Supporting Statement – Part A

Medicare Beneficiary and Family-Centered Satisfaction Survey

A. Background

The statutory authority for the 11th Statement of Work (SOW) is found in Part B of Title XI of the Social Security Act as amended by the Peer Review Improvement Act of 1982. The Social Security Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

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

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

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

One method used to ensure the QIOs are effectively meeting their mission, is a survey of complainants. This survey will be conducted by a contractor to the Centers for Medicare and Medicaid Services (CMS) and will address the following:

- Measure beneficiary satisfaction with the QIO's review processes and assure the process aligns with the principles outlined by the Picker Institute.
- The survey, will capture beneficiary satisfaction about quality of care, as well as appeals about discharge.

NOTE: QIO-specific data resulting from the survey will be provided every three months to each of the QIOs for use in on-going quality improvement efforts.

B. Justification

1. Need and Legal Basis

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

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

- Improve quality of care for beneficiaries;

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

2. Information Users

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

Since the approval of the survey, CMS worked with its 53 QIOs to better understand the QIOs interaction with Medicare beneficiaries in the QIOs case review activities. At times, the data garnered from the survey revealed a need for individual QIOs to improve their customer-centered focus, to provide fuller, more detailed information as a result of QIO case reviews or to listen more closely to the concerns raised by Medicare beneficiaries. In these instances, CMS followed up with each QIO on each satisfaction score to craft improvement strategies to address the substandard performance.

Other survey results indicated that individual QIOs were adequately interacting with Medicare beneficiaries, providing detailed and meaningful information in an easy to understand manner. With the latter results, again, CMS worked with individual QIOs to ensure that this performance was maintained over the contract term.

At the beginning on the 10th SoW, CMS cognitively tested the instruments for clarity of language and responses (this was not a formal pilot testing). At the time we submitted the OMB package for the survey currently in use, we relied on experience regarding response rate on similar surveys of Medicare beneficiaries. Consequently, CMS used the first two years of survey data to evaluate how QIOs processed cases, including how QIOs encouraged beneficiaries to agree to take the survey. CMS used satisfaction scores in the first two years as a process monitoring tool and not contract evaluation. The satisfaction data were used in year 3 for contract evaluation purposes.

Finally, CMS used the survey data for year 3 as a part of contract evaluation at the end of the QIO contract in 2014. Through the productive feedback of this survey during its testing phase in years 1 and 2 and in its formal use in year 3, all 53 QIOs were able to pass this element of the evaluation methodology.

3. Improved Information Technology

-Based on the methodological research into efficient collection of data and especially in light of the fact that the majority of respondents will be older adults, CMS proposes using mail-out surveys. No signature is required for consent to participate and participation in the survey is voluntary; the covering materials accompanying the mail-out survey will explain in further detail.

4. Duplication and/or Similar Information

The information required is not duplicative.

5. Small Business

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

6. Less Frequent Collection

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

Without these survey data, CMS would have one less means to understand and improve the customer-centered performance of its QIOs. At times, CMS does hear directly from Medicare beneficiaries who are dissatisfied with their interaction with a QIO, but this kind of contact is intermittent and non-systematic. CMS wishes to be more deliberate and systematic in acquiring feedback from its Medicare beneficiary customers. The satisfaction survey provides a formal framework for this constructive feedback, both positive and negative and as such, activities that ensure improvements or maintaining good performance can be implemented.

7. Special Circumstances for Information Collection

There are no special circumstances associated with this collection.

8. Federal Register and Outside Consultation

The 60-day Federal Register notice was published on July 21, 2015. There were no public comments received.

In the development of the final regulations that include these requirements, we considered the correspondence received from individuals, advocacy groups, hospitals, hospital associations,

business groups, and national medical organizations. The comments were discussed in the preamble to the final rule.

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

Exhibit 1: Survey development consultants

Organization	Name	Contact Information
Westat	W. Sherman Edwards	301-294-3993; ShermEdwards@westat.com
Westat	Vasudha Narayanan	301-251-2257 VasudhaNarayanan@westat.com
Westat	Stephanie Fry	301-294-2872 stephaniefry@westat.com
Avar Consulting	Wendy Gary	337.385.2144 WGary@avarconsulting.com

9. Payments or Gifts

There are no payments or gifts associated with this collection.

10. Confidentiality

Information from survey respondents is not confidential, as it does not contain PHI or PII (under HIPAA or the Privacy Act of 1974) or QIO Confidential Information (under 42 C.F.R. 480, *et seq*.). The Privacy Act is not applicable. The information collected describes respondents' interaction and satisfaction with the QIOs as a result of a beneficiary-initiated request for a QIO case review. The survey contractor has created a "dashboard" for CMS and the QIOs which provides aggregate scoring data for particular periods (contract to date, latest month, latest quarter, latest year, among other aggregate categories). Individual-level data are not available through the dashboard. Medicare beneficiaries are told that their comments will be "confidential," and this means that individual survey comments and scores are recorded but are not linked to a particular case. The survey contractor does provide the QIOs with individual comments provided by Medicare beneficiaries, but the comments are de-identified and not linked to particular cases or respondents.

11. Sensitive Questions

There are no questions of sensitive nature.

12. Estimate of Burden

Exhibit 2: Estimated burden hours

Data Collection	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Survey of Beneficiary Satisfaction with QIOs-Per Annum	6,404	1	0.25	1,601

Exhibit 3. Estimated cost burden

Data Collection	Number of respondents	Total burden hours	Average hourly wage rate[1]	Total cost burden
Survey of Beneficiary Satisfaction with QIOs-Per Annum	6,403	1,601	$10.96	$17,546.96

The number of respondents was calculated based on the following parameters:

- Average number of closed complaints and appeals cases for a 3 month period during the 9th SOW.
- Drawing a census of complaints cases (in order to achieve sufficient completes for analysis).
- Drawing a sample of appeals cases.
- Obtaining a 60% response rate (as estimated based on experience conducting surveys of Medicare Beneficiaries including the Medicare CAHPS.

The specific calculation for quarterly number of respondents is as follows:
Complaints cases
Closed cases = 1,912
Sample = 1,912
Estimated response rate = 60%
Number of respondents = 1,912 x 60% = 1,147

Appeals cases
Closed cases = 102,412
Sample = 8,760
Estimated response rate = 60%
Number of respondents = 8,760 x 60% = 5,256

Grand total respondents = 1,147 + 5,256 = 6,403
Completion of the survey is estimated to be 0.25 hours

Total burden hours per annum = 6,404 respondents x 0.25 hours = 1,601 burden hours.

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

13. Capital Cost

There are no capital costs associated with this collection.

14. Federal Cost Estimates

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

The cost of the study for Government personnel is estimated at $114,907.80 for 3 years for an estimated annualized cost per year of $38,302.60 (please see Exhibits 4 and 5 for detailed break down). The estimated government cost for a contract to carry out this study is $997,000. This cost is for roughly 14,593 person hours of which 55 percent are professional hours and 45 percent are support hours.

Exhibit 4

Annual government Cost for Federal Employee:

Grade 12:	$77,490 x 0.20	**$15,498.00**
Grade 13	$114,023 x 0.20	**$22,804.60**
Total		**$38,302.60***

Exhibit 5

Government cost for Federal Employee over three years:

Grade 12	$15,498.00	(3 years) =	**$46,494.00**
Grade 13	$22,804.60	(3 years) =	**$68,413.80**
Total			**114,907.80***

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

The contract is currently staffed by two CMS employees, a Contracting Officer's Representative (COR) located in a CMS Regional Office in Boston, Massachusetts, and a Subject Matter Expert (SME) located in the CMS Central Office in Baltimore, Maryland. While the COR and SME discuss performance and the work product of the satisfaction survey contract with others in the agency, it is solely these two employees who oversee and interact with the contractor. These two employees represent the total government associated cost.

15. Changes in Burden

There are no changes in burden at this time.

16. Publication and Tabulation Dates
n/a

17. OMB Expiration Date

The surveys will carry the expiration date on them.

18. Certification Statement
There are no exceptions to the certification statement.