Supporting Statement – Part A

Medicare Beneficiary and Family-Centered Satisfaction Survey

A. Background

The statutory authority for the 10th Statement of Work (SOW) is found in Part B of Title XI of the Social Security Act as amended by the Peer Review Improvement Act of 1982. The Social Security Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

The QIO Program is the Federal government's only major direct quality improvement program and serves as the Centers for Medicare and Medicaid Services (CMS) primary resource in its efforts to improve the quality of care for Medicare beneficiaries. One of the primary statutory missions of the Program, as set forth in Section 1862(g) of the Social Security Act is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. In accordance with recent quality efforts, CMS strives to improve the safety, timeliness and equity of person-centered care.

As a general matter, Section 1862(g) of the Social Security Act mandates that the Secretary enter into contracts with the QIO for the purpose of determining that Medicare services are reasonable and medically necessary, for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under Medicare.

QIOs, review health care services funded under Title XVIII of the Act (Medicare) to determine whether those services are reasonable, medically necessary, furnished in the appropriate setting, and meet professionally recognized standards of quality. The QIOs also review health care services where the beneficiary or a representative has complained about the quality of those services or is appealing alleged premature discharge.

One method used to ensure the QIOs are effectively meeting their mission, is a survey of complainants. This survey will be conducted by a contractor to the Centers for Medicare and Medicaid Services (CMS). QIO-specific data resulting from the survey will be provided every three months to each of the QIOs for use in on-going quality improvement efforts.

In 2009, CMS began a redesign of the QIO case review activities, currently known as Beneficiary Protection, to address recommendations from the Institute of Medicine (IOM), Office of the Inspector General (OIG), and Medicare beneficiaries. The redesign efforts aimed to make the case review processes more beneficiary-and family-centered, responsive to beneficiaries and other customers, and separate QIO administrative/regulatory functions from quality improvement functions.

As a result of the redesign efforts, CMS proposed to centralize the intake, triage and referral of beneficiary complaints and other types of case review. Additionally, changes will occur in the process by which the QIOs handle complaints from Medicare beneficiaries about quality of care, as well as appeals about discharge. In order to stay current with how the complaints and appeals

processes are taking place, a new beneficiary satisfaction survey and appropriate data collection methodology is necessary. The revised surveys will address the following:

- The 10th SOW includes a strong focus on making all processes beneficiary and family focused, in line with the principles outlined by the Picker Institute. The revised survey will measure beneficiary satisfaction with these new processes.

- The survey, which was used to measure beneficiary satisfaction in the 8th and 9th SOW measured beneficiary satisfaction with the quality of care complaint review process only. In the 10th SOW, the survey will also capture beneficiary satisfaction with the appeals review process.

The data for the first 30 months of the QIO 9th Scope of Work contract show a total of 102,395 beneficiary complaints and appeals received.

B. Justification

1. Need and Legal Basis

Section 1154 of the Social Security Act (hereinafter "the Act") sets forth the functions of the Peer Review Organizations, including, at 1154 (a) (1) (B), determining whether the quality of health care services meets professionally recognized standards of health care. Section 1871 (c) (3) specifies the maintenance of a data base which reflects the provision of care, including benefit denials and results of appeals.

Based on statutory language and the experience of the CMS in administering the Program, CMS has identified the following requirements for the QIO Program:

- Improve quality of care for beneficiaries;

- Protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; Emergency Medical Treatment and Labor Act (EMTALA) violations; and other related statutory QIO responsibilities.

2. Information Users

The information obtained using surveys will assist CMS in 1) evaluating the success of each state QIO in meeting its contractual requirements and 2) in assessing the satisfaction of Medicare beneficiaries and/or their representative with QIO contract mandated work. Because the surveys will be patient-centered, they will measure and improve coordination, communication, courtesy, respect and responsiveness between the QIO and the beneficiary.

3. Improved Information Technology

Not applicable - Based on the methodological research into efficient collection of data and especially in light of the fact that the majority of respondents will be older adults, CMS propose using mailout surveys. No signature is required for consent to participate and participation in the survey is voluntary; the covering materials accompanying the mailout survey will explain in further detail.

4. Duplication and/or Similar Information

The information required is not duplicative.

5. Small Business

These requirements affect only individuals and households. Therefore, there is no economic impact on small businesses and the impact on individuals is minor.

6. Less Frequent Collection

These information requirements are collected on an as-needed basis. It is not a recurrent process.

7. Special Circumstances for Information Collection

There are no special circumstances associated with this collection.

8. Federal Register and Outside Consultation

The 60-day Federal Register notice was published on June 10, 2011.

In the development of the final regulations that include these requirements, we considered the correspondence received from individuals, advocacy groups, hospitals, hospital associations, business groups, and national medical organizations. The comments were discussed in the preamble to the final rule.

The individuals listed in exhibit 1 were consulted in the development of the surveys, sampling and data collection methodologies.

Exhibit 1: Survey development consultants

Organization	Name	Contact Information
CMS	Robert Kambic	410-786-1515 Robert.Kambic@cms.hhs.gov
	Coles Mercier	410-786-2112; Coles.Mercier@cms.hhs.gov

Organization	Name	Contact Information
Westat	W. Sherman Edwards	301-294-3993; ShermEdwards@westat.com
	Vasudha Narayanan	301-251-2257 VasudhaNarayanan@westat.com
	Stephanie Fry	301-294-2872 stephaniefry@westat.com

9. Payments or Gifts

There are no payments or gifts associated with this collection.

10. Confidentiality

We do not pledge confidentiality of the data obtained in this collection. In order to effect quality improvement QIOs need access to the identified survey data.

11. Sensitive Questions

There are no questions of sensitive nature.

12. Estimate of Burden

The regulatory text implementing and further defining the requirements to qualify as to undertake a QIO contract are located at 42 CFR: 476.70 through 476.104.

The information that an organization is required to supply to demonstrate that it is eligible for a QIO contract is information that it would ordinarily maintain in its files. Consequently, these requirements impose no additional burden on the Medicare beneficiary.

Exhibit 2: Estimated burden hours

Data Collection	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Survey of Beneficiary Satisfaction with QIOs-Per round	1,601	1	0.25	400.25
Total for the 10th SOW (August	**16,010**	**1**	**0.25**	**4002.5**

2011 - July 2014) (10 rounds)				

Exhibit 3. Estimated cost burden

Data Collection	Number of respondents	Total burden hours	Average hourly wage rate[1]	Total cost burden
Survey of Beneficiary Satisfaction with QIOs-Per round	1,601	400.25	$10.96	$4,387
Total for the 10th SOW (August 2011 - July 2014) (10 rounds)	**16,010**	**4002.5**	**$10.96**	**$43,867**

13. Capital Cost

There are no capital costs associated with this collection.

14. Federal Cost Estimates

The cost estimates for the redesign of the Beneficiary Satisfaction Survey and subsequent administration are estimated as follows:

The cost of the study for Government personnel is estimated at $97,056 for 3 years for an estimated annualized cost per year of $32,352 (please see Exhibits 4 and 5 for detailed break down). The estimated government cost for a contract to carry out this study is $997,000. This cost is for roughly 14,593 person hours of which 55 percent are professional hours and 45 percent are support hours.

Exhibit 4

Annual government Cost for Federal Employee:

Grade 9:	$ 59, 371.60	x 0.20 =	$11,874.32
Grade 13:	$ 102, 387.70	x 0.20 =	$20,477.54
			$32,351.86*

Exhibit 5

Government cost for Federal Employee over three years:

Grade 9:	$ 11,874.32	x	(3 years) =	$35,622.96
Grade13:	$ 20,477.54	x	(3 years) =	$61,432.62
				$97,055.58*

*Annual Rates by Grade and Step for Federal Employees found on the U.S. Office of Personnel Management Website

15. Changes in Burden

[1] Based on 2010 Medicare Chart book published by the Kaiser Family Foundation Median annual income of $22,800. http://facts.kff.org/chart.aspx?cb=58&sctn=162&ch=1724

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There are no changes in burden at this time. Subsequent to the publication of the 60-day Federal Register notice (June 10, 2011; 76 FR 34076), the survey instrument has been separated into two surveys. Prior to this action, there was one survey proposed for the Quality of Care and Appeals review types. Once approved by OMB, there will be two survey instruments that will request similar information: one for Quality of Care and one for Appeals.

16. Publication and Tabulation Dates

We anticipate that we would need 2-4 weeks after receipt of OMB approval to prepare and begin the first round of data collection for this study. Projected data collection dates are noted below.

- May 2012– Pull sample file in preparation for Pilot testing
- May 2012 – Pilot test (pending OMB approval)
- July 2012 – Reporting of Pilot results
- August 2012 – Quarterly data collection begins

17. OMB Expiration Date

This collection will be conducted by mail. The surveys will carry the expiration date on them.

18. Certification Statement

There are no exceptions to the certification statement.

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