## C. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

### 1. Respondent Universe and Sampling Methods

#### a. Respondent Universe

The MCMP demonstration targets practices serving at least 50 traditional fee-for-service Medicare beneficiaries with selected chronic conditions for whom the practices are providing primary care. The target populations consist of (1) the physicians (for the physician survey) affiliated with the targeted practices and (2) the Medicare beneficiaries (for the beneficiary survey) associated to these practices.

The Quality Improvement Organizations (QIOs) in the four demonstration states—Arkansas, California, Massachusetts, and Utah—recruited practices on relationships built through CMS's Doctor's Office Quality-Information Technology (DOQ-IT) project. Only practices participating in DOQ-IT were eligible to participate in the demonstration. The demonstration enrolled 106 practices in Arkansas, 236 practices in California, 236 practices in Massachusetts, and 121 practices in Utah, with an estimated 2,800 physicians participating in MCMP. Comparison practices were chosen from DOQ-IT practices in non-demonstration states. Each demonstration state was matched to a non-demonstration state based on specific criteria that included demographic features, degree of health information technology and pay for performance programs going on in the state, and other factors. Comparison practices were matched to the demonstration practices based on practice size, experience with HIT, whether the practice was in a medically underserved area, the average number of hospital visits per beneficiary in the practice, the number of evaluation and management visits per beneficiary in the practice, and the number of beneficiaries with the chronic conditions specified by the demonstration.

The demonstration states, and the practices within them, are not randomly selected from a population of states and practices. Instead, CMS selected the four states following criteria specified in the enabling legislation. Furthermore, physician practices volunteered to participate. Thus, the sampled population cannot be generalized beyond those practices enrolled in the demonstration and their matched counterparts.

**b. Sampling Methods**

The sample of physicians for the physician survey will be stratified by the number of physicians in the participating practices (that is, practice size). Table C.1 presents the distribution of eligible practices, by size, in the four demonstration states. To select the physician sample, MPR will use a list of physicians in the demonstration practices collected from the demonstration's application form, to select one or more physicians from each of the 699 treatment practices. MPR will obtain the list of physicians for the comparison practices from the Office Systems Survey. MPR will use this list to select one or more physicians from the approximately 700 comparison group practices for this survey. For solo practices, the physician will be selected with certainty. MPR will select a sample of 2,376 physicians—1,144 from practices in demonstration states and 1,232 from practices in comparison states—to get the desired 1,600 completed interviews. The goal is to have 200 completed interviews with physicians in demonstration practices in each state and 200 completed interviews with physicians in comparison practices per state for a total of 1600 interviews.

For the beneficiary survey, MPR will stratify sample members by medical condition. The financial support contractor will provide MPR with lists of Medicare beneficiaries linked with any of the demonstration or comparison-group practices during the first year of demonstration operations (that is, July 2007 to June 2008). From these lists, MPR will select a sample of 6,400 beneficiaries to get the desired 4,800 completed interviews. The sample will be evenly split

across demonstration and comparison practices in each state (800 beneficiaries in demonstration practices and 800 beneficiaries in comparison practices in each state).

TABLE C.1

DISTRIBUTION OF ELIGIBLE PRACTICES, BY SIZE, IN DEMONSTRATION STATES

| State | Practice Size | Number of Practices | Percentage |
|---|---|---|---|
| Arkansas | 1 | 99 | 18.6 |
| | 2 | 259 | 48.8 |
| | 3 | 45 | 8.5 |
| | 4 | 48 | 9.0 |
| | 5 | 21 | 4.0 |
| | 6 | 20 | 3.8 |
| | 7 | 8 | 1.5 |
| | 8 | 16 | 3.0 |
| | 9 | 4 | 0.8 |
| | 10 | 11 | 2.1 |
| California | 1 | 3,051 | 43.6 |
| | 2 | 2,570 | 36.7 |
| | 3 | 518 | 7.4 |
| | 4 | 302 | 4.3 |
| | 5 | 154 | 2.2 |
| | 6 | 134 | 1.9 |
| | 7 | 103 | 1.5 |
| | 8 | 73 | 1.0 |
| | 9 | 45 | 0.6 |
| | 10 | 45 | 0.6 |
| Massachusetts | 1 | 468 | 41.8 |
| | 2 | 324 | 29.0 |
| | 3 | 90 | 8.0 |
| | 4 | 63 | 5.6 |
| | 5 | 52 | 4.7 |
| | 6 | 34 | 3.0 |
| | 7 | 26 | 2.3 |
| | 8 | 26 | 2.3 |
| | 9 | 22 | 2.0 |
| | 10 | 14 | 1.3 |
| Utah | 1 | 39 | 16.3 |
| | 2 | 112 | 46.7 |
| | 3 | 23 | 9.6 |
| | 4 | 23 | 9.6 |
| | 5 | 15 | 6.3 |
| | 6 | 9 | 3.8 |
| | 7 | 3 | 1.3 |
| | 8 | 7 | 2.9 |
| | 9 | 6 | 2.5 |
| | 10 | 3 | 1.3 |

Source: MCMP financial support contractor.

Table C.2 shows the distribution of Medicare beneficiaries by medical condition. In each state, the total percentage exceeds 100 percent because there is overlap among conditions that could not be accounted with the available data.[1] Thus, MPR will stratify the sample into two groups: (1) beneficiaries reported with at least one of the conditions of coronary artery disease (CAD), congestive heart failure (CHF), and/or diabetes; and (2) beneficiaries reported with any of the other conditions, but not CAD, CHF, or diabetes.[2] The percentage of beneficiaries having at least one of the target conditions (CAD, CHF, and/or diabetes) is estimated by summing the percentages for specific conditions and dividing it by the total. For example, in Arkansas, the sum of the percentages across conditions is 145 percent. Thus, the estimated percentage of individuals with CAD, CHF, and/or diabetes is 39 percent [ = (22+13+22)/145].

## 2. Procedures for the Collection of Information

### a. Beneficiary Survey

A self-administered mail survey will be the primary data collection mode for the beneficiary survey. The survey will start approximately 19 months after the beginning of the demonstration's operations (in January 2009). Respondents will be sent a packet containing (1) a letter (printed on CMS letterhead and signed by the CMS Privacy Officer) describing the survey, (2) a fact sheet of commonly asked questions and their answers, (3) the questionnaire, and (4) prepaid return mailing materials.

[1] For example, someone who has both diabetes and a kidney condition is included in both percentages. It is not known how many individuals have only diabetes and no other condition, and how many have diabetes in combination with one or more of the other conditions.

[2] The first stratum includes beneficiaries reported with CAD, CHF, or diabetes in combination with one or more of the other conditions.

TABLE C.2

DISTRIBUTION OF MEDICARE BENEFICIARIES BY CHRONIC CONDITION AND STATE

| State | Condition | Number | Percentage |
|---|---|---|---|
| Arkansas | Coronary artery disease | 36,293 | 22 |
| | Congestive heart failure | 20,316 | 13 |
| | Diabetes | 36,195 | 22 |
| | Age-related macular degeneration | 22,874 | 14 |
| | Heart condition | 33,340 | 21 |
| | Bone condition | 33,076 | 20 |
| | Cancer | 19,527 | 12 |
| | Kidney condition | 8,950 | 6 |
| | Lung condition | 24,442 | 15 |
| California | Coronary artery disease | 307,628 | 22 |
| | Congestive heart failure | 163,726 | 12 |
| | Diabetes | 348,704 | 25 |
| | Age-related macular degeneration | 184,929 | 13 |
| | Heart condition | 333,685 | 24 |
| | Bone condition | 350,863 | 25 |
| | Cancer | 232,224 | 17 |
| | Kidney condition | 108,289 | 8 |
| | Lung condition | 211,878 | 15 |
| Massachusetts | Coronary artery disease | 53,816 | 21 |
| | Congestive heart failure | 26,710 | 11 |
| | Diabetes | 56,927 | 23 |
| | Age-related macular degeneration | 47,754 | 19 |
| | Heart condition | 63,343 | 25 |
| | Bone condition | 51,865 | 21 |
| | Cancer | 41,653 | 17 |
| | Kidney condition | 18,215 | 7 |
| | Lung condition | 37,729 | 15 |
| Utah | Coronary artery disease | 7,585 | 14 |
| | Congestive heart failure | 5,512 | 10 |
| | Diabetes | 11,323 | 21 |
| | Age-related macular degeneration | 7,782 | 14 |
| | Heart condition | 9,978 | 18 |
| | Bone condition | 11,631 | 21 |
| | Cancer | 7,605 | 14 |
| | Kidney condition | 2,815 | 5 |
| | Lung condition | 5,396 | 10 |

Source: MCMP financial support contractor.

A copy of the letter that will be sent to respondents is included as Appendix C to this submission; the fact sheet is in Appendix D. The beneficiary questionnaire (Appendix E) has been designed with a high level of sensitivity to the age of the target population. A larger font size than is typical for use with the general population will be used for the survey. MPR expects that beneficiaries will be able to complete the survey in 15 minutes or less. The questionnaire and all accompanying survey materials will be available in both English and Spanish.

The following topics will be covered by the beneficiary survey:

- ***Section A: Health Status.*** This section collects self-reported health status and obtains information about medical diagnoses and knowledge of health conditions.
- ***Section B: Access to Care.*** This section asks about the usual sources of care, primary care physician identification, and frequency of health care visits.
- ***Section C: Health Care Processes.*** This section collects information about the procedures followed and advice obtained during physician visits.
- ***Section D: Care Coordination.*** This section collects information about physician's knowledge of beneficiary's health information.
- ***Section E: Satisfaction with Care.*** This section collects information on the level of satisfaction with various aspects of medical care received.
- ***Section F: Background Information.*** This section collects information on beneficiary's level of education, languages spoken, marital status, living arrangements, employment status, and income.

Most of the questions contained in the beneficiary survey have been used in previous studies as stand-alone items as described below:

- The Social HMO Demonstration, sponsored by CMS and conducted by Mathematica, was the source for questions on chronic health conditions (A2a-A2o); visits to physicians in the past 12 months (B11); and visits to emergency rooms or urgent care centers in past 12 months (B12). Over 200,000 interviews were completed for this study between 1997 and 2008.
- The Evaluation of Programs of Coordinated Care and Disease Management, sponsored by CMS and conducted by Mathematica, was the source for questions on pneumonia vaccination (C1d); lung examination (C1e); foot examination (C1f and C5); provision of materials (C1h); cutting down or quitting drinking (C2c); cutting

salt in the diet (C2d); self weighing (C6); doctor's awareness of test results (D3); and satisfaction with various aspects of care (E1). More than 7,000 interviews were conducted for this study between 2003 and 2004.

- The Behavioral Risk Factor Surveillance System (BRFSS), sponsored by the Centers for Disease Control, was the source for questions on usual source of care (B6 and B7); physician's advice regarding increasing exercise (C2a); quitting smoking (C2b); and eating fewer high fat and high cholesterol foods (C2f). The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.
- The Picker Ambulatory Care Patient Interview was the source for questions about what to expect in the future (C1i); what to do if symptoms worsened (C1j); and care coordination (D1 and D2). The Picker Ambulatory Care Survey, developed at Beth Israel Hospital (now Beth Israel Deaconess Medical Center), was a spinoff from the Picker Inpatient questionnaire. These questions came from a literature review and focus groups with patients. Many of these questions are now found, in altered form, in the CAHPS Group and Clinician Survey.

In addition to these sources, the MCMP beneficiary survey was pretested with nine Medicare beneficiaries. The questionnaire was completed by mail, and telephone debriefings were conducted following receipt. Pretest participants did not report any problems understanding the questions or providing answers to them during these sessions. Reviews of the completed questionnaires validated such understanding.

MPR's goal is to complete surveys with 4,800 eligible beneficiaries (600 from the demonstration group and 600 from the comparison group in each state), for a 75 percent response rate. The beneficiary survey will be administered over a 12-month period.

Several attempts will be made to reach beneficiaries after the initial mailing. Approximately three weeks following the initial mailing, a reminder postcard will be sent to non-respondents. (This interval allows mail to be forwarded and/or returned if undeliverable.) Then, a second full mailing (letter, FAQs, mail questionnaire, and return envelope) will be sent to remaining non-respondents, approximately four weeks following the first postcard mailing. A second reminder postcard will be sent around week 9 of data collection. A third full mailing, perhaps using

priority mail service, will be sent about 3 to 4 weeks later, about week 12 or 13. A third reminder postcard will be mailed to the remaining non-responding sample approximately two weeks later.

In the interim, locating letters will also be sent to alternate addresses for sample members whose mail is returned as undeliverable.

It is important to note that we will be assessing the response to our mail efforts on an ongoing basis and will make mid-stream adjustments as appropriate. For example, if we find that we receive good responses to the reminder postcards and/or our additional full mailings, we may substitute additional reminder postcards and full mailings using regular service before employing the more expensive priority mail option.

We will also be accepting call-ins from sample members from the beginning of data collection. The table below shows the planned data collection activities by week.

| Week of Data Collection | Activity |
|---|---|
| 1 | Advance letter mailed to beneficiaries |
| 3 | First Reminder Postcard mailed |
| 7 | Second full mailing to beneficiaries |
| 9 | Second Reminder Postcard mailed |
| 13 | Third full mailing to beneficiaries (this may be a priority mailing) |
| 15 | Third reminder postcard mailed |
| 1-15 | Telephone call-ins taken |
| 16 | Telephone call-outs begin |
| 17-End | Additional Reminder and Specialty (i.e., mailings on request) mailings as needed |

### b. Physician Survey

For the physician survey, MPR's goal is to complete surveys with 1,600 respondents (200 physicians from practices in each demonstration state and 200 physicians from practices in each comparison state). These estimates assume response rates of 70 percent for demonstration physicians and 65 percent for comparison physicians. MPR projects a lower response rate for the comparison states because comparison group physicians will have no clear incentive to participate in a survey. These response rate assumptions are consistent with MPR's recent experience interviewing physicians whose patients were participating in CMS's care coordination or disease management demonstrations.

The physician survey will be fielded approximately 25 months after the start of the demonstration (in July 2009). MPR will also use a mail survey (with telephone follow-up) as the data collection strategy for the physician survey. However, MPR will begin telephone data collection immediately following the initial mailing. The initial mailing is being used primarily as a way to alert the physicians that they will be receiving a call about the survey. Some physicians will prefer to complete the survey by mail, and the mailing will facilitate completion for them. MPR selected this approach because physicians' busy schedules may make it difficult for them to respond to an unscheduled telephone survey. The physician survey questionnaire for demonstration physicians is included in Appendix F. Appendix G contains the version for comparison group physicians. The surveys collect data on the following topics:

- ***Section A: Use of Electronic Medical Records.*** This section asks about the physician's experience with electronic medical records.
- ***Section B: Barriers to Adoption and Use of Electronic Medical Records.*** This section asks about factors that may have been barriers in the adoption and use of electronic medical records and the physician's involvement in efforts to improve quality and assess technology needs.

- ***Section C: Caring for Medicare Patients with Chronic Illnesses.*** This section collects information about communication with Medicare patients.
- ***Section D: Experiences with the MCMP Demonstration (Demonstration Physicians Only).*** This section collects information from demonstration group physicians. It asks for their opinions about the demonstration and its effect on their service to Medicare patients.
- ***Section E: Demographic and Socioeconomic Characteristics.*** This section asks for the physician's demographic and socioeconomic characteristics, including racial and ethnic background and board certification status.

MPR will mail survey material to demonstration and comparison group physicians using official CMS letterhead and envelopes. Included in the survey material will be a cover letter signed by the CMS Privacy Officer, a mail questionnaire, and prepaid return mailing materials. The advance letter will include a toll-free number giving physicians the option to call and complete the survey by telephone. Demonstration and comparison group physicians will receive slightly different versions of the advance letter (see Appendixes H and I). In addition, comparison group physicians will be sent a fact sheet about the demonstration (see Appendix J).

The initial mailing to physicians will occur in July 2009. Two weeks after the initial mailing, MPR will begin telephone contact to schedule appointments and conduct interviews with sampled physicians. This effort will continue throughout the 11-month survey period—from July 2009 through June 2010. MPR will train staff experienced in interviewing physicians to negotiate access with gatekeepers and to conduct the estimated 10-minute interview. About midway through the survey period, MPR will send a second mailing appealing to physicians who have not completed surveys or scheduled appointments. MPR expects that about 60 percent of the completed surveys will come from CATI and that 40 percent will be completed by mail. Table C.3 shows the data collection schedule for both surveys.

TABLE C.3

DATA COLLECTION SCHEDULE

| Data Collection Activity | Start Date | End Date |
|---|---|---|
| Beneficiary survey | January 2009 | December 2009 |
| Physician survey | July 2009 | June 2010 |

The proposed data collection periods of 12 months for the beneficiary survey and 11 months for the physician survey are based on the time we believe it will take to achieve the projected response rates. There are several reasons for needing a long field period for both surveys. Firstly, mail surveys require a longer field period that phone surveys to allow time for the mail to reach sample members and completed questionnaires to be returned before sending additional mailings. Secondly, physicians are a very difficult population to survey and require a great deal of follow-up which takes time (particularly during summer months when many take vacation). Thirdly, in the absence of a monetary incentive to encourage beneficiaries and physicians (especially comparison group practice physicians) to participate, additional follow-up efforts will be needed to reach the targeted response rates. We believe that if the field period is sufficiently long, the survey sufficiently short, and creative contact approaches are used, we can achieve the desired response rates. Nevertheless, we will make every effort to complete data collection in fewer months.

**3. Methods to Maximize Response Rates and Analyze Nonresponse Bias**

**a. Beneficiary Survey**

MPR will take a number of steps to maximize response to the survey of beneficiaries for the MCMP evaluation. First, the cover letter that will accompany survey mailings will be printed on CMS letterhead, personally addressed, and signed by the CMS Privacy Officer. The letter will include a telephone number and Internet address for CMS, a toll-free number at which to

complete the survey or get additional information from MPR, and a fact sheet about the survey. The letter will describe the evaluation and the purpose of the mail survey and will provide prepaid return mailing materials for completed surveys. The letter will also indicate that the survey is voluntary and will estimate the time needed to complete it (that is, 15 minutes).

A reminder postcard will follow the initial mailing to beneficiaries. Nonresponders to the initial and reminder mailings will receive a second full mailing, a second reminder postcard, and a priority mailing to encourage response. When these efforts are exhausted, trained interviewers will begin to contact beneficiaries by telephone to complete the survey. All materials for the beneficiary survey will be available in both English and Spanish. MPR projects a 75 percent response rate for the beneficiary survey.

**b. Physician Survey**

MPR will utilize an initial mailing to alert both demonstration and comparison group physicians about the MCMP physician survey. The cover letter for the initial mailing will be printed on CMS letterhead, personally addressed, and signed by the CMS Privacy Officer. The initial mailing will include a self-administered mail questionnaire and prepaid return mailing materials.

Physicians participating in the demonstration will be aware that a survey will be conducted as part of the evaluation and will, MPR hopes, be motivated to respond. Comparison group physicians are less likely to be aware of the demonstration. The CMS Internet address and telephone number that will be included in the letter should be helpful in providing information about the demonstration to this group. Physicians will also be provided with the toll-free number to call MPR to complete the survey by telephone. About two weeks following the initial mailing to physicians, telephone interviewers trained at negotiating with gatekeepers for access to physicians will begin to contact sampled physicians by telephone to complete the survey. These

telephone efforts will be supplemented by a second mailing to nonresponding physicians midway through the data collection period. These efforts are projected to yield a response rate of 70 percent among demonstration physicians and 65 percent among comparison group physicians.

**c. Nonresponse Bias Analysis Plan**

Nonresponse weights will be calculated using information from the sampling frame as covariates in logistic regression models with a binary indicator of whether the interviewee responded or not as the dependent variable. By choosing covariates that are related both to the outcome variables of interest and to the propensity to respond, nonresponse bias will be reduced. However, it will not be possible to remove nonresponse bias entirely. The following describes procedures to investigate nonresponse bias that is not alleviated by the use of nonresponse weights. If evidence of such bias is found, further investigation will be required to ascertain the source of the bias, and caution will be needed when reporting and interpreting estimates from the surveys.

We plan to compare respondents and nonrespondents on information available from the sampling frame. We will also compare frame values with weighted values from sample respondents, with weights adjusted and unadjusted for nonresponse. The comparison between sample values using adjusted and unadjusted weights will allow us to (1) see the potential bias with nonrespondents removed and no nonresponse weight adjustment and (2) assess the potential of the nonresponse bias adjustment to remove any bias or introduce bias. These comparisons will include demographic characteristics of the respondents and nonrespondents, as well as membership status (start and stop dates) in HMO, if applicable; Medicare Part A; and Medicare Part B. Although using these variables in the nonresponse weight adjustment models will alleviate nonresponse bias, the risk of nonresponse bias is still increased if response rates differ between subpopulations defined by the different levels of these variables.

In addition, some of the important outcome variables are likely to be strongly correlated with practice-level characteristics. Although the number of beneficiaries and physicians sampled within individual practices will be small, making a practice-level comparison of response rates unrealistic, we will attempt to compare response rates across different types of practices (for example, medium-size practices vs. small practices). We will also compare frame values to sample values using sampling weights adjusted and unadjusted for nonresponse.

Finally, we will be able to match data from the sampling frame with data from Medicare claims. As indicated in the evaluation design report (Chapter III), data on quality measures (such as whether beneficiaries received appropriate medical tests) can be obtained using information from both the Medicare claims and from the beneficiary survey, and data on continuity of care is available from the Medicare claims, beneficiary survey, and physician survey. We will compare data from Medicare claims, which are available for respondents and nonrespondents, with similar items in the beneficiary or physician surveys to determine if unusual response patterns emerge. We will also compare impact estimates for quality measures drawn from the Medicare claims data (for example, whether beneficiaries with diabetes had a dilated retinal exam) for the full sample of beneficiaries (including non-respondents) to impact estimates for the sample of beneficiaries responding to the survey. The magnitude of the difference between the impact estimates based on the full sample from impact estimates based on the sample of respondents will allow us to assess the degree of nonresponse bias.

**4. Tests of Procedures or Methods**

MPR conducted pretests to assess the clarity of questions, identify possible modifications to question content and/or sequence, and estimate respondent burden for both survey instruments. Convenience samples of Medicare beneficiaries and physicians were used for the pretests.[3] The

[3] MPR staff identified pretest sample members for both surveys.

pretests mirrored the data collection strategy planned for the main survey to the extent possible. That is, mail surveys were sent to all sample members as the initial contact mechanism. These surveys were followed up with a telephone call to debrief with the pretest sample members about their experience completing the survey. During the debriefing calls, MPR asked questions to assess respondents' cognitive understanding of terms used and to identify problems they may have had answering the questions. Respondents were asked to record their start and end times on the survey.

**a. Beneficiary Pretest**

Eight Medicare beneficiaries participated in the beneficiary survey pretest. Respondents took an average of 11 minutes to complete the pretest survey, with completion times ranging from 10 to 14 minutes. Overall, the response to the pretest was positive. Respondents provided some suggestions for changes but found the questions easy to understand. All suggested changes were considered and have been incorporated to the extent appropriate. In addition to the pretest respondents, internal reviewers and reviewers at CMS provided comments on the survey drafts; these have been incorporated as well.

**b. Physician Pretest**

MPR mailed pretest packets, including a cover letter, questionnaire, and prepaid return mailing materials, to nine physicians. Of these, eight returned completed questionnaires. Seven of the eight physicians currently serve Medicare patients. On average, physicians completed the survey in 8 minutes, with completion times ranging from 4 to 18 minutes. Debriefing conversations with physician respondents were also conducted. Pretest physicians provided valuable feedback about terminology and concepts covered in the questionnaire. These comments, along with those of MPR's internal reviewers, external consultants, and CMS, have been integrated into the revised version of the questionnaire that is included with this package.

Revisions reflecting the lessons learned from the pretests have been incorporated into the current versions of both instruments included with this submission.

**5. Individuals Involved in Design**

The following individuals have contributed to the study design and to the design of the physician and beneficiary survey instruments:

- Dr. Lorenzo Moreno, an MPR senior health researcher and study project director, (609) 936-2776
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- Ms. Jillian Stein, an MPR survey associate, (609) 716-4395
- Dr. Eric Grau, an MPR sampling statistician, (609) 945-3330
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- Dr. Lorraine Johnson, CMS Project Officer, Office of Research, Development, and Information, (410) 786-9457

## 6. Additional Information

Personally identifiable information and social security numbers are not being collected as part of the beneficiary and physician surveys being conducted for MCMP.[4] Mail questionnaires will not contain names or other identifiers. Instead, a unique barcode will be affixed to each questionnaire.

### a. Safeguarding Personally Identifiable Identifiable (PII) Information

No personally identifiable information, including SSNs, is being collected for this project. All information will be collected electronically using Computer-Assisted Telephone Interviewing (CATI). The information will be stored electronically in a Non-CMS system. DUA # 15692 is in place for collection and storage of claims data.

If you have questions about privacy impact assessments, contact Maribel Franey, Director, Division of Privacy Compliance, Office of Information Services.

### b. Social Security Numbers (SSN)

Social Security Numbers (SSNs) are not being collected.

[4] Identifiable data only will be used to draw the sample for the beneficiary survey from the Medicare enrollment database, which includes beneficiary social security number and other personal identifiers. Access to these data is governed by a Data Use Agreement between MPR and CMS for the MCMP demonstration. The sample frame for the physician survey does not contain social security numbers, although it includes the tax identification number of the practice to which the physician belongs. Access to these data also is governed by a Data Use Agreement between MPR and MassPRO—the Massachusetts Quality Improvement Organization—for this demonstration.

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