Request for OMB Clearance
Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries

Supporting Statement – Part A

A. BACKGROUND

Introduction

This request for Office of Management and Budget (OMB) review asks for clearance for the following documents.

- One interview protocol for American Indian and Alaska Native (AI/AN) Medicare beneficiaries.
- One focus group protocol for American Indian and Alaska Native Medicare beneficiaries and family members.
- One interview protocol for health care providers of American Indian and Alaska Native Medicare beneficiaries.

Study Purpose

The Centers for Medicare and Medicaid Services (CMS) is an agency of the U.S. Department of Health and Human Services with a mission to "ensure effective, up-to-date health coverage and to promote quality care for beneficiaries." The purpose of the proposed research is to conduct an exploratory study to identify and analyze transportation barriers associated with the utilization of Medicare services by American Indian and Alaska Native (AI/AN) beneficiaries, to identify and analyze the health outcomes resulting from those barriers, and ultimately to identify potential solutions that could help mitigate the problem and produce meaningful improvements in health care use and health outcomes for this population.

The study questions that will be explored are as follows:

- Do physicians and other health care providers in AI/AN health care systems not refer Medicare beneficiaries to optimum health care services because of their concerns about transportation and related barriers?

- What recommended or referred health care services (unmet need) do AI/AN Medicare beneficiaries not receive due to transportation-related barriers?
- What types of health care services do AI/AN Medicare beneficiaries not receive as prescribed due to transportation-related issues?

- How do Medicare beneficiary health transportation needs affect individual and Indian Health Service (IHS) or tribal health care budgets?

- What are the consequences of provider and patient transportation-related decisions on the outcomes of health care and projected mortality and morbidity?

- What are the perceived consequences of external government and/or referral system factors (i.e. appointment times, state or local government public transportation systems available for medical transport, etc.) on the outcomes of heath care and projected mortality and morbidity?

STUDY METHODOLOGY

This section identifies the components that comprise the qualitative methodology for this 2-year study. They include the conceptual framework, evaluation design, recruitment, data collection methods, and data analysis plan.

Conceptual Framework

We will use an indigenous framework for evaluation (e.g., American Indian Higher Education Consortium, n.d.) to conceptualize and conduct this study. Using an indigenous framework means that the study is built on the values of the participating communities; this includes respecting and honoring the values around the ways knowledge can and should be created; fostering a sense of ownership at the different sites, fostering participation in implementation and analysis activities; and developing a study design that accommodates unique community characteristics and needs, while allowing for the detection of differences across communities.

Case Study Design

A case study design will be used for this exploratory study. It captures the uniqueness of the different health care sites and transportation options offered, as well as the constraints of those options on access and utilization of Medicare services for beneficiaries. The design also gives special attention to the context, reconstruction, and analysis of the data gathered from each site, and allows comparisons across sites. It is suited to addressing a problem such as transportation barriers to the utilization of Medicare services for AI/AN beneficiaries because it enables the researcher to focus on specific areas of interest rather than a broad spectrum of concerns.

To help ensure the findings are valid, a mixed methods approach will be used. This approach, which uses quantitative and qualitative data collection methods, enables the researcher to triangulate findings from different data sources. Used in case studies, it provides the researcher an avenue for a deeper exploration of a condition or situation (Tellis, 1997). As a procedure in the social sciences, triangulation entails the juxtaposition of multiple data sets, both quantitative and qualitative, as a means of contextualizing and cross-checking findings in order to (a) ascertain trustworthiness of data, (b) gain insight into to what extent the data may be an artifact of an instrument or a method of data collection, and (c) explore contextual aspects of an experience or understanding (Guba, 1981; Duffy, 1987). Three qualitative instruments will be used to collect contextualized

and more nuanced data: AI/AN Medicare Beneficiary Interview, Health Care Provider Interview,
and AI/AN Medicare Beneficiaries and Family Members Focus Group.

We propose to conduct descriptive case studies of 12 sites that will be drawn from each of the 12 Indian
Health Service (IHS) Administrative Areas and identified by CMS.

To conduct this exploratory study we will use convenience sampling, as described below, to select one site from each of the 12 Indian Health Service (IHS) Administrative Areas. Six Tribal health care centers (IHS currently compacts with 328 tribes that administer their own health programs) and six IHS service units will be identified. Selection criteria will include remoteness of location, underdeveloped infrastructure and geographical diversity. To ensure we obtain an adequate number of interviews at each site, the facility must serve no less than 500 American Indians and Alaska Native people. In an effort to obtain geographic diversity, only one site (IHS service unit or Tribal health center) will be chosen from each of the 12 IHS Administrative Areas. If a site does not wish to or cannot participate in the study, another site will be chosen from its category using the same criteria. This process will be repeated until a site accepts the invitation to participate in the study.

Strategy for selecting beneficiaries and providers

The number of beneficiaries and providers recruited at each site will be the same across all sites.

We will use the following sample sizes for each of the 12 case studies.

- Health Care Provider Semi-Structured Interview: 10
- AI/AN Medicare Beneficiary Semi-Structured Interview: 10
- AI/AN Medicare Beneficiaries and Family Members Focus Group: one group with approximately 10 participants

Based on the above breakdown, we anticipate the following number of interviews and focus groups will be conducted across all sites.

- Health Care Provider Interview: 120

- AI/AN Medicare Beneficiary Interview: 120
- AI/AN Medicare Beneficiaries and Family Members Focus Group: 12 (120 participants)

This descriptive case study will employ the following strategies to identify participants.

- AI/AN Medicare Beneficiary Interviews. A convenience sample of beneficiaries will be obtained by inviting them to attend meetings. Additional individuals who may not attend the health center frequently, be home bound, or live in an isolated area may be identified through a "snowball sample" based on the meeting attendees.
- AI/AN Medicare Beneficiaries and Family Members Focus Groups. A purposive sampling of individuals who play a supportive role in the care of the beneficiary (e.g., provide transportation to health care appointments) as well as beneficiaries will make up the sample for the focus groups.
- Health Care Provider Interviews. A purposive sampling of providers who are involved in primary, secondary, and tertiary care to AI/AN Medicare beneficiaries will be conducted for the interviews.

Medicare Beneficiary and Health Care Provider Data Collection Instruments

The following instruments were developed based on 1) consultation with experts in AI/AN Medicare and Medicaid service delivery; 2) examination of existing instruments; 3) literature review of existing research on AI/AN patient's barriers to accessing health care; and interviews with key AI/AN health care experts. Particular attention was paid to developing instruments that address beneficiaries with disabilities as well as those without, and that are sensitive to assessing the transportation conditions unique to various regions.

A total of three instruments will be used for this exploratory study.

AI/AN Medicare Beneficiary Interview Protocol. The AI/AN Medicare Beneficiary Interview was designed to produce a more qualitative response than survey instruments. The semi-structured interview is useful for probing experiences, reconstructing events, describing social processes, exploring historical contexts, delving into personal issues, shedding new light on old problems, and examining issues from various perspectives (Rubin & Rubin, 2005). The interview contains a demographic section, including but not limited to Medicare coverage, health care delivery sites, location relative to health care delivery, education, and distance from primary health care facility. It also addresses the key areas of transportation barriers, focusing on transportation barriers and unmet needs. This instrument was pretested with nine beneficiaries and took, on average, 30 minutes to administer. **(See Appendix C: Medicare Beneficiary Interview Protocol.)**

Medicare Beneficiaries and Family Members Focus Group Guide. When the group convenes for the focus group the moderator will, along with introducing the process and collecting consent forms, collect basic demographic data (**See Appendix D:**

Demographic Survey) prior to the discussion. The purpose of collecting the demographic data is to gather basic data about age, gender, tribal affiliation, Zip code, education, and employment status in order to contextualize the findings of the focus groups. As with the AI/AN Medicare Beneficiary Interview, the Focus Group Guide will access more contextualized and nuanced data than a survey instrument. Focus groups are a crucial part of the data collection process among beneficiaries, as the format provides a forum for participants to give voice to challenges they face regarding transportation-related barriers to accessing Medicare services. Focus groups furnish the researcher a useful tool to understand a targeted population's views on complex issues (Morgan, 1998), such as challenges and issues surrounding transportation barriers to health care services. This data collection method is frequently used in Indian Country and has been used with considerable success with American Indians (see e.g., Devlin, et al., 2006; Severson and Wilson Duclos, 2003; and Poupart and Becker, 1997).

Focus groups generate in-depth data guided by dialogue among participants. Thus, beneficiaries' and family members' focus group questions, while similar to the types of questions asked during the beneficiary interview, are fewer in number and probe into more general topics than the semi-structured interview instruments. They are designed to enable greater examination of issues, affording participants the opportunity to draw on their personal experiences while developing a group picture of transportation barriers and how they envision these problems could be addressed. This format allows for lengthier dialogue among participants and does not restrict focus group members' responses. The combined time for demographic survey and the conduct of the focus based on pretest with seven beneficiaries and family members took, on average, 90 minutes to complete. **(See Appendix E: AI/AN Medicare Beneficiaries and Family Members Focus Group Guide Protocol.)**

Health Care Provider Interview Protocol. Interview questions focus on each professional's experience working with AI/AN Medicare beneficiaries including demographic information about their professional qualifications, where they work, and the types of patients that access care at their facility; knowledge of transportation barriers to patients' receiving and utilizing optimal services; availability of transportation services within the community and to the Indian health care center; personal and organizational protocols for referring (or not referring) beneficiaries for Medicare services due to concerns about transportation; beliefs about how transportation needs do and/or would impact their organization's budget; and how their professional decisions influence the overall well-being and projected mortality and morbidity for patients. This instrument was pretested with nine providers and took, on average, 30 minutes to administer. **(See Appendix F: Health Care Provider Interview Protocol.)**

All semi-structured interviews and focus groups will be digitally recorded to ensure completeness of data collection.

The project team will employ a systematic approach to the analysis of the qualitative data and the verifiability of the findings (Krueger, 1998). In general, steps will include the execution of a transcript based upon the digital recording; creation of a word processing file for the text; and the analysis of the data using a qualitative software package, NVivo9, the latest edition of the program previously known as NUD*IST. NVivo9 has diverse functionality and great flexibility. Among its many features is its ability to enable the researcher to analyze materials straight from audio files. It also contains controls to playback audio at varying speeds as well as to skip to different sections. Researchers can use NVivo8 to synchronize the scroll of their text to the audio playback. In the analysis of each focus group, the senior researcher will be able to use two types of information. One will be the transcript of the discussion that allows for electronic manipulations. The second will be the actual audio recordings that allow the project team to decipher not just what a participant says but how the participant says it. The analysis will consider verbal and non-verbal reactions of the participants and include words, context, and internal consistency as well as the frequency, extensiveness, intensity, and specificity of comments. To analyze the interviews and focus groups, the following steps will be followed:

- Transcription: A professional transcriber will create a written text from the digital recording.
- Preliminary codes: The program manager and senior researcher will create a preliminary set of codes.
- Application of the codes: The program manager and senior researcher and program evaluator will independently apply the codes to the transcripts.
- Consultation among researchers: Cooperative work between program manager and senior researcher will lead to a final cross-coding with differences resolved through dialogue.
- Development of themes: Using NVivo9, program manager and senior researcher will create themes.
- Development of Context: Program manager and senior researcher will create themes and engage in ongoing dialogue and repeated analysis of data to develop context for the participants’ observations.
- Execution of a draft narrative of findings: Program manager will complete a draft of the detailed findings and choose verbatim quotes to illustrate key concepts.
- Review of the draft: Any other staff who took part in the focus groups or interviews will have an opportunity to verify and edit the draft.

B. JUSTIFICATION

1. <u>Need and Legal Basis</u>

The Federal obligation to provide health services to AI/ANs is based upon a unique historical government-to-government relationship established through treaties and affirmed over time through laws, Executive Orders, and court decisions. Health services in particular were guaranteed in treaties negotiated between tribes and the U.S. Government, and funding was specifically authorized by Congress in The Snyder Act of 1921. Later, the U.S. Indian Health Service (IHS) was established by authority of the Transfer Act of 1954, which transferred the responsibility for health service delivery to

AI/ANs from the Department of the Interior's Bureau of Indian Affairs to the U.S. Surgeon General's Public Health Service. Since then, significant health status improvements have been achieved through a comprehensive public health approach targeting preventive, curative, rehabilitative, and environmental services for AI/AN communities in some of the most remote reaches of the Nation. This new IHS system of public health outreach and education, sanitary water/sewer systems, outpatient service units, small rural hospitals, regional referral hospitals, and contracts with specialists and local hospitals represented a pivotally important initiative that turned the declining health status of the AI/AN population toward a process of steady and documented improvements over the last 50 years. But with these improvements, health disparities are still prevalent, and AI/ANs have a life expectancy that is 2.4 years less than the U.S. all races population (IHS, 2006).

In the mid-1970s two laws were enacted that dramatically changed the face of Indian health care delivery. The Indian Self Determination and Education Assistance Act of 1975 provided authority to federally recognized tribes to take over and administer for themselves the Federal programs of the IHS designed to serve them, shifting the control and direction of health priorities to local tribal governments. Over the years, this authority has been clarified and expanded to allow tribes to contract under Title I or Title V of the amended Act, so that tribal governments design and manage their own health care systems. Today, the IHS reports that a total of $1.15 billion is compacted (Title V) to 328 tribes and another $490 million contracted (Title I) to 238 tribes, representing more than half of the total IHS budget administered locally by tribal governments.

The other significant change was the enactment of the Indian Health Care Improvement Act of 1976 (IHCIA), which clarified Federal policy to "elevate the health status of Indians and Alaska Natives to the highest possible level" and provided specific targets for this new policy, including health professional training, health facility construction and modernization, and access to Medicaid and Medicare reimbursement for IHS and tribally provided services.

Despite these positive changes, the annual appropriation for IHS has not kept pace with the demand for health care services of the AI/AN population. Over the years, the IHS and its tribal contractors have used a system to "ration" care in an effort to extend the limited budgets through each fiscal year. Local budgets used to pay private providers and hospitals under the IHS Contract Health Services (CHS) fund are often forced to limit CHS payments for "life or limb" episodes only, postponing surgeries and procedures due to a lack of funds.

Title IV of the IHCIA opened the door for IHS and eventually tribally run clinics and hospitals to bill Medicare and Medicaid for eligible patients served in those facilities, creating a new resource for both patient and provider. Although a small percentage of the total Medicare and Medicaid expenditures nationally, these dollars represent the single largest investment in Indian health care outside of the annual Congressional appropriation for the IHS, and a relief to thousands of eligible patients who might otherwise go without needed services.

Today, the IHS system expects to collect approximately $166.7 million annually from Medicare for services to eligible patients, representing just 5% of their total $3.5 billion budget authority (DHHS, FY2010). This percentage will likely increase as the Medicare-eligible population grows and as barriers to accessing Medicare are eliminated. Unlike the general population of Medicare beneficiaries, the AI/AN beneficiary population is younger and composed of more people with disabilities (Crouch et al., 2009). Because little racial data on AI/AN beneficiaries has actually been recorded through CMS or through Social Security, the bulk of this identification has come from the IHS determination (member of a federally recognized tribe or their descendants and are active patients of the IHS health care delivery system, which is currently at least once in the past three years).

Despite the availability of Medicare coverage, significant barriers prevent AI/AN beneficiaries from accessing care. Indeed, as noted in the CMS Tribal Technical Advisory Group (TTAG) Strategic Plan, additional barriers experienced by AI/ANs include “needing information in their own Native language, low literacy, *lack of transportation* . . . help understanding forms . . . and cultural differences” (emphasis added).

Transportation issues and their effects on older AI/ANs’ access to health care are also substantiated elsewhere. For example, a 2006 study by the Federal Transit Administration suggests that AI/AN transportation problems are similar but more extreme than those found in other areas of the rural U.S. and that these transportation issues prevent AI/ANs from accessing important services, such as medical care (Hensley-Quinn & Shawn, 2006). Despite the evidence of the problem found in this and other publications as well as in the stories of tribal communities members across the U.S., the extent of the problem of transportation (as well as its impact on access to health services and, ultimately, health care outcomes) has not been thoroughly analyzed, necessitating further research, as called for in a 2003 study commissioned by CMS.

To address the requirements of CMS, through the issuance of the Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries Project, Contract No. GS-00F-0012S, Task Order No: HHSM 500-2009-00097G, a contractor, Kauffman & Associates, Inc. (KAI), was asked to design a study to analyze the transportation barriers experienced by AI/AN Medicare beneficiaries and quantify transportation-related consequences for health status that result from living in a rural area.

The information that will be collected through the use of instruments and the study developed under the Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries Project has not been collected or evaluated previously by any agency or individual, so data on the transportation barriers for rural AI/AN beneficiaries to Medicare services by AI/AN Medicare beneficiaries are not currently available.

2. <u>Information Users</u>

The information gathered as part of the project —through the use of interview and focus group instruments—will be used by CMS to identify transportation barriers to Medicare services for AI/AN Medicare beneficiaries. It will provide the first exploratory study of transportation barriers to health care for this population.

3. Use of Information Technology

The Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries Project will use a multi-modal approach to data collection.

Medicare Beneficiary Interview

The Medicare Beneficiary Interview was designed to be orally administered by contractor staff in order to elicit an in-depth response. A multi-modal approach will be taken to collect data on the Medicare Beneficiary Interview. To ensure the maximum comfort for the interviewee, the interviewer will enter the respondent's answers by hand. The interviews will also be digitally recorded and subsequently transcribed to ensure all comments are collected with complete fidelity. If, for whatever reason, the respondent is not comfortable with the electronic setup because of a lack of familiarity and possible discomfort with electronic technology, an audio digital recorder will not be used. We do not anticipate that any of the interviews will be electronically entered at the time of administration.

Medicare Beneficiaries and Family Members Focus Group

The Medicare Beneficiaries and Family Members Focus Group will be digitally recorded, transcribed, and analyzed unless otherwise indicated. Notes will be taken as a backup by contractor staff. The Demographic Survey for the Medicare Beneficiaries and Family Members Focus Group will be on hard copy as each participant will complete this short, 7-item form at the start of the session. We anticipate 100% of the focus groups will be audio digitally recorded. The only other electronic device that will be used during the sessions is a laptop computer for note taking.

Health Care Provider Interview

As with the Medicare Beneficiary Interview, the Health Care Provider Interview was designed to be orally administered in order to elicit an in-depth response. The interviews will be conducted both face-to-face and over the telephone by contractor staff. A computer will be used to enter all comments and a digital recorder will also be used to ensure all comments are captured. If, for whatever reason, a respondent is not comfortable with the electronic setup, hand written notes will be taken. We anticipate 85% of providers will have their interviews electronically entered at the time of administration.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

The information collection does not impact small businesses. The only small entities it may impact are local community center elders' programs at which some recruitment and interviews will be conducted. Burden will be minimized by conducting recruitment and interviews at the convenience and location of the organization and the participant.

6. Less Frequent Collection

The consequences for not conducting this one time information collection will be that CMS will not be able to meet its accountability requirements to the Tribal Technical Advisory Group which requested the study to assess the degree of access barrier to Medicare services for AI/AN beneficiaries and its impact on their morbidity and mortality.

7. Special Circumstances

There are no circumstances that would cause an information collection to require 1) respondents to report information to the agency more than once; 2) preparation of a written response to a collection of information in fewer than 30 days after receipt of it; 3) respondents to submit more than an original copy of any document; 4) respondents to retain any records; or 5) the use of a statistical data classification that has not been reviewed and approved by OMB. 6) There are no circumstances that would cause an information collection to be conducted in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of the study. 7) There are no circumstances that would cause an information collection to require inclusion of a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use. 8) There are no circumstances that would cause an information collection to require respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice was published on July 1, 2011 (76 FR 38655).

9. Payments/Gifts to Respondents

Remuneration for participation in the interview or focus group for Medicare beneficiaries and family members will be provided in the form of gift cards for $30. The gift card recognizes the work and effort expended in participating in the project. Since many of the health care providers could be federal employees working for IHS, all health care providers will receive a small gift, e.g., a mug, in lieu of a gift card for their participation.

10. Confidentiality

All participants will be informed through email and the informed consent process that all information shared is done so voluntarily and that anything said will be held in strict confidentiality. All participants will be informed in writing of the need to have an OMB number on all documents associated with this clearance package. The following statement will be provided: “According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number.” The valid OMB control number for this information collection is 0938-xxxx.

Participation in this study is voluntary and personally identifiable information will not be maintained for the participants. During the informed consent process, participants will be asked to read and sign the consent form (**See Appendix G: Consent Forms**). If needed, the interviewer will also read the consent form aloud to ensure literacy level is not a barrier to informed consent. The consenting process will occur prior to participation in the study. All consent forms will provide contact information for further information. After the participant and the interviewer/moderator sign the forms, copies will be made for the participants to have for their records. Only individuals who sign the consent form will be eligible to participate in the interview or focus group.

11. Sensitive Questions

No questions of a sensitive nature will be asked of respondents. They will be asked to answer questions and/or discuss health care as it relates to transportation barriers. The only minimally sensitive questions would be for respondents to comment on how, if at all, their health has been affected by transportation issues related to getting to and from a medical appointment or procedure.

12. Burden Estimates (Hours & Wages)

This study includes interviews with Medicare beneficiaries, focus groups with Medicare beneficiaries and family members, and interviews with health care providers.

12.a. Number of Respondents, Frequency of Response, and Annual Hour Burden

The total number of annual respondents is **360**.

The estimated annual response burden is **300** person hours.

The frequency of response is one time only.

Respondents are AI/AN Medicare beneficiaries and their family members and health care providers at Indian health care centers that serve AI/AN Medicare beneficiaries. There are currently 350 IHS and tribal health centers and hospitals currently serving AI/AN people on or near a reservation. Of that number, 12 health centers will comprise the sample for this study. There will be 180 AI/AN Medicare beneficiaries, 60 family members of beneficiaries who will be asked to provide demographic, health and health care, and transportation-related information about themselves or family members. There will also be 120 health care providers who will be asked demographic and health care and transportation-related information about their AI/AN Medicare beneficiaries.

Respondents will provide answers to the instruments just once over the 2-year period of this study. Also, over the 3-year life of this clearance no new awards will be made, and all active awards will expire.

To determine the burden hours per respondent, pretests were conducted on the interview instruments at three sites with three respondents per instrument per site. The focus group was held at one site and had seven participants. Pretesting was conducted at the following sites: San Xavier Public Health Service Health Center (SXHC) on the San Xavier Reservation in AZ; Benewah Medical/Health Center (BMC/WC) on the Coeur d'Alene Reservation, ID; and Yukon Kuskokwim Health Corporation (YKHC) in Bethel, AK. The focus group was held at the BMHC. Based on the length of time it took respondents to complete the different instruments, we were able to determine the following burden hours per respondent.

The estimated burden was calculated as follows:

Table 1. Estimated Burden Hours Per Respondent

Respondent Type	Number of Respondents	Burden Hours Per Respondent	Annual Person Hour Total
Medicare Beneficiaries	120 60	30 minutes 90 minutes	60.0 90.0
Family Members of Medicare Beneficiaries	60	90 minutes	90.0
Health Care Providers	120	30 minutes	60.0
Total Respondents	600		300.0

12.b. Estimates of Annualized Cost to Respondents for the Hour Burdens

The overall annualized cost to the respondents is estimated to be **$7,270.00**. Annualized cost, which is rounded to the nearest dollar amount, is based on the 2-year time length of this evaluation; total cost was divided by 2 to derive annualized cost. The estimated hourly wage rates for the various respondents were based on information found in the Bureau of Labor Statistics, Health and Human Services, IHS job listings, and federal employee sources. Because family members and non-retired Medicare beneficiaries can have any type of employment, an average wage was used.

In Table 2 are the estimated annualized costs to respondents for the site visit forms.

Table 2. Estimated Annualized Cost to Respondents

Respondent Type	Hourly Salary Estimate	Burden Hours per Respondent	Total Number of Respondents Across Sites	Total Burden Hours Across Sites	Costs
Medicare Beneficiaries Interview					
Nonworking Medicare Beneficiaries	N/A	.5 hour	90	45	0.00
Working Medicare Beneficiaries	$35/hr	.5 hour	30	15	$ 525.00
Medicare Beneficiaries and Family Members Focus Group					
Nonworking Medicare Beneficiaries	N/A	1.5 hours	45	68	0.00
Working Medicare Beneficiaries/Family Members	$35/hr	1.5 hours	75	113	$3955.00
Health Care Providers Interview					
Doctors, Dentists	$58/hr	.5 hour	40	20	$1160.00
Managers, PAs NPs,	$42/hr	.5 hour	40	20	$ 840.00
RNS, X-ray Techs, etc.	$26/hr	.5 hour	40	20	$ 520.00
Total					**$7,270.00**

13. Capital Costs

13.a. Estimate of Total Annual Cost Burden to Respondents

There is no overall annual cost burden to respondents or record keepers that results from the Analysis of Transportation Barriers to Utilization of Medicare Services by AI/AN Medicare Beneficiaries other than the time spent responding to instruments including interviews or focus groups that are attached as appendices to this request.

13.b. Operation and Maintenance Costs to Respondents or Record Keepers

No purchase or maintenance of equipment or software will be necessary to respond to any of the methods—interview or focus group—for data collection. There will be no additional cost for the operation and maintenance of any equipment other than what the respondents are already using in their regular work.

14. Cost to Federal Government

The estimated cost to the government of all data collection, analysis, and reporting activities for this study is **$277,719.**

The estimated costs include:

Personnel		
Project Director/Sr. Research Associate, Program Manager/ Senior Research Associate, Research Associates (2), Project Specialist II		
Personnel Total (Labor hours and labor costs)		***$189,885.00***
Other Direct Costs		
Staff travel and per diem (12 sites: one 3-day site visits for two staff)		$ 45,934.00
Transcriber ($20/hr for 690 hours)		$ 13,800.00
Incentives		
Beneficiary interviews (120), $30 each	$ 3,600.00	
Beneficiary/family member (120) @ $30 each	$ 3,600.00	
Provider interview (120) gifts, $20 each	$ 2,400.00	
		$ 9,600.00
Print/copy/materials/postage		$ 1,500.00
Total ODC		***$ 70,834.00***
Indirect Costs (G&A and Fee on Other Direct Costs)		***$ 1,700.00***
TOTAL COSTS		**$277,719.00**

BUDGET JUSTIFICATION

Personnel:

Project Director/Senior Research Associate (.05 FTE). This person will supervise the project and mobilize corporate resources needed to fulfill contract requirements; prioritize resource allocations; and communicate with the CMS Project Officer as needed to monitor the progress and satisfaction of contract deliverables. This individual will oversee the budget, participate in focus group data collection and analysis, and review the final report.

Program Manager/ Sr. Research Associate (.3 FTE). This individual will oversee the implementation of the project and the timely, high-quality completion of all deliverables. The program manager/senior research associate will oversee the day-to-day operation of the project, supervise the research team, be responsible for the work plan, and the final report. This individual will develop a protocol for quality control for onsite data collection and will work closely with the research associate in obtaining institutional consent. This person will participate in onsite data collection; securing, managing, and analyzing the data; and writing up findings.

Research Associate (.3 FTE). The research associate will work closely with the senior researcher on all aspects of the project. This individual will have an integral role in onsite data collection and ensuring quality control of the data. The research associate will assist in analyzing data and conducting qualitative interviews with health care providers. The associate will assist with site visits and take the lead in obtaining institutional consent at the different sites.

Research Associate (.2 FTE). This individual will be part of the data collection team and will assist in obtaining institutional consent and data analysis.

Project Specialist II (.3 FTE). The project specialist will provide logistical support to the project and team, including assisting with travel, instrument preparation, incentives (including shipping to sites), IRBs, and data entry.

Other Direct Costs:

Staff travel.

Two staff will travel to each of the 12 sites for one 3-day visits. These visits will entail conducting the Medicare Beneficiary Interviews, Medicare Beneficiaries and Family Members Focus Groups, and Health Care Provider Interviews.

Transcriber (690 hours). A professional transcriber will provide written transcripts of the Medicare Beneficiaries and Family members Focus Groups and the Health Care Provider and Medicare Beneficiary Interviews. These transcripts will then be analyzed using a software program such as NVivo 9. Having an accurate transcript is critical to a good analysis of the qualitative data.

Print/copy/materials. These materials will be necessary to conduct the interviews that would not otherwise be electronically recorded.

Postage/overnight postage. Postage will be needed to receive all printed material as well as to send incentives to sites.

15. Changes to Burden

The number of participants in the study remains the same. Due to an error in data entry, the total burden of hours for working Medicare beneficiaries responding to the Medicare Beneficiary Survey was underreported. It was originally reported as 307 when it is actually 468. The focus group burden of hours across sites for working Medicare beneficiaries and family members was similarly underreported. It was reported as 180 hours when it is actually 225 hours. Because of these errors, there was an overall reported error in the annualized cost to the respondents. It was originally reported as $16,011.00. This error was amended to $19,541.00. This was a $3,530.00 increase in annualized cost to the respondents. In addition, due to reconfiguring costs of the project, the cost to the Federal Government decreased from $1,000,000 to $698,572. This was a $301,428 reduction in cost.

The project is no longer a two-phase study nor is it using a stratified randomized sample. Instead, it is a smaller, exploratory study that is using a convenience sample for beneficiaries and family members and a purposive sampling strategy for health care providers. The number of the participants in the study has been reduced from 3,418 to 360, lessening the total burden of hours on the participants from 2544 to 300 hours. Because it was no longer using a two phase design or on-site data collectors, the overall cost to the Federal government reduced from $698,572 to $383,670. This was a $314,902 reduction in cost.

The annualized cost across sites for working Medicare beneficiaries and family members participating in the focus groups was underreported for the case study. It was mistakenly reported as 23 hours when it is actually is 113 hours. This change alters the burden of cost for working Medicare beneficiaries and family members (n=75) to $3,955. Because the project has been further redesigned to exclude survey data collection, the actual burden of cost has only changed by $95 from $7,175 to $7,270. By eliminating the survey data collection and analysis from the study, the overall cost to the Federal government for the case study has been reduced from $383,670 to $277,719, a reduction of $105,951.

16. Publication/Tabulation Dates

The data are being collected for assessment purposes. We anticipate the data collection to occur from August 2012 to April 2013. The final report, incorporating all the analyses of these data, will be completed by the end of July 2013.

KAI is conducting this third-party study of Transportation Barriers to Utilization of Medicare Services by AI/AN Medicare Beneficiaries on behalf of CMS. After the products are delivered, CMS will determine whether the work warrants publication by CMS, as CMS is the sole publisher of the information it collects. Once the information is delivered, CMS will determine the format and means it will use to disseminate the information.

CMS will make the findings of this study available to interested parties. It will observe all protocols to protect the privacy of all the respondents that will have taken part in the different portions of the study (semi-structured interview and focus group). Several methods will be used to disseminate results to the communities that participated in the study. Results will be reported in the form of a user-friendly report, webinars, CMS Tribal Technical Advisory Group meetings, and if appropriate, conferences.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement identified in Item 19, “Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

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