managers, or doctors. These individuals make up your health care team. Please think about your health care team when answering the questions below.

12. During the past 6 months, has someone from your health care team helped you set goals to take care of your health problems?

- ☐ Yes
- ☐ No

13. During the past 6 months, has someone from your health care team helped you make a plan to take care of your health problems?

- ☐ Yes
- ☐ No

These next questions are about services you may have received during the past 6 months. Please consider information you may have received from your health care team, at physicians' offices, during telephone calls from someone from your health care team, or by mail when answering the next questions.

14. How helpful were the one-on-one educational or counselling sessions you may have received to help you care for your health problems?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not receive counseling
☐	☐	☐	☐	☐

15. How helpful were discussions you may have had with your health care team about how and when to take your medicine?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss medicine
☐	☐	☐	☐	☐

Your Health Care

16. How helpful were discussions you may have had with your health care team about how to deal with stress or feeling sad?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss stress/sadness
☐	☐	☐	☐	☐

17. How helpful were discussions you may have had with your health care team about the foods you should be eating?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss food
☐	☐	☐	☐	☐

18. How helpful were discussions you may have had with your health care team about the amount of exercise you should get?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss exercise
☐	☐	☐	☐	☐

Taking Care of Your Health

The next questions ask about how sure you are that you can do certain things for your health.

19. How sure are you that …

a. You can take all of your medications when you should?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

b. You can plan your meals and snacks according to dietary guidelines?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

c. You can exercise two or three times weekly?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

The questions below ask about self-care activities.

20. On how many of the <u>past 7 days</u> did you take your medication as prescribed?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

21. On how many of the <u>past 7 days</u> did you participate in at least 30 minutes of continuous physical activity (including walking)?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

22. On average, over the <u>past month</u>, how many DAYS PER WEEK have you followed your healthy eating plan?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

Your Health Care Experience

A health care team consists of a variety of people who help you take care of your health condition. For some people, this team may include nurses, case managers, or doctors. These individuals make up your health care team. Please think about your health care team when answering the questions below.

23. Please think about all the health care providers you have talked with either by phone or in-person over the <u>past 6 months</u>, including any doctors, nurses, or other providers such as pharmacists who you talked to about your health problems.

Overall, how would you rate your experience with these health care providers in helping you cope with your condition?

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

24. In the <u>past 6 months</u>, how often did your health care team …

a. Explain things in a way that was easy to understand?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

b. Listen carefully to you?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

c. Spend enough time with you?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

Your Health Care Experience

25. In the <u>past 12 months</u>, did your health care team talk with you about the pros and cons of each choice for your treatment or health care?

Definitely yes	Somewhat yes	Somewhat no	Definitely no
☐	☐	☐	☐

26. In the <u>past 12 months</u>, how often did your healthcare team give you easy to understand instructions about what to do to take care of these health problems or concerns?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

27. In the <u>past 12 months</u>, how often did your healthcare team seem informed and up-to-date about your health?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

28. In the <u>past 12 months</u>, when you called someone on your healthcare team with a medical question during regular office hours, how often did you get an answer to your question that same day?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

Your Health Care Experience

29. In the <u>past 12 months</u>, when you called someone on your healthcare team after regular office hours, how often did you get an answer to your question?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

30. In the <u>past 12 months</u>, how often did your health care team show respect for what you had to say?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

31. How much of a problem are each of these for you?

a. Lack of information about my medical conditions

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

b. Lack of information about my treatment options

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

c. Lack of information about why my medications have been prescribed to me

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

d. Problems getting my medications refilled on time

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

e. Uncertainty about when or how to take my medications

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

f. Side effects from my medications

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

About You

These next questions ask for information about you.

32. Are you of Hispanic or Latino origin or descent?

Yes, Hispanic or Latino	No, not Hispanic or Latino
☐	☐

33. What is your race? Please mark one or more.

White	Black or African American	Asian	Native Hawaiian or other Pacific Islander	American Indian or Alaska Native
☐	☐	☐	☐	☐

34. What is the highest grade or level of school that you have completed?

8th grade or less	Some high school, but did not graduate	High school graduate or GED	Some college or 2-year degree	4-year college graduate	More than 4-year college degree
☐	☐	☐	☐	☐	☐

35. What is your current living arrangement? Right now, are you living … (check all that apply)

Alone..... ☐

With spouse or partner..... ☐

With others who are related to you..... ☐

With others who are not related to you..... ☐

36. Some people who have Medicare also have <u>other insurance</u> to help pay for some of the costs of their health care. Do you have any other insurance that pays at least some of the cost of your health care?

- ☐ Yes
- ☐ No

37. Do you have insurance that helps to pay for at least some of the cost of your prescription drugs (check all that apply)?

- ☐ Yes, Medicare Part D
- ☐ Yes, Other insurance
- ☐ No

38. Please mark the box below for <u>each type</u> of health insurance that you have (check all that apply).

Medigap..... ☐

Employer, Union, or Retiree Health Coverage..... ☐

Veteran's Retiree Benefits, also known as VA Benefits..... ☐

Military Retiree Benefits, also known as Tricare..... ☐

Medicaid, also known as state medical assistance..... ☐

Other..... ☐

I don't have health insurance other than Medicare..... ☐

39. Who completed this survey form?

Person to whom this survey was addressed..... ☐

Family member or relative of person to whom the survey was addressed..... ☐

Friend of person to whom the survey was addressed..... ☐

Other..... ☐