Supporting Statement

Request for Clearance

of

Medicare Contractor Provider Satisfaction Survey

(MCPSS)

National Implementation

Revised October 20, 2009

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Introduction

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) develop contract performance requirements and standards for measuring provider satisfaction. CMS developed the Medicare Contractor Provider Satisfaction Survey (MCPSS) to meet this requirement. Each year CMS obtains information from Medicare providers and suppliers via a survey about satisfaction, attitudes, and perceptions regarding the services provided by Medicare fee-for-service (FFS) contractors, i.e., carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs) and Part A/Part B MACs. (Hereafter the term Medicare contractor applies to all Medicare FFS contractor types, unless otherwise noted.) The survey focuses on basic business functions provided by the Medicare contractors, such as provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. CMS uses the survey to monitor its contractors and to provide incentives for improved performance.

On December 15, 2008, the Office of Management and Budget (OMB) granted CMS a 3-year approval (OMB 0938-0915) for the administration of the MCPSS. CMS seeks to minimally revise the survey instrument for the 2010 administration and submits this request for clearance. CMS would like to obtain more focused feedback on the providers' perception of their interactions with their contractor. (Hereafter, the term provider applies to all Medicare provider and supplier types, unless otherwise noted.) By narrowing the focus of the questions, CMS can provide more specific feedback to the contractors in targeted areas of performance.

The survey is structured to include instructions and an introduction to the survey, followed by a brief questionnaire regarding the provider's practice or facility, their overall satisfaction rating, and seven sections covering each of the Medicare business functions.

The changes to the current MCPSS submitted for OMB consideration are as follows:

- A change to the survey response scale used to assess provider satisfaction; i.e., a revision from a 6-point scale with only the ends labeled, "1-Not at all Satisfied" and "6-Completely Satisfied", to a 5-point scale that is fully labeled "1-Very Dissatisfied", "2-Dissatisfied", "3-Neither Satisfied nor Dissatisfied", "4-Satisfied", and "5-Very Satisfied".

- A limited revision to the content of the survey by rewording, adding, or deleting questions, as displayed in the 2009-2010 MCPSS Question Crosswalk in Section 4 of this package.

- A reservation to exercise the right to add up to three questions to the survey. These questions would be reserved for emerging topics of interest to CMS leadership. The exact questions are not known at the time of this submission. The exact questions will be provided as an addendum to this submission (if any research needs are determined after this package is submitted).

The 2010 administration of the MCPSS is scheduled to begin immediately following OMB approval of the revised survey, and prior to December 1, 2009.

A. Background

Medicare contractors are charged with processing Medicare claims and performing related activities that support regular daily interaction with participating Medicare providers. The MCPSS measures the level of satisfaction providers experience with this contractor-provider 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 4 of the national implementation of the MCPSS (OMB No 0938-0915) and is submitting this request for changes to be implemented in year 5 and to continue in subsequent years.

The MCPSS questionnaire assesses provider satisfaction with seven business functions within the contractors' organizations: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. The study sample includes the following provider types:

- Hospitals and In-patient Clinics
- Skilled Nursing Facilities
- Rural Health Clinics

- End Stage Renal Disease Clinics
- Other provider groups participating in Medicare Part A, (e.g., Federally Qualified Healthcare Centers, Community Mental Health Clinics, Comprehensive Outpatient Rehabilitation Facilities)
- Home Health Agencies and Hospice Facilities
- Physicians
- Ambulance Service Providers
- Licensed Practitioners, Registered Nurses, Physician's Assistants
- Other provider groups participating in Medicare Part B, (e.g., immunization or radiation centers, pain management centers)
- Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Providers are asked to rate their satisfaction with their Medicare contractors' performance. 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 Section 911 (b) (3) (B) of the MMA to develop contract performance requirements and standards for measurement, which shall include provider satisfaction levels. Additionally, under Title XVIII, Section 1816(f) of the Social Security Act and 42 Code of Federal Regulations (CFR) Sections 421.120, 421.122, and 421.201, CMS is required to develop standards, criteria, and procedures to evaluate contractors' performance.

CMS primarily reaches its providers through its Medicare contractors. Knowledge of the relationships and interactions between providers and contractors provides CMS with information on how to better provide quality healthcare to Medicare beneficiaries. One way to examine this contractor-provider relationship is to understand satisfaction with contractor performance from the provider's prospective. CMS uses the MCPSS survey data to support contractor process improvements designed to better serve providers, and to support contracting reform in the Medicare program.

One major function of the MCPSS is to produce reliable estimates of provider satisfaction with contractors at the state level. This is important due to the transition of contractors to the MAC environment. As these transitions may cause difficulties for providers, CMS wants to ensure that state-level data is available to assist in monitoring the transitions.

The survey is aimed at gauging provider satisfaction with, and perceptions of, contractors. The survey results data is used to develop a satisfaction score for each contractor. This information is necessary to:

- Increase the understanding of contractor performance using quantitative 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

The survey data is used 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 (provider comments relevant to specific business functions). The questionnaire includes seven sections that address most of the interactions between contractors and providers. The sections are:

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

Some of these sections do not pertain to some contractors and their respective providers. As such, the questionnaire is customized so providers receive a questionnaire with sections that are relevant to their interaction with their contractor.

Aggregate satisfaction scores for each section, provider type, contractor, and state and/or jurisdiction are obtained. 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., DME MACs receive their own score and the average score of all DME MACs for comparison purposes.

The survey results are used to:

- Capture and quantify contractor performance using provider satisfaction as a measure.
- Identify opportunities for improving provider satisfaction.
- Assist contractors in identifying areas for improvement.
- Identify problematic aspects of the Medicare program from the providers' perspective.
- Apply the results in contractor oversight.

B-3. Use of Information Technology

The studies that accompanied the development of the survey found that offering an electronic survey via the Internet would significantly reduce burden on respondents and reduce costs. In the pilot and subsequent national implementations, all sampled providers could access the survey on a secure website. The site provides background information and instructions for completing the survey online. CMS found that the Internet application worked efficiently and continues to promote this option during the national implementations.

Electronic submissions reduce human error, can be tracked and monitored for quality control issues, provide for rejection of any duplicate submissions from a provider, and produce status reports. Electronic efforts also provide a level of security, as completing the survey electronically can create, select, assign, and verify all identification numbers and 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 contractor keeps all identifying information about a provider, linked to their identification number, in strict confidence (and will continue to do so to the extent allowed by the law). The survey instructions encourage providers to take advantage of the electronic survey as it helps minimize processing errors as well.

Usability testing of the Internet survey application was conducted for purposes of improving the functionality and navigation of the electronic survey. Feedback from the testing performed by CMS staff, Medicare contractors, and providers was used to revise and fine-tune the survey application.

CMS is also using the Internet interface to present the study results. The on-line reporting tool enhances the contractors' ability to access the reports, drill down to the information needed

only by the contractors, and use the results for quality improvement. Usability testing of the on-line reporting tool was conducted by CMS staff and the contractors and received a very favorable response. The contractors and CMS users indicated that the system is very user-friendly. 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 reported that both the quantitative and qualitative data have been useful in their quality improvement efforts.

B-4. Duplication of Efforts

There are no other surveys of provider satisfaction with Medicare contractors' performance for the seven business functions that allow for comparisons across contractors and provider types. While there had been some efforts to develop provider satisfaction surveys, none offer information as valid, thorough, or specific to meet the needs described in this application.

B-5. Small Businesses

The survey's requirements do not have a significant impact on small businesses. The sample size for this survey is kept to the minimum needed to achieve reliable data and the survey content is 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 section. The number of relevant questions varies by provider type, thereby minimizing the burden.

B-6. Less Frequent Collection

Without annual collection of the MCPSS data, CMS will not get a valid or complete picture of provider satisfaction with Medicare contractor performance. Fluctuations in the number of contractors from year-to-year during the MAC transition period, as well as the cycle of MAC contract renewals, require data collection on at least an annual basis. The MCPSS captures ongoing feedback directly from representative providers about how well Medicare contractors are performing their duties as contracted by CMS. To ensure the improvement and protection of beneficiary healthcare, provider satisfaction with contractor performance must be monitored and managed via annual collection of MCPSS data.

B-7. Special Circumstances

There are no special circumstances.

B-8 Federal Register/Outside Consultation

1. Federal register Notice: {July 2, 2009}
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
    - Vasudha Narayanan, Senior Study Director, 301-294-3808
3. The CMS staff who participated in the proposed 2010 survey design includes:
    - Geraldine Nicholson, Director, Provider Communications Group, 410-786-6967
    - Rich Cuchna, Deputy Director, Provider Communications Group, 410-786-7239
    - Robin Fritter, Director, Division of Provider Relations and Evaluations, 410-786-7485
    - Teresa Mundell, MCPSS Project Officer, Division of Provider Relations and Evaluations, 410-786-9176
    - Carlene Randolph, Division of Provider Relations and Evaluations, 410-786-4008
    - Colette Shatto, Division of Provider Relations and Evaluations, 410-786-6932
    - Karen Jackson, Director, Medicare Contractor Management Group, 410-786-0079

B-9. Payments/Gifts to Respondents

The CMS does not offer payment or gifts to providers as incentives to complete the survey.

B-10. Confidentiality

CMS collects the MCPSS data with a guarantee that the survey contractor will hold identifying information of both the respondent and the Medicare contractor in strict confidence (to the extent allowed by the law). Any transfer of identifying data between CMS and its survey contractor (e.g., identifying data that allows the survey contractor to contact sampled providers), or between the survey contractor and the FFS contractors, 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 contractor has access to the identities associated with each number. Submitted hard copies of questionnaires are stored in locked rooms. The survey contractor protects the Internet survey application by requiring access via a password and identification number. Sampled providers can access the electronic

survey only with the password and identification number assigned to them. Survey results are made public only in an aggregate, statistical form. Additionally, small analytic cells of information are automatically suppressed so that users cannot generate frequencies that would allow for identification of an individual provider.

Finally, the MCPSS material includes the following text that assures confidentiality of individual respondents:

"Please note that your participation is voluntary. The reports prepared for this study will summarize findings across the sample and will not associate responses with a specific individual, practice, or facility. We will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law."

B-11. Sensitive Questions

The survey collects data about the provider's satisfaction with their contractor's performance on specific business functions; it does not contain questions considered personally sensitive or commercially proprietary.

B-12. Burden Estimates (Hours and Wages)

Estimated Burden to Respondents - Cleaning the Sample / Screening Activities: Before data collection begins, the entire sample is cleaned. There are two steps to the cleaning process. The first step is to obtain updated contact information from a third-party contractor that maintains large databases of all providers in the United States. The second step, if needed, is to call facilities to verify their contact information, and to obtain the name of the survey contact. During this screening call, the respondent is asked to estimate the number and type of facilities for which he or she handles claims. Based on recent experience, the screening call takes an average of four minutes for a provider facility to complete. This is included in the burden estimates in Table 1, Time Burden per Survey Section.

Estimated Burden to Respondents - Main Survey: The survey is designed to ensure that the most appropriate staff will complete each topic section in order to produce the most comprehensive and accurate results possible. The burden of the entire survey is not placed on

any one respondent unless the provider chooses to do so. Providers need only complete the applicable sections. Scoring takes into account any skipped or not applicable sections submitted by providers. See Section C.2 Procedures for Collecting Information for more information about scoring.

Table 1 provides estimates of time needed to complete each section.

Table 1. Time Burden per Survey Section

Topic	Main Questions	Number of Items	Time (minutes)
Introductory section (background and overall satisfaction)	3	5	1.0
Provider Inquiries	5	11	2.5
Provider Outreach and Education	9	22	4.7
Provider Outreach and Education *Emerging CMS Topics*	3	3	0.6
Claims Processing	2	9	2.1
Appeals	2	9	2.1
Provider Enrollment	4	8	1.9
Medical Review	3	10	2.3
Provider Audit and Reimbursement	2	14	3.1
All Topics	**33**	**91**	**20.3**
Pre-screener Interview			4.0
Total			**24.3**

The estimates provided here assume an average of 12 seconds to answer a closed-ended question (or sub-item), and 30 seconds (on average) to respond to each of the seven open-ended questions. All totaled across the 33 questions, there are 91 sub-items. Of these, 84 are closed-ended items and 7 are optional open-ended questions. The 20.3 minutes for the survey was calculated as: (84 x 12 seconds) + (7 x 30 seconds) = 20.3 minutes.

We believe our burden estimates are conservative, since not all providers are asked to answer every item (some items are skipped if the questions do not apply to the specific provider). Moreover, in 2010, certain providers will not be screened. If we have already identified a knowledgeable respondent and have an email address, we will deliver access to the survey instrument without screening.

Costs to providers vary according to which sections of the survey they complete. DMEPOS suppliers are not asked to complete the *Provider Enrollment* or *Provider Audit and Reimbursement* sections, as these sections do not apply to their contractor's duties. Similarly, Part B providers are not asked to complete the *Provider Audit and Reimbursement* section, as it does not apply to their contractor's duties. For estimating purposes, CMS assumes that each provider that makes a submission will complete all appropriate sections (seven for providers served by Intermediaries/Part A MACs and RHHIs; five for providers served by DME MACs, and six for providers served by Carriers/Part B MACs).

Note that burden will be placed only on those sampled providers that make a submission. Burden is not estimated for those who reject a request to participate and do not complete the survey.

Based on earlier research of salary wages, we estimate that the average annual salary of a respondent is about $55,000 for mid-to-senior staff in healthcare administration (billing managers, office managers, etc.). Therefore, we used the hourly wage of $26.44 to estimate the cost burden on providers (average wage per minute multiplied by total time burden).

Table 2, Time and Cost Burden, depicts the number of providers that 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 Burden Hrs
FI / A MAC	9,000	24.3	$10.71	$96,390	3,645
Carrier / B MAC	11,000	21.2	$9.34	$102,740	3,887
RHHI	2,500	24.3	$10.71	$26,775	1,013
DME MAC	2,500	19.3	$8.51	$21,275	804
Total	25,000	22.44 Avg	$9.89 Avg	$247,180	9,349

NOTE: The averages of 22.44 minutes/respondent and $9.89/respondent are weighted across the four contractor types.

B-13. Capital Costs

There is no capital cost to respondents.

B-14. Cost to Federal Government

Costs to the Federal government ($1.7million in 2009) include: updating and testing the secure Internet website for the survey and 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. In the most recently completed administration (2008), data collection accounted for about 80 percent of the total costs.

B-15. Changes to Burden

The overall reported burden to respondents has increased from what was presented to OMB in last year's package. The number of hours currently approved by OMB is 8,346; we are estimating a burden of 9,349 hours (annually) in this current package.

B-16. Publication/Tabulation Dates

CMS will continue to develop a public report of the overall study results for each administration of the MCPSS. This report is made available through the survey contractor's website https://www.mcpsstudy.org/default.asp and the CMS website https://www.cms.hhs.gov/mcpss.

Table 3 provides a time schedule for the survey. The timeline is similar to previous annual administrations of the MCPSS.

Table 3. Schedule of Key Project Activities and Milestone Dates for MCPSS

Activity	Milestone Dates
Outreach after results are released	July-August
Roll-out/outreach to providers via CMS and contractor communications and partnerships with local, state, and national associations	October onwards
Sample selection completed	October
Sample cleaning / screening begins	Mid-November
Mailings (experimental) begin	Mid-November
Telephone interviews begin	Late November
Internet survey made available	Mid-November
Survey field period ends	Late April / Early May
Draft reports submitted (contractors, CMS, public)	June
Final CMS and contractor reports available via on-line reporting system	July
Final public report available via on-line reporting system	August

B-17. Expiration Date

The OMB approval number and expiration date will be displayed.

B-18. Certification Statement

There are no exceptions to the certification statement.