MCPSS | MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY

CENTERS FOR MEDICARE & MEDICAID SERVICES

Supporting Statement

Request for Clearance

For

Medicare Contractor Provider Satisfaction Survey

(MCPSS)

National Implementation

Part A

January 26, 2007

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SUPPORTING STATEMENT

REQUEST FOR CLEARANCE

MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY (MCPSS)

Introduction

On January 7, 2007, the Office of Management and Budget (OMB) approved the Centers for Medicare and Medicaid Services (CMS) administration of the 2007-2009 Medicare Contractor Provider Satisfaction Survey (MCPSS). OMB approved CMS to conduct the MCPSS with 20,514 completed surveys, using a 67 item instrument, estimated to take 22 minutes to complete.

Due to changes in CMS' reporting needs, CMS is requesting a potential increase in the number of completed surveys (from the current 20,514 to 24,239 respondents). This increase will allow CMS to have not only Contractor-specific, but also jurisdiction and state-specific data which, in turn, will enable Contractors to increase and implement performance improvement activities within their organizations. This increase will affect the 2008 and 2009 administrations.

As CMS moves closer to a Medicare Administrative Contractor (MAC) procurement environment (CMS is currently in Cycle 2 of this transition), sampling and aggregating the data by state will allow CMS to determine if the providers served by its Contractors are receiving an acceptable level of service by CMS standards. It will also afford CMS the opportunity to provide the Cycle 2 MACs baseline data as it relates to provider satisfaction levels in their jurisdiction. It is the hope of CMS that providing this baseline data will lessen the learning curve for the MACs, as well as offer a tool to pinpoint any deficiencies and/or benchmark current practices.

There are three reasons for this current submission:

1) address the increase in the sample size;

2) provide OMB the revised MCPSS survey instrument for administration in 2008; and

3) address research and development needed to continuously improve the study.

It is important to note that CMS is currently administering the 2007 survey. Hence where relevant, CMS will refer to the results of the 2006 survey that will help inform future administrations of MCPSS.

A. Background

Medicare Contractors are charged with processing Medicare claims and related activities and providers interact with them on a daily basis. The Medicare Contractor Provider Satisfaction Survey (MCPSS) measures this Provider-Contractor relationship. The Contractors are currently using, and will continue to use, the MCPSS results to implement performance improvement activities within their organizations.

CMS is currently conducting year-2 of the national implementation (OMB No 0938-0915) and is presenting this request for years 3 and onward of the national implementation.

The MCPSS questionnaire includes the following topics: provider inquiries, provider outreach & education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The study sample includes the following provider types:

- Hospitals and in-patient Clinics
- Skilled Nursing Facilities (SNFs)
- Rural Health Clinics
- End Stage Renal Disease Clinics
- Other provider groups participating in Medicare Part A, e.g., federally qualified health care centers, community mental health clinics, comprehensive outpatient rehabilitation facilities
- Home Health Agencies and Hospice Facilities
- Physicians
- Ambulance Service Providers
- Licensed practitioners, e.g., LPs, RNs, Physician's assistants
- Other provider groups participating in Part B, e.g., immunization or radiation centers, pain management centers,
- Durable Medical Equipment (DME) Suppliers

These providers are asked to rate their satisfaction with Medicare Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and Part A/B Medicare Administrative Contractors. A more detailed description of the sampling and data collection plans for this Survey is included in Section C of this Supporting Statement.

B. Justification

B-1. Need and Legal Basis

CMS is required under the Medicare Modernization Act of 2003 Section 911 (b) (3) (B) to develop contract performance requirements and standards for measurement, which shall include provider satisfaction levels.

Under Section 18(f) of the Social Security Act, and cited in 42 CFR 421.120 and 421.122, CMS is required to develop standards, criteria and procedures to evaluate Contractors' performance.

CMS is responsible for the administration of the Medicare program. As such, one of CMS' many goals is to protect and improve beneficiary health and satisfaction. Beneficiary health and satisfaction is most strongly affected by their Medicare providers (physicians, hospitals, home health agencies, etc). Therefore, it is imperative that Medicare providers are able to provide innovative, high quality care to beneficiaries and save money in Medicare the right way, by preventing avoidable complications and by making our health system work more efficiently.

CMS realizes that there are challenges imposed on providers by both the Medicare program and the broader healthcare environment. CMS is actively working to give Medicare's 1.2 million physicians, providers, and suppliers the information they need to understand the program, keep current of the changes and bill correctly. CMS has set the goal of being responsive to providers. The Provider Communications Group (PCG) within CMS is charged with improving provider communication and education efforts for the Medicare Program. Since its initiation, PCG has succeeded in defining and addressing various provider communication issues by developing a wide array of educational products using a variety of information delivery systems including enlisting the help of national and regional provider associations.

CMS primarily reaches its providers through Medicare Fee-for-Service (FFS) and Medicare Administrative Contractors (MAC). CMS contracts with them to act as a liaison with providers on its behalf. The Contractor-Provider interaction takes place on a daily basis since Contractors are charged with Medicare claims administration. The relationships and interactions between providers and Contractors tell CMS a great deal about barriers and obstacles to reaching the goals related to the care that beneficiaries ultimately receive from the Medicare program.

One way to examine this Contractor-Provider relationship is to understand satisfaction with Contractor performance from the provider's prospective. CMS will use the survey data to support process improvements by Contractors to better serve providers and to support contract reform in the

Medicare Program. The Medicare Contractor Provider Satisfaction Survey (Survey) grew out of this need described above.

One major part of MCPSS' utility to CMS is that, not only can it produce reliable estimates of provider satisfaction with Contractors, but that it will also be able to determine provider satisfaction at the state level. This is important due to the CMS transition to the MAC environment. Since CMS is concerned that this transition may cause difficulties for providers, it wants to ensure that it has state-level data with which to monitor the transition.

The Survey is aimed at gauging provider satisfaction with and perceptions of Contractors. CMS is using and will continue to use the survey data to develop a satisfaction score for each Contractor. This information is necessary for CMS to:

- Increase its understanding of Contractor performance using quantitative, objective measures;
- Appropriately understand provider concerns regarding their interactions with the Contractors; and
- Provide information for Contractors in using the survey results for process improvement initiatives.

B-2. Information Users

CMS is using and will continue to use the survey data to meet the information needs described above. The Survey is designed to measure provider satisfaction, attitudes, perceptions and opinions about the services provided by their respective Contractor. The results include quantitative data (a satisfaction score) and qualitative information (comments relevant to specific topics). The questionnaire includes seven topics that address most of the interactions between Contractors and providers. The topics are:

- Provider Inquiries
- Provider Outreach & Education
- Claims Processing
- Appeals
- Provider Enrollment
- Medical Review
- Provider Audit & Reimbursement

Some of these topics do not pertain to some Contractors and their respective providers. As such, CMS customizes the questionnaire, so providers receive a questionnaire with topics that are relevant to their interaction with the Contractor.

CMS obtains aggregate satisfaction scores for each section, provider-type and Contractor. With this approval, Contractors will also have state-level scores. In addition to their own scores, Contractors also receive a "benchmark" score, which is the average score of all Contractors (of a similar type). e.g., Fiscal Intermediaries (FI) get their own individual scores and comparisons to an FI average score. Both the Contractor scores and the comparison scores (all Contractor averages) reflect **only** services rendered by the Contractor to their providers.

The information is being used and will continue to be used to:

- Capture and quantify a thorough examination of the effects of Contractor performance using provider satisfaction as a measure.
- Identify opportunities for improving provider satisfaction.
- Assist Contractors to identify areas for improvement.
- Identify problematic aspects of the Medicare program from the providers' perspective.
- Allow CMS to also use the results for Contractor oversight.

B-3. Use of Information Technology

The studies that accompanied the development of the survey found that offering an electronic survey would significantly reduce burden on respondents and reduce costs to CMS. In the pilot and first national implementation, all sampled providers could access the survey on a secure Web site. The site provides background information and instructions for completing the Survey on-line. CMS found that the Web application worked very smoothly, and it was used successfully again during the first national implementation.

The electronic submissions reduce human error. Electronic submissions can be tracked and monitored for quality control issues, reject any duplicate submissions from a provider, and produce status reports.

Electronic efforts also provide CMS with security, as it can create, select, assign and verify all identification numbers and all passwords used with every submission. Providers use the pre-coded identification numbers to identify their submission without requiring them to include demographic information on every page of their submission. The survey vendor keeps all identifying information

about a provider, linked to their identification number, in strict confidence.

The survey instructions encourage providers to take advantage of the Web survey; as it helps minimize processing errors.

CMS has conducted usability testing of the Web survey application. The purpose of the testing was to improve the functionality and navigation of the Web survey. CMS staff, Medicare Contractors and providers tested the application. Feedback from the testing was used to revise and fine tune the application.

CMS is also using the Web interface to present the study results. The on-line reporting tool enhances Contractors' ability to access the reports, drill down to the information they need, and use the results for quality improvement. The tool also allows CMS to suppress small cells and thus ensure respondent confidentiality (this suppression allows the MCPSS to maintain compliance with the Confidential Information Protection and Statistical Efficiency Act, CIPSEA). CMS conducted usability testing of the on-line tool as well and it has received a very favorable response from both CMS and the Medicare Contractors. The Contractors and CMS users indicate that the system is very user-friendly and that they are using the survey to identify areas for improvement. Not only do Contractors use it to compare their results with other Contractors, but they also use the site to review qualitative comments provided by respondents – Contractors have said that these qualitative data have been quite useful in their quality improvement efforts. With this submission, CMS will provide state-level data which will enhance Contractor's ability to make further organizational changes.

B-4. Duplication of Efforts

Currently, there are no surveys of provider satisfaction with Medicare FFS Contractors' or MAC's performance of the seven business functions that allow for comparisons across Contractors and provider types. Prior to implementing the MCPSS, CMS thoroughly reviewed existing literature and did not identify any duplicate Surveys. Several meetings were held with the Program Integrity Group (PIG) and other groups within CMS that have similar federal objectives in order to identify what, if any, sources for this or similar information are available. While there had been some efforts to develop provider satisfaction surveys, none offer information as valid, thorough or specific enough as what is necessary to meet the needs described in this application.

B-5. Small Businesses

The respondents for the MCPSS will be primarily the billing office managers for various types of Medicare providers. While most of the organizations are large, some may be small businesses. The Survey's requirements do not have a significant impact on small businesses. CMS has kept the sample for this survey to the minimum needed to achieve reliable data and the survey content has been limited to information essential to the research objectives. Furthermore, the Survey is voluntary and the introduction to each section includes a time estimate for each module.

B-6. Less Frequent Collection

Without these data, CMS will not get a valid or complete review of how or where the Medicare program is affecting its providers. Medicare will not hear directly from representative providers about how well Contractors are performing their duties as contracted by CMS. If CMS is to ensure the improvement and protection of beneficiary health, provider satisfaction with Contractor performance must be monitored and managed. CMS cannot do this effectively or as well without this information.

B-7. Special Circumstances

There are no special circumstances.

B-8 Federal Register/Outside Consultation

1. Federal register Notice: Friday, February 16, 2007
2. Outside consultation From Westat:
    - David Cantor, Associate Director, 301.294.2080
    - Sherm Edwards, Vice President, 301.294.3993
    - Pamela Giambo, Senior Study Director, 240.453.2981
    - Huseyin Goksel, Senior Statistician, 301.251.4395
    - Terita Jackson, Research Associate, 240.314.2479
    - Vasudha Narayanan, Senior Study Director, 301.294.3808
3. CMS staff who participated in the design include:
    - David Clark, Director, Division of Provider Relations and Evaluations, 410.786.6843
    - Alan Constantian, Acting Regional Administrator, Seattle Regional Office, 206.615.2306
    - Elizabeth Goldstein, PhD, Director, Division of Beneficiary Analysis, 410.786.6665
    - Mel Ingber, PhD, Director, Division of Payment Research, 410.786.1913

- Karen Jackson, Director, Medicare Contractor Management Group, 410.786.0079
- Rene Mentnech, Director, Division of Beneficiary Analysis, 410.786.6692
- Geraldine Nicholson, Director, Provider Communications Group, 410.786. 6967
- Colette Shatto, Division of Provider Relations and Evaluations, 410.786.6932
- Gladys Valentín, MCPSS Project Officer, Division of Provider Relations and Evaluations, 410.786.1620

B-9. Payments/Gifts to Respondents

CMS will not offer payment or gifts to providers as incentives to complete the Survey.

B-10. Confidentiality

CMS is and will continue to collect the data with a guarantee that the survey vendor will hold identifying information in strict confidence. As information is made public, it is only in an aggregate, statistical form. The survey vendor has taken (and will continue to take) precautionary measures to minimize the risk of unauthorized access to the survey data and identifying information, such as password protection for electronic data files and storage of the hard copy questionnaires in locked rooms. Any transfer of identifying data between CMS and Westat, or between Westat and the Contractors (for example, data that allow Westat to contact sampled entities), is completed using encryption software, so that the data cannot be read by third parties. All identifying information are protected and masked with a pre-coded identification number. Only the survey vendor has access to the identities associated with each number. The survey vendor protects (and will continue to protect) the Web survey application with a password and identification number. Sampled providers can access the Web survey ONLY with the password and ID assigned to them. Finally, small analytic cells are automatically suppressed so that Contractors cannot generate frequencies that would allow for identification of an individual provider.

Finally, the survey material includes the following text:

"Responses to this data collection will be used only for statistical purposes. The reports prepared for this study will summarize findings across the sample and will not associate responses with a specific individual. We will not provide information that identifies you to anyone outside the study team, except as required by law."

B-11. Sensitive Questions

The Survey asks about the providers' satisfaction with their Contractor's performance on specific topics; it does not contain questions considered personally sensitive or commercially proprietary.

B-12. Burden Estimates (Hours & Wages)

The MCPSS asks provider staff to rate their satisfaction with their Contractor's performance on the following topics:

- Inquiries
- Provider Outreach & Education
- Claims Processing
- Appeals
- Provider Enrollment
- Medical Review
- Provider Audit & Reimbursement

CMS has promoted (and will continue to promote) the survey through State professional associations, Contractor communications and CMS communications as appropriate. Newsletters, email and other standard outreach efforts that have NO additional burden are used to alert providers to the following messages regarding the Survey:

- CMS is conducting a survey to measure provider satisfaction with Contractor performance.
- A sample of providers will be selected each year to participate in the Survey.
- CMS notifies sampled providers about the survey.
- The selection notification and invitation to complete the Survey arrive in specially marked CMS stationery, to distinguish it from all other mail items.
- Results from the prior year are available at the MCPSS Web site.

Estimate for research and development activities: Each year, CMS will complete research and development (R&D) activities so that it can continuously improve the instrument and the data collection methods, as well as to improve the dissemination of information to CMS staff, the Contractors and to public stakeholders. Generally, these activities include: discussions with CMS key

area experts (for example, to revise questionnaire content); discussions and/or testing with the CMS Medicare Contractors (for example, to revise their on-line reporting tool); interviews with providers (for example, to fine tune revised questions, or to ensure that the instrument includes the necessary content). Since the latter group, providers are subject to OMB burden restrictions, CMS is including the potential burden in this submission. While CMS tries to keep the provider interviews brief – to no more than 1 to 1 ½ hours per interview – CMS may need to interview more than nine respondents as part of its continuous improvement efforts for the MCPSS. CMS may need to speak with as many as 40 providers in any given year of the MCPSS. These discussions with providers might focus on: the survey design, survey cooperation, and data dissemination. This potential burden is included in Table 2, *Time and Cost Burden*, the row labeled "R&D efforts". Attachment 4 includes an example of a cognitive interview protocol that may be used.

Estimate for Cleaning the Sample / Screening Activities: Before data collection begins, the entire sample will be cleaned. There are two steps to the cleaning. The first step is to obtain updated contact information from a third-party vendor that maintains large databases of all providers in the US. The second step is to call all the facilities to verify their contact information, if needed, and to obtain the name of the survey contact. This pre-screening call also asks about the number and type of facilities the respondent handles claims for (which is needed for estimation). Based on prior experience, the screening call will take an average of seven minutes for a provider facility to complete.

Estimate for Main Study: The survey is designed to ensure that the most appropriate staff will complete each topic in order to produce the most comprehensive and accurate results possible. The burden of the entire Survey will not be placed on any one respondent unless the provider chooses to do so. At the same time, providers need only complete the applicable topics. Scoring takes into account any 'skipped' or 'not applicable' topics submitted by providers (see Section C.2 *Procedures for Collection of Information* for more information about scoring).

Table 1 provides estimates of time to complete each section.

Table 1 Time Burden per Survey Module

Topic	Questions	Time (minutes)
Inquiries	11	2
Provider Outreach & Education	13	3
Claims Processing	8	2
Appeals	5	1
Provider Enrollment	7	2
Medical review	8	2
Provider Audit & Reimbursement	11	2
Overall Satisfaction	2	1
All Topics		15
Prescreener Interview		7
Total	65	22

Costs to providers vary according to which topics of the Survey they complete. DME suppliers are not asked to complete the *Provider Enrollment, Medical Review* or *Provider Audit & Reimbursement* topics, as these topics do not apply to their Contractor's duties. Similarly, Carrier providers are not asked to complete the *Provider Audit & Reimbursement* module, as it does not apply to their Contractor's duties. For estimate purposes, CMS assumes that each provider that makes a submission will complete all appropriate topics (seven for Intermediaries, Part A MACs and RHHIs; four for DMACs and six for Carriers and Part B MACs).

Note that burden will be placed only on those sampled providers that make a submission. Those who reject a request to participate and do not complete the survey will not be burdened. Furthermore, sampled providers will not need explanation or research about the purpose or content of the Survey, since most likely already be aware of the Survey via numerous the communications CMS undertakes. Therefore, CMS does not expect any additional time burden for sampled providers when they receive the notification and make a decision about participating.

CMS researched salary wages and found that the highest average annual salary is about

$52,168 for mid-to-senior staff in healthcare administration (billing managers, office managers, etc). Using this wage, we estimated the cost burden on providers (average wage per minute multiplied by total time burden).

Table 2 shows how many providers are estimated to submit the Survey as well as corresponding minutes and cost burdens; the Table also includes the potential burden of the research and development activities.

Table 2 Time and Cost Burden

Contractor Type	Provider Respondents	Estimated Minutes/ Respondent	Estimated cost/ Respondent	Total cost of all interviews	Total cost/hour	Total Burden Hrs
FIs	8,584	22	$9.30	$79,853	$29,279	3417
Carriers	10,798	20	$8.03	$86,751	$31,809	3599
RHHI	2,443	22	$9.30	$22,726	$8,333	896
DMERC	2,414	16	$6.34	$15,311	$5,614	644
Total Survey	**24,239**			$204,641	$75,035	**8286**
R&D efforts	40	90	$37.62	$1,505	$2,257	60
Total	**24,279**			$206,146	$77,292	**8346**

Note: all burden estimates include both prescreening and survey completion activities

B-13. Capital Costs

There is no capital cost to respondents.

B-14. Cost to Federal Government

Costs to the Federal government ($1.5 mn) include: updating and testing the secure Internet Website for the survey and Computer Assisted Telephone Interviewing (CATI) program; creating the sample frame, drawing and cleaning the sample; data collection; data processing; weighting and analyzing the survey data; and reporting the survey results. Data collection accounts for about 71% of the total costs.

B-15. Changes to Burden

The overall sample burden, including both prescreening and survey completion activities, has been increased from 6923 to 8286, an increase of 1,363 hours. The reason for this increase is so that

CMS can obtain state-level estimates, and thus better monitor the work that Contractors are doing with the Medicare providers. We also estimate an additional 60 burden hours for research and development activities. The total annual increase in burden is 1,423 hours.

B-16. Publication/Tabulation Dates

As it did for the first MCPSS national implementation in 2006, CMS will develop a public report of the overall study results for each administration of the MCPSS. This report is (and will be) available through the study Web site (www.mcpsstudy.org) and CMS' Web site (www.CMS.gov).

Table 3 provides a time schedule for the 2008 survey. The timeline is similar for each annual administration of MCPSS.

Table 3 Schedule of Key Project Activities and Milestones for 2008 MCPSS

Activity	Milestone Date
Outreach after 2007 Results are released	July-August 2007
Roll-out/outreach to providers via CMS and Contractor communications and partnerships with local, state, and national associations	October 2007 onwards
Sample selection completed	October-November 2007
Sample "cleaning" / screening begins	End November 2007
Telephone interviewing begins.	End November 2007
Web survey made available	1st week of Jan 2008
Survey field period ends	End of April 2008
Draft Report for Contractors Submitted	1st week of June 2008
Draft report for CMS Submitted	Mid-June 2008
Final Contractor reports available via on-line reporting system	End of June 2008
Final CMS and public report available via on-line reporting system	Mid July 2008

B-17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

B-18. Certification Statement

There are no exceptions to the certification statement.