SUPPORTING STATEMENT

Part A

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

Version: 2015

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. In 2016, we are collecting some information on characteristics of medical organizations to MPC office based providers.

- 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 December 20th, 2012, and will expire on December 31st, 2015.

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 all sections included in the core instrument, including detailed descriptions of all changes since the last OMB approved instrument. All sections of the current core instrument are available on the AHRQ website at http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp (see also Attachments 26 to 67). See Attachments 2 to 17 and Attachments 24 and 25 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 18). 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). This questionnaire is unchanged from the previous OMB clearance.

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 19 and 20.

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 21 for the pharmacy authorization form and Attachment 22 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 23 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, 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.

There is one addition to the MEPS-MPC being implemented in this renewal request, the MEPS MPC Medical Organizations Survey (MOS). The MEPS MOS will expand current MPC data collection activities to include information on the organization of the practices of office based care providers

identified as a usual source of care in the MEPS MPC. This additional data collection will be for a subset of office based care providers already included in the MEPS MPC sample. In the MEPS MPC sample, for a nationally representative sample of adults, primary location for individuals office based usual sources of care will be identified. The MEPS MPC will contact these places where medical care is provided, determine the appropriate respondent and administer a MEPS Medical Organization Survey (MOS). The design of the survey will be multi-modal including some telephone contact. Additional data collection methods may include phone, fax, mail, self-administration, electronic transmission, and the Web. The data collection method chosen for a provider shall be the method that results in the most complete and accurate data with least burden to the provider.

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 (or ICD-10) 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 these seven provider types in the MEPS-MPC, except for the two home care provider types which use the same screening form; see Attachments 68 through 73.

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 74 for the questionnaire and Attachments 75 to 77 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 78 for the questionnaire and Attachments 75 to 77 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 79 for the questionnaire and Attachments 80 to 82 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 83 for the questionnaire and Attachments 84 to 86 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 87 for the questionnaire and Attachments 88 to 91 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 92 for the questionnaire. Attachments 88 to 91 from the Hospital materials are also used for Institutions.

   Attachment 93 contains letters, email templates, and other documents used to contact potential points of contacts, across provider types.

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 94 for the questionnaire and Attachments to 95 for 99 the associated respondent materials.

9. **Medical Organizations Survey Questionnaire.** This questionnaire will collect essential information on important features of the staffing, organization, policies, and financing for identified usual source of office based care providers. This additional data collection will be a subset of office based care providers already included in the MEPS MPC sample and will be a nationally representative sample of adults primary location for individuals office based usual sources of care. See Attachment 100 for the draft version of this questionnaire.

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 produced by AHRQ, including the National Health Care Quality Report and the National Health Care Disparities Report.

The MEPS MPC MOS data will be used to create a database that will be unique in providing an internally consistent source of information both on individuals' characteristics and health care utilization and expenditures, and on the characteristics of the providers they use. The following areas will be addressed in the MOS as they potentially affect individuals' access to, use of and affordability of health care services:

- Organizational characteristics, e.g., size, specialties covered, practice rules and procedures, patient mix and scope of care provided, membership in an ACO, certification as a primary care medical home
- Use of health information technology

- Policies and practices related to the ACA
- Financial arrangements, e.g., reimbursement methods, number and types of insurance contracts, compensation arrangements within the practice

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. More recently, to reduce burden for providers the MPC has begun offering data transfer options such as downloading records files through secure File Transfer Protocol (FTP), and is currently completing a pilot of a secure email process for encrypted records files. The MOS will offer web based survey administration as well as mail, phone and fax options to limit respondent burden.

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), notices were published in the Federal Register on May 20th 2015, for 60 days and again on for 30 days (see Attachment 101). 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

Name	**Affiliation**
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

MEPS-HC respondents will be offered a monetary gift as a token of appreciation for their participation in the MEPS. A gift has been offered to respondents at the end of each round since the inception of MEPS in 1996; the current amount of $50 per round has been in place since 2011 (OMB approval obtained January 26, 2010 version 1). For household respondents, participation includes not only time being interviewed, but also keeping track of their medical events and expenditures between interviews. 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 to the Adult SAQ or 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 one third of providers will request remuneration. Table 2 shows the total and average per record remuneration by provider type, based on the 2013 data collection, the most recent year for which data is available. For those providers that required remuneration the average payment per medical record was $43.15.

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	2,725	$35.30	$96,193
Office Based Providers	1,084	$16.46	$17,843
Institutions	6	$112.02	$672
Home Care Provider (Health Care Providers)	28	$33.52	$939
Home Care Provider (Non-Health Care Providers)	0	$0	$0
Pharmacy	6,099	$50.39	$307,329
Separately Billing Doctors	420	$57.47	$24,137
Total MPC	10,362		$447,112

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 92 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 5.4 forms, which require about 3minutes 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 67,826 hours.

All medical providers and pharmacies included in the MEPS-MPC will receive a screening call and the MEPS-MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 2 to 19 minutes to complete. The total annual burden hours for the MEPS-MPC are estimated to be 18,876 hours. The total annual burden for the MEPS-HC and MPC is estimated to be 86,702 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 $1,540,328; the annual cost burden for the MEPS-MPC is estimated to be $302,985. The total annual cost burden for the MEPS-HC and MPC is estimated to be $1,843,313.

Exhibit 1. Estimated annualized burden hours

Form Name	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
MEPS-HC				
MEPS-HC Core Interview	15,093*	2.5	92/60	57,857
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	5.4	3/60	3,912
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	67,826
MEPS-MPC/MOS				
MPC Contact Guide/Screening Call**	35,222	1	2/60	1,174
Home care for health care providers questionnaire	532	1.49	9/60	119
Home care for non-health care providers questionnaire	25	1	11/60	5
Office-based providers questionnaire	11,785	1.44	10/60	2,828
Separately billing doctors questionnaire	12,693	3.43	13/60	9,433
Hospitals questionnaire	5,077	3.51	9/60	2,673
Institutions (non-hospital) questionnaire	117	2.03	9/60	36
Pharmacies questionnaire	4,993	4.44	3/60	1,108
Medical Organizations Survey questionnaire	6,000	1	15/60	1,500
Subtotal for the MEPS-MPC	76,444	na	na	18,876
Grand Total	155,895	na	na	86,702

* 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 office based, separately billing doctor, hospital, institution, and pharmacy provider types, and the two home care provider types 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
MEPS-HC				
MEPS-HC Core Interview	15,093	57,857	$22.71*	$1,313,932
Adult SAQ	28,254	3,296	$22.71*	$74,852
Diabetes care SAQ	2,345	117	$22.71*	$2,657
Authorization forms for the MEPS-MPC Provider Survey	14,489	3,912	$22.71*	$88,842
Authorization form for the MEPS-MPC Pharmacy Survey	14,489	2,246	$22.71*	$51,007
MEPS-HC Validation Interview	4,781	398	$22.71*	$9,039
Subtotal for the MEPS-HC	79,451	67,826	Na	$1,540,328
MEPS-MPC/MOS				
MPC Contact Guide/Screening Call	35,222	1,174	$16.12**	$18,925
Home care for health care providers questionnaire	532	119	$16.12**	$1,918
Home care for non-health care providers questionnaire	25	5	$16.12**	$81
Office-based providers questionnaire	11,785	2,828	$16.12**	$45,587
Separately billing doctors questionnaire	12,693	9,433	$16.12**	$152,060
Hospitals questionnaire	5,077	2,673	$16.12**	$43,089
Institutions (non-hospital) questionnaire	117	36	$16.12**	$580
Pharmacies questionnaire	4,993	1,108	$14.95***	$16,565
Medical Organizations Survey questionnaire	6,000	1,500	$16.12**	$24,180
Subtotal for the MEPS-MPC	76,444	18,876	na	$302,985
Grand Total	155,895	86,073	na	$1,843,313

* 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 2014 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***

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 $58,160,850 in each of the three years covered by this information collection request. Exhibits 4 and 5 show the total and annualized cost of MEPS-HC and MEPS-MPC oversight, respectively.

Exhibit 3. Estimated Total and Annualized Cost

Cost Component	Total Cost	Annualized Cost
Sampling Activities	$3,397,587	$1,132,529
Interviewer Recruitment and Training	$10,398,665	$3,466,222
Data Collection Activities	$105,921,228	$35,307,076
Data Processing	$26,123,600	$8,707,867
Production of Public Use Data Files	$23,850,999	$7,950,333
Project Management	$4,790,471	$1,596,824
Total	$174,482,550	$58,160,850

Exhibit 4: Annual Cost to AHRQ for MEPS-HC Oversight

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management Support: GS-15, Step 5 average	2	$143,079	50.0%	$143,079
Survey/Statistical Support: GS-14, Step 5 average	3	$121,635	33.3%	$121,635
Research Support: GS-13, Step 5 average	4	$102,932	50.0%	$205,864
Research Support: GS-12, Step 5 average	2	$86,564	75.0%	$129,846
Total				$600,424

Exhibit 5: Annual Cost to AHRQ for MEPS-MPC Oversight

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost

Management Support: GS-15, Step 5 average	2	$143,079	33.3%	$95,386
Survey/Statistical Support: GS-14, Step 5 average	2	$121,635	50.0%	$121,635
Research Support: GS-13, Step 5 average	1	$102,932	50.0%	$51,466
Research Support: GS-12, Step 5 average	1	$86,564	33.0%	$28,855
Total				$297,342

Annual salaries based on 2015 OPM Pay Schedule for Washington/DC area:
http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/DCB.pdf

Note that these oversight costs are included in "Overhead" in Exhibit 3.

15. Changes in Hour Burden

The total estimated annual burden hours for the MEPS have been increased from 82,821 hours in the previous clearance to 86,702 hours in this clearance request, an increase of 3,881 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 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 early January 2016. 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 2016.

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 Why is Participation in MEPS so Important?
Attachment 3 – HC MEPS: A Survey of Health Care Use and Spending
Attachment 4 – HC What MEPS tells us about…Charts
Attachment 5 – HC About the MEPS-MPC Authorization Form
Attachment 6 – HC Data protection is word ONE with MEPS
Attachment 7 – HC Respondent Recruitment Video
Attachment 8 – HC Important Information About Your Participation in MEPS
Attachment 9 – HC MEPS Data Example & FAQs
Attachment 10 – HC Respondent Letters, Postcards and Notes
Attachment 11 – HC MEPS FAQs Brochure
Attachment 12 – HC MEPS Monthly Planner
Attachment 13 – HC MEPS Record Keeper
Attachment 14 – HC Showcards
Attachment 15 – HC Validation Letter
Attachment 16 – HC Certificate of Appreciation
Attachment 17 – HC Who Uses MEPS Data
Attachment 18 – HC Adult SAQ
Attachment 19 – HC Diabetes SAQ – Proxy
Attachment 20 – HC Diabetes SAQ – Self
Attachment 21 – HC Authorization Form for the MEPS-MPC – Pharmacy
Attachment 22 – HC Authorization Form for the MEPS-MPC – Provider
Attachment 23 – HC MEPS Validation Interview Form
Attachment 24 – HC MEPS Tip Sheet
Attachment 25 – HC Tips for Making Your MEPS Interview Easier
Attachment 26 – HC Access to Care Section
Attachment 27 – HC Preventive Care Section
Attachment 28 – HC Assets Section
Attachment 29 – HC Calendar Section
Attachment 30 – HC Condition Enumeration Section
Attachment 31 – HC Closing Section
Attachment 32 – HC Accident Injury and Conditions Section
Attachment 33 – HC Charge Payment Section
Attachment 34 – HC Flat Fee Section
Attachment 35 – HC Child Preventive Health Supplement Section
Attachment 36 – HC Disability Days Section
Attachment 37 – HC Dental Care Section
Attachment 38 – HC Event Driver Section
Attachment 39 – HC Employment (EM) Section
Attachment 40 – HC Review of Employment Information (RJ) Section
Attachment 41 – HC Employment Driver (OE) Section
Attachment 42 – HC Employment Wage (EW) Section
Attachment 43 – HC Emergency Room Section
Attachment 44 – HC Event Roster Section

Attachment 45 – HC Health Status Section
Attachment 46 – HC Help Text
Attachment 47 – HC Home Health Section
Attachment 48 – HC Health Insurance (HX) Section
Attachment 49 – HC Private Health Insurance Detail (HP) Section
Attachment 50 – HC Time Covered Detail (HQ) Section
Attachment 51 – HC Managed Care (MC) Section
Attachment 52 – HC Old Employment Health Insurance (OE) Section
Attachment 53 – HC Old Public Related Insurance (PR) Section
Attachment 54 – HC Hospital Stay Section
Attachment 55 – HC Income Section
Attachment 56 – HC Medical Provider Section
Attachment 57 – HC Other Medical Expense Section
Attachment 58 – HC Outpatient Department Section
Attachment 59 – HC Quality (Priority Conditions) Supplement Section
Attachment 60 – HC Provider Directory Section
Attachment 61 – HC Priority Conditions Enumeration Section
Attachment 62 – HC Prescribed Medicines Section
Attachment 63 – HC Provider Probes Section
Attachment 64 – HC Provider Roster Section
Attachment 65 – HC Reenumeration Subsection A
Attachment 66 – HC Reenumeration Subsection B
Attachment 67 – HC RU Information Screener
Attachment 68 – MPC Hospital Contact Guide
Attachment 69 – MPC Office-Based Doctor Contact Guide
Attachment 70 – MPC Home Care Contact Guide
Attachment 71 – MPC Institution Contact Guide
Attachment 72 – MPC Pharmacy Contact Guide
Attachment 73 – MPC Separate Billing Doctor Contact Guide
Attachment 74 – MPC Home Care Provider Questionnaire for Health Care Providers
Attachment 75 – MPC Home Care Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 76 – MPC Home Care Provider Authorization Form Package, Records to be Provided via Fax Anticipated
Attachment 77 – MPC Home Care Provider Overflow Patient List
Attachment 78 – MPC Home Care Provider Questionnaire for Non-Health Care Providers
Attachment 79 – MPC Office-Based Doctor Provider Questionnaire
Attachment 80 – MPC Office-Based Doctor Provider Authorization Form Package, Records to be Provided via Fax Anticipated
Attachment 81 – MPC Office-Based Doctor Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 82 – MPC Office-Based Doctor Provider Overflow Patient List
Attachment 83 – MPC Separately Billing Doctor Provider Questionnaire
Attachment 84 – MPC Separately Billing Doctor Provider Authorization Form Package, Records to be Provided via Fax Anticipated
Attachment 85 – MPC Separately Billing Doctor Provider Authorization Form Package, Phone Data Collection Anticipated

Attachment 86 – MPC Separately Billing Doctor Provider Overflow Patient List
Attachment 87 – MPC Hospital Provider Questionnaire
Attachment 88 – MPC Hospital Provider Authorization Form Package, One Point of Contact for Medical and Patient Account Records
Attachment 89 – MPC Hospital Provider Authorization Form Package, Point of Contact for Medical Records
Attachment 90 – MPC Hospital Provider Authorization Form Package, Point of Contact for Patient Account Records
Attachment 91 – MPC Hospital Provider Overflow Patient List
Attachment 92 – MPC Institution Provider Questionnaire
Attachment 93 – MPC Letters, Email Templates, and Other Documents
Attachment 94 – MPC Pharmacy Provider Questionnaire
Attachment 95 – MPC Pharmacy Provider Authorization Form Package, Records to be Provided via Fax Anticipated
Attachment 96 – MPC Pharmacy Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 97 – MPC Pharmacy Provider Overflow Patient List
Attachment 98 – MPC Durable Medical Equipment Provider Authorization Form Package
Attachment 99 – MPC Pharmacy Provider Letters, Email Templates, and Other Documents
Attachment 100 – MPC Medical Organizations Survey Draft Questionnaire
Attachment 101 – 60 Day Federal Register Notice