

# **SUPPORTING STATEMENT**

## **Part A**

Medical Expenditure Panel Survey (MEPS) Household Component and the MEPS  
Medical Provider Component

**Version:** August 27<sup>th</sup>, 2012

Agency of Healthcare Research and Quality (AHRQ)

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## **A. Justification**

This request is for renewal of the OMB clearance for the data collections of the Household and Medical Provider Components of the Medical Expenditure Panel Survey (MEPS). The MEPS Household Component (MEPS-HC) and Medical Provider Component (MEPS-MPC) are two of three components of the MEPS.

- Household Component (MEPS-HC): A sample of households participating in the National Health Interview Survey (NHIS) in the prior calendar year are interviewed 5 times over a 2 and one half (2.5) year period. These 5 interviews yield two years of information on use of and expenditures for health care, sources of payment for that health care, insurance status, employment, health status and health care quality.
- Medical Provider Component (MEPS-MPC): The MEPS-MPC collects information from medical and financial records maintained by hospitals, physicians, pharmacies and home health agencies named as sources of care by household respondents.
- Insurance Component (MEPS-IC): The MEPS-IC collects information on establishment characteristics, insurance offerings and premiums from employers. The MEPS-IC is conducted by the Census Bureau for AHRQ and is cleared separately.

This request is for the MEPS-HC and MEPS-MPC only. The OMB Control Number for the MEPS-HC and MPC is 0935-0118, which was last approved by OMB on January 26<sup>th</sup>, 2010, and will expire on January 31<sup>st</sup>, 2013.

### ***1. Circumstances that make the collection of information necessary***

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see <http://www.ahrq.gov/hrqa99.pdf>), is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by:

1. collecting data on and producing measures of the quality, safety, effectiveness, and efficiency of American health care and health care systems; and
2. fostering the development of knowledge about improving health care, health care systems, and capacity; and
3. partnering with stakeholders to implement proven strategies for health care improvement.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2)

minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

Households selected for participation in the MEPS-HC are interviewed five times in person. These rounds of interviewing are spaced about 5 months apart. The interview will take place with a family respondent who will report for him/herself and for other family members.

The MEPS-HC has the following goal:

- To provide nationally representative estimates for the U.S. civilian noninstitutionalized population for:
  - health care use, expenditures, sources of payment
  - health insurance coverage

To achieve the goals of the MEPS-HC the following data collections are implemented:

1. **Household Component Core Instrument.** The core instrument collects data about persons in sample households. Topical areas asked in each round of interviewing include condition enumeration, health status, health care utilization including prescribed medicines, expense and payment, employment, and health insurance. Other topical areas that are asked only once a year include access to care, income, assets, satisfaction with health plans and providers, children's health, and adult preventive care. While many of the questions are asked about the entire reporting unit (RU), which is typically a family, only one person normally provides this information. See Attachment 1 for a brief description of the 42 sections included in the core instrument, including detailed descriptions of all changes since the last OMB approved instrument. All 42 sections of the current core instrument are available on the AHRQ website at [http://meps.ahrq.gov/mepsweb/survey\\_comp/survey\\_questionnaires.jsp](http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp). See Attachments 2 to 20 for all of the core instrument respondent materials.
2. **Adult Self Administered Questionnaire.** A brief self-administered questionnaire (SAQ) will be used to collect self-reported (rather than through household proxy) information on health status, health opinions and satisfaction with health care for adults 18 and older (see Attachment 21). The

satisfaction with health care items are a subset of items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The health status items are from the Short Form 12 Version 2 (SF-12 version 2), which has been widely used as a measure of self-reported health status in the United States, the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ-2). Changes to the Adult SAQ are being implemented with this clearance; see Attachment 1 for a description of these changes.

3. **Diabetes Care SAQ.** A brief self administered paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during round 3 and 5) to persons identified as having diabetes. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or insulin. This questionnaire is unchanged from the previous OMB clearance. See Attachments 22 and 23.
4. **Authorization forms for the MEPS-MPC Provider and Pharmacy Survey.** As in previous panels of the MEPS, we will ask respondents for authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies. See Attachment 24 for the pharmacy authorization form and Attachment 25 for the provider authorization form.
5. **MEPS Validation Interview.** Each interviewer is required to have at least 15 percent of his/her caseload validated to insure that CAPI questionnaire content was asked appropriately and procedures followed, for example the use of show cards. Validation flags are set programmatically for cases pre-selected by data processing staff before each round of interviewing. Home office and field management may also request that other cases be validated throughout the field period. When an interviewer fails a validation all their work is subject to 100 percent validation. Additionally, any case completed in less than 30 minutes is validated. A validation abstract form containing selected data collected in the CAPI interview is generated and used by the validator to guide the validation interview. See Attachment 26 for the validation interview questionnaire.

The MEPS-MPC will contact medical providers (hospitals, physicians, home health agencies and institutions) identified by household respondents in the MEPS-HC as sources of medical care for the time period covered by the interview, and all pharmacies providing prescription drugs to household members during the covered time period. The MEPS-MPC is not designed to yield national estimates as a stand-alone survey. The sample is designed to target the types of individuals and providers for whom household reported expenditure data was expected to be insufficient. For example, households with one or more Medicaid enrollees are targeted for inclusion in the MEPS-MPC because this group is expected to have limited information about payments for their medical care. No changes to the MEPS-MPC are being implemented in this renewal request.

The MEPS-MPC collects event level data about medical care received by sampled persons during the relevant time period. The data collected from medical providers include:

- Dates on which medical encounters during the reference period occurred
- Data on the medical content of each encounter, including ICD-9 and CPT-4 codes
- Data on the charges associated with each encounter, the sources paying for the medical care—including the patient/family, public sources, and private insurance, and amounts paid by each source

Data collected from pharmacies include:

- Date of prescription fill
- National drug code (NDC) or Prescription name, strength and form
- Quantity
- Payments, by source

The MEPS-MPC has the following goal:

- To serve as an imputation source for and to supplement/replace household reported expenditure and source of payment information. This data will supplement, replace and verify information provided by household respondents about the charges, payments, and sources of payment associated with specific health care encounters.

To achieve the goal of the MEPS-MPC the following data collections are implemented:

1. **MPC Contact Guide/Screening Call.** An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS-MPC, the appropriate MEPS-MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of the seven provider types in the MEPS-MPC, except for the two home care provider types which use the same screening form; see Attachments 29, 35, 37, 41, 47 and 49.
2. **Home Care Provider Questionnaire for Health Care Providers.** This questionnaire is used to collect data from home health care agencies which provide medical care services to household respondents. Information collected includes type of personnel providing care, hours or visits provided per month, and the charges and payments for services received. See Attachment 27 for the questionnaire and Attachments 29 to 31 for the associated respondent materials.
3. **Home Care Provider Questionnaire for Non-Health Care Providers.** This questionnaire is used to collect information about services provided in the home by non-health care workers to household respondents because of a medical condition; for example, cleaning or yard work, transportation, shopping, or child care. See Attachment 28 for the questionnaire and Attachments 29 to 31 for the associated respondent materials.
4. **Medical Event Questionnaire for Office-Based Providers.** This questionnaire is for office-based physicians, including doctors of medicine (MDs) and osteopathy (DOs), as well as providers practicing under the direction or supervision of an MD or DO (e.g., physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff model HMOs

are included. See Attachment 32 for the questionnaire and Attachments 33 to 35 for the associated respondent materials.

5. **Medical Event Questionnaire for Separately Billing Doctors.** This questionnaire collects information from physicians identified by hospitals (during the Hospital Event data collection) as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital. See Attachment 36 for the questionnaire and Attachments 37 to 39 for the associated respondent materials.
6. **Hospital Event Questionnaire.** This questionnaire is used to collect information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the hospital itself; the doctors that do bill separately from the hospital will be contacted as part of the Medical Event Questionnaire for Separately Billing Doctors. HMOs are included in this provider type. See Attachment 40 for the questionnaire and Attachments 41 to 45 for the associated respondent materials.
7. **Institutions Event Questionnaire.** This questionnaire is used to collect information about institution events, including nursing homes, rehabilitation facilities and skilled nursing facilities. Institution data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay. In many cases, the institution administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the institution itself. See Attachment 46 for the questionnaire and Attachments 47 and 42 to 45 for the associated respondent materials (Attachments 42 to 45 from the hospital materials are also used for the institutions).
8. **Pharmacy Data Collection Questionnaire.** This questionnaire requests the national drug code (NDC) and when that is not available the prescription name, date prescription was filled, payments by source, prescription strength and form (when the NDC is not available), quantity, and person for whom the prescription was filled. When the NDC is available, we do not ask for prescription name, strength or form because that information is embedded in the NDC; this reduces burden on the respondent. Most pharmacies have the requested information available in electronic format and respond by providing a computer generated printout of the patient's prescription information. If the computerized form is unavailable, the pharmacy can report their data to a telephone interviewer. Pharmacies are also able to provide a CD-ROM with the requested information if that is preferred. HMOs are included in this provider type. See Attachment 48 for the questionnaire and Attachments 49 to 51 for the associated respondent materials.

Dentists, optometrists, psychologists, podiatrists, chiropractors, and others not providing care under the supervision of a MD or DO are considered out of scope for the MEPS-MPC.

This study is being conducted by AHRQ through its contractors, Westat and RTI International, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the

delivery of such care, including activities with respect to the cost and use of health care services and with respect to health statistics and surveys. 42 U.S.C. 299a(a)(3) and (8); 42 U.S.C. 299b-2.

## **2. Purpose and Use of Information**

The MEPS is a multi-purpose survey. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, consumer assessment of health care, health insurance coverage, demographic characteristics, employment and access to health care indicators. Estimates can be provided for individuals, families and population subgroups of interest. Data obtained in this study are used to provide, among others, the following national estimates:

- annual estimates of health care use and expenditures for persons and families
- annual estimates of sources of payment for health care utilizations, including public programs such as Medicare and Medicaid, private insurance, and out of pocket payments
- annual estimates of health care use, expenditures and sources of payment of persons and families by type of utilization including inpatient stay, ambulatory care, home health, dental care and prescribed medications
- the number and characteristics of the population eligible for public programs including the use of services and expenditures of the population(s) eligible for benefits under Medicare and Medicaid
- the number, characteristics, and use of services and expenditures of persons and families with various forms of insurance
- annual estimates of consumer satisfaction with health care, and indicators of health care quality for key conditions
- annual estimates to track disparities in health care use and access

In addition to national estimates, data collected in this ongoing longitudinal study are used to study the determinants of the use of services and expenditures, and changes in the access to and the provision of health care in relation to:

- socio-economic and demographic factors such as employment or income
- the health status and satisfaction with health care of individuals and families
- the health needs and circumstances of specific subpopulation groups such as the elderly and children

To meet the need for national data on healthcare use, access, cost and quality, MEPS-HC collects information on:

- access to care and barriers to receiving needed care
- satisfaction with usual providers
- health status and limitations in activities
- medical conditions for which health care was used
- use, expense and payment (as well as insurance status of person receiving care) for health services

Given the twin problems of nonresponse and response error of some household reported data, information is collected directly from medical providers in the MEPS-MPC to improve the accuracy of expenditure estimates derived from the MEPS-HC. Because of their greater level of precision and



detail, we also use MEPS-MPC data as the main source of imputations of missing expenditure data. Thus, the MEPS-MPC is designed to satisfy the following analytical objectives:

- Serve as source data for household reported events with missing expenditure information
- Serve as an imputation source to reduce the level of bias in survey estimates of medical expenditures due to item nonresponse and less complete and less accurate household data
- Serve as the primary data source for expenditure estimates of medical care provided by separately billing doctors in hospitals, emergency rooms, and outpatient departments, Medicaid recipients and expenditure estimates for pharmacies
- Allow for an examination of the level of agreement in reported expenditures from household respondents and medical providers

Data from the MEPS, both the HC and MPC components, are intended for a number of annual reports required to be produced by AHRQ, including the National Health Care Quality Report and the National Health Care Disparities Report.

### ***3. Use of Improved Information Technology***

As in previous panels of the MEPS-HC, a CAPI instrument will be used (except the SAQs). The mode of administration for the MEPS-MPC (including the pharmacy component) varies based on the preferences of the provider and includes phone interviews, mail and electronic submission of information. Starting with the 2009 MEPS-MPC data collection, a computer-assisted system was developed for both interviewing and record abstraction. This Integrated Data Collection System (IDCS) supported the effort to recruit providers by telephone and to interview medical records and billing staffs of medical facilities. For providers that prefer to send hard copy records, the IDCS is used to abstract information from medical records and patient accounts. The IDCS consists of two main systems: 1) a Web component in ASP.Net in which the MEPS-MPC forms (Contact Guides and Event Forms) are programmed for either data entry either during telephone calls or record abstraction and 2) a Case Management System (CMS) that manages the medical providers and associated forms for call scheduling, contact information, appointment times, and event/status information.

### ***4. Efforts to Identify Duplication***

There is no other survey that is now or has been recently conducted that will meet all of the objectives of the MEPS. Some federal surveys do collect health insurance information from households (SIPP, NHIS); however these surveys do not collect the depth of information on health care use and expenses available in the MEPS. Moreover, MEPS is the only survey which links information collected from households with information collected from medical providers to inform the estimation of expenditures.

### ***5. Involvement of Small Entities***

The MEPS-HC collects information only from households. The MEPS-MPC will survey medical facilities, physicians, and pharmacies. Some of the MPC respondents may be small businesses. The MEPS-MPC instrument and procedures used to collect data are designed to minimize the burden on all respondents.

## **6. Consequences if Information Collected Less Frequently**

The design of the MEPS-HC in which households are contacted 5 times over the course of 2 years enables the gathering of medical use data at the event level and permits the estimation of expenditures and payments for persons by event type. Reducing the number of rounds in which the data are collected would hamper the availability and quality of information due to long recall periods.

MEPS-MPC respondents are contacted at least once during the calendar year for the preceding data collection year. Sometimes a follow up contact is necessary to clarify ambiguous or collect missing information. Contacts on a less frequent basis than the envisioned timetable jeopardizes the access of the study to information from records that could otherwise be destroyed or archived.

## **7. Special Circumstances**

Aside from offering compensation to respondents, the MEPS-HC and MPC will fully comply with 5 CFR 1320.6.

## **8. Federal Register Notice and Outside Consultations**

### **8.a. Federal Register Notice**

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on June 13<sup>th</sup>, 2012, for 60 days and again on September 20<sup>th</sup>, 2012 for 30 days (see Attachment 52). No substantive comments were received.

### **8.b. Outside Consultations**

Individuals or groups outside the Agency consulted about the MEPS project over the last several years are listed below:

Table 1. MEPS Consultants

<b>Name</b>	<b>Affiliation</b>
Jill Jacobsen Ashman, Ph.D.	Centers for Disease Control and Prevention National Center for Health Statistics
Brenda G. Cox, Ph.D.	Independent Consultant
Judith H. Mopsik, M.H.S.	Vice President for Business Development, Abt Associates Inc.
Constance F. Citro, Ph.D.	Committee on National Statistics Division of Behavioral and Social Sciences and Education
Sarah Q. Duffy, Ph.D.	National Institute on Drug Abuse, National Institutes of Health
Llewellyn Cornelius, Ph.D.	University of Maryland
Michael L. Cohen, Ph.D.	Committee on National Statistics
Joan S Cwi, Ph.D.	Independent Consultant

## **9. Gifts/Payments to Respondents**

As in previous years, MEPS-HC respondents will be offered a monetary gift as a token of appreciation for their participation in the MEPS. For household respondents, participation includes not only time being interviewed, but also keeping track of their medical events and expenditures between interviews.

Each household respondent will be provided a gift of \$50 for the effort they put forth in being interviewed and maintaining records for the survey at the end of each round. Household respondents will also be given a gift of \$5 for completing the Adult SAQ. Household respondents will be informed of the gift at the first in-person contact and all eligible respondents will be given the same amount. No gift will be offered to respondents of the Diabetes Care SAQ.

The MEPS-MPC interviewer will be authorized to offer remuneration to providers who present cost as a salient objection to responding or if a flat fee is applied to any request for medical or billing records. Based on the past two cycles of data collection fewer than 16 percent of providers will request remuneration. Table 2 shows the total and average per record remuneration by provider type, based on the 2010 data collection, the most recent year for which data is available. For those providers that required remuneration the average payment per medical record was \$32.98.

**Table 2. Total and Average Remuneration by Provider Type for the MEPS-MPC**

Provider Type	Number of Records with Payment	Average Payment	Total Remuneration
Hospital	1,240	\$27.85	\$34,534
Office Based Providers	422	\$25.28	\$10,668
Institutions	0	0	0
Home Care Provider (Health Care Providers)	0	0	0
Home Care Provider (Non-Health Care Providers)	0	0	0
Pharmacy	6,050	\$35.70	\$215,985
Separately Billing Doctors	502	\$19.42	\$9,749
Total	8,214	\$32.98	\$270,936

### **10. Assurance of Confidentiality**

Confidentiality is protected by Sections 944(c) and 308(d) of the Public Health Service Act (42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)). This research project will be carried out in compliance with these confidentiality statutes. Respondents will be told the purposes for which the information is being collected, that the confidentiality of their responses will be maintained, and that no information that could identify an individual or establishment will be disclosed unless that individual or establishment has consented to such disclosure.

### **11. Questions of a Sensitive Nature**

The MEPS questionnaires for the Household Component include questions on income and medical conditions that some respondents may perceive as sensitive.

### **12. Estimates of Annualized Burden Hours and Costs**

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS-HC and the MEPS-MPC. The MEPS-HC Core Interview will be completed by 15,093\* (see note below Exhibit 1) "family level" respondents, also referred to as RU respondents. Since the MEPS-HC consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS-HC core requires an average response

time of 86 minutes to administer. The Adult SAQ will be completed once a year by each person in the RU that is 18 years old and older, an estimated 28,254 persons. The Adult SAQ requires an average of 7 minutes to complete. The Diabetes care SAQ will be completed once a year by each person in the RU identified as having diabetes, an estimated 2,345 persons, and takes about 3 minutes to complete. The authorization form for the MEPS-MPC Provider Survey will be completed once for each medical provider seen by any RU member. The 14,489\* RUs in the MEPS-HC will complete an average of 5.2 forms, which require about 3 minutes each to complete. The authorization form for the MEPS-MPC Pharmacy Survey will be completed once for each pharmacy for any RU member who has obtained a prescription medication. RUs will complete an average of 3.1 forms, which take about 3 minutes to complete. About one third of all interviewed RUs will complete a validation interview as part of the MEPS-HC quality control, which takes an average of 5 minutes to complete. The total annual burden hours for the MEPS-HC are estimated to be 63,907 hours.

All 34,000 medical providers and pharmacies included in the MEPS-MPC will receive a screening call which will take 3 minutes on average. The MEPS-MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 3 to 5 minutes to complete. The total annual burden hours for the MEPS-MPC are estimated to be 18,914 hours. The total annual burden for the MEPS-HC and MPC is estimated to be 82,821 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS-HC is estimated to be \$1,389,339; the annual cost burden for the MEPS-MPC is estimated to be \$285,680. The total annual cost burden for the MEPS-HC and MPC is estimated to be \$1,675,019.

**Exhibit 1. Estimated annualized burden hours**

Form Name	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
<b>MEPS-HC</b>				
MEPS-HC Core Interview	15,093*	2.5	86/60	54,083
Adult SAQ	28,254	1	7/60	3,296
Diabetes care SAQ	2,345	1	3/60	117
Authorization form for the MEPS-MPC Provider Survey	14,489	5.2	3/60	3,767
Authorization form for the MEPS-MPC Pharmacy Survey	14,489	3.1	3/60	2,246
MEPS-HC Validation Interview	4,781	1	5/60	398
Subtotal for the MEPS-HC	79,451	na	na	63,907
<b>MEPS-MPC</b>				
MPC Contact Guide/Screening Call**	34,000	1	3/60	1,700
Home care for health care providers questionnaire	465	6.5	5/60	252
Home care for non-health care providers questionnaire	35	6.6	5/60	19
Office-based providers questionnaire	10,800	5.8	5/60	5,220
Separately billing doctors questionnaire	10,800	2	3/60	1,080

Hospitals questionnaire	5,000	6.5	5/60	2,708
Institutions (non-hospital) questionnaire	100	1.5	5/60	13
Pharmacies questionnaire	6,800	23.3	3/60	7,922
Subtotal for the MEPS-MPC	68,000	na	na	18,914
<b>Grand Total</b>	147,451	na	na	82,821

\* While the expected number of responding units for the annual estimates is 14,489, it is necessary to adjust for survey attrition of initial respondents by a factor of 0.96 (15,093=14,489/0.96).

\*\* There are 6 different contact guides; one for each provider type, except for the two home care provider types which use the same contact guide.

### Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate	Total Cost Burden
<b>MEPS-HC</b>				
MEPS-HC Core Interview	15,093	54,083	\$21.74*	\$1,175,764
Adult SAQ	28,254	3,296	\$21.74	\$71,655
Diabetes care SAQ	2,345	117	\$21.74	\$2,544
Authorization forms for the MEPS-MPC Provider Survey	14,489	3,767	\$21.74	\$81,895
Authorization form for the MEPS-MPC Pharmacy Survey	14,489	2,246	\$21.74	\$48,828
MEPS-HC Validation Interview	4,781	398	\$21.74	\$8,653
Subtotal for the MEPS-HC	79,451	63,907	na	\$1,389,339
<b>MEPS-MPC</b>				
MPC Contact Guide/Screening Call	34,000	1,700	\$15.59**	\$26,503
Home care for health care providers questionnaire	465	252	\$15.59	\$3,929
Home care for non-health care providers questionnaire	35	19	\$15.59	\$296
Office-based providers questionnaire	10,800	5,220	\$15.59	\$81,380
Separately billing doctors questionnaire	10,800	1,080	\$15.59	\$16,837
Hospitals questionnaire	5,000	2,708	\$15.59	\$42,218
Institutions (non-hospital) questionnaire	100	13	\$15.59	\$203
Pharmacies questionnaire	6,800	7,922	\$14.43***	\$114,314
Subtotal for the MEPS-MPC	68,000	18,347	na	\$285,680
<b>Grand Total</b>	147,451	82,254	na	\$1,675,019

\* Mean hourly wage for All Occupations (00-0000)

\*\* Mean hourly wage for Medical Secretaries (43-6013)

\*\*\* Mean hourly wage for Pharmacy Technicians (29-2052)

Occupational Employment Statistics, May 2011 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics. [http://www.bls.gov/oes/current/oes\\_nat.htm#b29-0000](http://www.bls.gov/oes/current/oes_nat.htm#b29-0000)

### **13. Estimates of Annualized Respondent Capital and Maintenance Costs**

Capital and maintenance costs include the purchase of equipment, computers or computer software or services, or storage facilities for records, as a result of complying with this data collection. There are no direct costs to respondents other than their time to participate in the study.

### **14. Estimates of Annualized Cost to the Government**

Exhibit 3 shows the total and annualized cost of this information collection. The cost associated with the design and data collection of the MEPS-HC and MEPS-MPC is estimated to be \$51,401,596 in each of the three years covered by this information collection request.

#### **Exhibit 3. Estimated Total and Annualized Cost**

<b>Cost Component</b>	<b>Total Cost</b>	<b>Annualized Cost</b>
Sampling Activities	\$3,002,731	\$1,000,910
Interviewer Recruitment and Training	\$9,190,168	\$3,063,389
Data Collection Activities	\$93,611,428	\$31,203,809
Data Processing	\$23,087,605	\$7,695,868
Production of Public Use Data Files	\$21,079,118	\$7,026,373
Project Management	\$4,233,739	\$1,411,246
<b>Total</b>	<b>\$154,204,789</b>	<b>\$51,401,596</b>

### **15. Changes in Hour Burden**

The total estimated annual burden hours for the MEPS have been increased from 82,767 hours in the previous clearance to 82,821 hours in this clearance request, an increase of 54 hours.

#### **16a. Time Schedule, Publication and Analysis Plans**

Data collected from the MEPS will be used in a variety of descriptive analysis. Our website [www.meps.ahrq.gov](http://www.meps.ahrq.gov) contains examples of publications. Those publications include statistical briefs, research findings, chartbooks, and journal articles. In addition, tabular data is presented on the website as static tables, as interactive tables, and through an interactive tool – MEPSnet. Special analytic reports will be issued on an ad-hoc basis, and other analyses will be presented at annual meetings of professional associations and in professional journals.

To the extent possible, given our commitment to respondent confidentiality, we have endeavored to release public use files from this project as soon as possible.

#### **16b. Schedule for Data Collection**

Data collection for the MEPS under this request begins in late January 2013. Rounds 1, 3, and 5 of the MEPS-HC start in January and continue through mid July. Rounds 2 and 4 begin in July of each year and continue through early December. The dates for each round of data collection are included in the response rate tables in The Supporting Statement Part B. Data collection for the MEPS-MPC will begin in February 2013.

### **17. Exemption for Display of Expiration Date**

AHRQ does not seek this exemption.

## List of Attachments:

- Attachment 1 -- MEPS-HC Section Summary and Changes
- Attachment 2 -- HC About MEPS Booklet
- Attachment 3 -- HC Why is Participation in MEPS so Important?
- Attachment 4 -- HC Policy Impact Award
- Attachment 5 -- HC MEPS: A Survey of Health Care Use and Spending
- Attachment 6 -- HC MEPS Statistical Brief Abstracts
- Attachment 7 -- HC About the MEPS-MPC Authorization Form
- Attachment 8 -- HC Data protection is word ONE with MEPS
- Attachment 9 -- HC DVD Companion Booklet
- Attachment 10 -- HC Respondent Recruitment DVD
- Attachment 11 -- HC Important Information About Your Participation in MEPS
- Attachment 12 -- HC MEPS Data Example & FAQs
- Attachment 13 -- HC Respondent Letters, Postcards and Notes
- Attachment 14 -- HC MEPS FAQs Brochure
- Attachment 15 -- HC MEPS Monthly Planner
- Attachment 16 -- HC MEPS Record Keeper
- Attachment 17 -- HC Showcards
- Attachment 18 -- HC Validation Letter
- Attachment 19 -- HC Certificate of Appreciation
- Attachment 20 -- HC Who Uses MEPS Data
- Attachment 21 -- HC Adult SAQ
- Attachment 22 -- HC Diabetes SAQ – Proxy
- Attachment 23 -- HC Diabetes SAQ – Self
- Attachment 24 -- HC Authorization Form for the MEPS-MPC – Pharmacy
- Attachment 25 -- HC Authorization Form for the MEPS-MPC – Provider
- Attachment 26 -- MEPS-HC Validation Interview Form
- Attachment 27 -- MPC Home Care for Health Care Providers Questionnaire
- Attachment 28 -- MPC Home Care for Non-health Care Providers Questionnaire
- Attachment 29 -- MPC Home Health Contact Guide for Organizations
- Attachment 30 -- MPC Home Health Respondent Materials - FAX Version
- Attachment 31 -- MPC Home Health Respondent Materials - Phone Version
- Attachment 32 -- MPC Office Based Providers Questionnaire
- Attachment 33 -- MPC Office Based Respondent Materials - FAX Version
- Attachment 34 -- MPC Office Based Respondent Materials - Phone Version
- Attachment 35 -- MPC Office Based Contact Guide
- Attachment 36 -- MPC SBD Questionnaire
- Attachment 37 -- MPC SBD Contact Guide
- Attachment 38 -- MPC SBD Respondent Materials - Fax Version
- Attachment 39 -- MPC SBD Respondent Materials - Phone Version
- Attachment 40 -- MPC Hospital Questionnaire
- Attachment 41 -- MPC Hospital Contact Guide
- Attachment 42 -- MPC Hospital Respondent Materials - Patient Accounts - FAX Version
- Attachment 43 -- MPC Hospital Respondent Materials - Patient Accounts - Phone Version
- Attachment 44 -- MPC Hospital Respondent Materials - Patient Records - Fax Version
- Attachment 45 -- MPC Hospital Respondent Materials - Patient Records - Phone Version

Attachment 46 -- MPC Institutions (non-hospital) Questionnaire  
Attachment 47 -- MPC Institution Contact Guide  
Attachment 48 -- MPC Pharmacies Questionnaire  
Attachment 49 -- MPC Pharmacy Contact Guide  
Attachment 50 -- MPC Pharmacy Respondent Materials - FAX Version  
Attachment 51 -- MPC Pharmacy Respondent Materials - Phone Version  
Attachment 52 -- Federal Register Notice