

**Supporting Statement A  
for Revision of Currently Approved Collection:**

**Medicare Current Beneficiary Survey (MCBS)**

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April 13, 2016

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## A. Background

The Centers for Medicare & Medicaid Services (CMS) is the largest single payer of health care in the United States. With full implementation of the Affordable Care Act of 2010 (ACA), the agency will play a direct or indirect role in administering health insurance coverage for more than 120 million people across the Medicare, Medicaid, CHIP, and Exchange populations. A critical aim for CMS is to be an effective steward, major force, and trustworthy partner in leading the transformation of the health care system. CMS also aims to provide Americans with high quality care and better health at lower costs through improvement. At the forefront of these initiatives is the Center for Medicare and Medicaid Innovation (CMMI).

The CMMI is authorized by Section 1115A of the Social Security Act, as established by Section 3021 of the ACA. It was established to “test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished” to Medicare, Medicaid and CHIP beneficiaries. Implicit across all of CMMI activities is an emphasis on diffusion – finding and validating innovative models that have the potential to scale, facilitating rapid adoption, and letting them take root in organizations, health systems, and communities across America.

CMS activities result in substantial data generation. Although administrative data are a critical resource for CMS and its partners, there remains an important need for self-reported data in order to obtain information that is not captured through other CMS operations. For example, a Medicare beneficiary’s satisfaction with, access to, and quality of care are important pieces of information that can only be captured by obtaining the beneficiary’s unique perspective. In addition, information on beneficiary insurance coverage and payments from non-Medicare sources (including beneficiary out-of-pocket spending) are collected by surveying beneficiaries because these data are currently not available to CMS in administrative data. These survey-collected data elements complete the picture of a beneficiary’s health care experience and provide a vital component in the development and evaluation of CMMI models and analysis conducted by CMS.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through CMS operations. The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by CMS and directed by the Office of Enterprise Data and Analytics (OEDA) in partnership with the CMMI. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event data, enrollment data, and so forth) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years, encompassing over 1 million interviews with more than 100,000 survey participants. Respondents participate in three interviews each year for four years, or 12 interviews in total. This gives a comprehensive picture of health care costs and utilization over a period of time.

The primary goals of the MCBS are to:

- provide information on the Medicare beneficiary population that is not available in CMS

administrative data and that is uniquely suited to evaluate or report on key outcomes and characteristics associated with beneficiaries treated in innovative payment and service delivery models;

- determine expenditures and sources of payment for all services (including services not covered by Medicare) used by Medicare beneficiaries, including copayments, deductibles, and non-covered services;
- ascertain all types of health insurance coverage among Medicare beneficiaries (e.g., Medigap coverage, retiree coverage) and relate this coverage to payment for specific services; and
- track changes in key beneficiary metrics over time, such as changes in health and functional status, spending down to Medicaid eligibility, access and satisfaction with Medicare programs and providers, and fluctuations in out-of-pocket spending.

The core of the MCBS is a series of interviews administered to a stratified random sample of the Medicare population, including aged and disabled enrollees, residing in the community or in long term health care facilities. Questions are asked about enrollees' patterns of health care use, charges, insurance coverage, and payments over time. Respondents are asked about their sources of health care coverage and payment, their demographic characteristics, their health and work history, and their family living circumstances. In addition to collecting information through the core questionnaire, the MCBS collects information periodically on special topics through supplements, also referred to as modules. Module topics include enrollees' income and assets, access to health care, health and functional status and satisfaction with care.

The MCBS respondents are interviewed three times per year using four-month recall periods; the rounds are referred to as fall, winter, and summer. New survey participants always join in the fall round; this panel's first round includes baseline information for the analysis of access to care and establishes a recall boundary for the next interview (the interview reference period is since the date of the previous interview). For the next 10 rounds, cost and utilization information (core) and specific modules are administered to the panel. Finally, the panel exits the survey after its 12<sup>th</sup> round which always occurs in the summer.

The MCBS has been at the forefront of in-person survey collection and data processing, most notably as one of the first surveys to successfully 1) implement a computer assisted personal interview (CAPI) and, 2) match survey and claims data to adjust and correct for underreporting in survey reported health care utilization. The CMS vision for the MCBS is to continue to provide unique, high-quality and high-value data in a timely manner, continue to break ground in innovative, efficient and analytically powerful new areas of survey data administration, design and development, and to increase the survey's ability to develop, monitor, assess and evaluate the impact of CMMI care delivery and payment models. To succeed in these areas, CMS aims to:

- capture high-value, unbiased, minimally burdensome, self-reported content that is multipurpose in use;
- improve the integration of existing and new sources of administrative data with MCBS survey collected data;
- develop and implement more efficient, cost-effective, accurate and innovative data collection strategies when possible; and

- enhance the understanding, usefulness, and promotion of MCBS through the dissemination of user tools and key scientific findings based on MCBS data.

The current clearance expires at the end of July 2017. The terms of clearance for the last revision (2014) were: It is OMB’s understanding that the CMS is studying recommendations to modernize the MCBS. Within four months of approval of this ICR, CMS commits to briefing OMB on the changes to the MCBS that are being considered and the developmental work that it will pursue in advance of fielding new design elements. OMB commits to working with CMS to put into place generic clearance mechanisms, as appropriate, to aid said developmental work.

- o To that end, CMS briefed OMB in November, 2015 about the plans to update MCBS content over time. CMS also launched an internal Content Management Group which has established a process for the review of the MCBS. The review will not necessarily result in recommended changes to this clearance. The following review schedule will be conducted over the next three years:
  - o Year 1: Access to Care (ACQ), Satisfaction with Care (SCQ), Usual Source of Care (USQ), Patient Activation (PAQ), Patient Perceptions of Integrated Care (PPIC), Drug Coverage (RXQ), and Closing (CLQ)
  - o Year 2: Introduction (INQ), Address Verification (AVQ), Exit Interview (EXQ), Enumeration Summary (ENS), Housing Characteristics (HAQ) , Beneficiary Knowledge (KNQ)
  - o Year 3: Demographics and Income (DIQ), Income and Assets (IAQ)

The most recent non-substantive changes were made to the MCBS in August 2015 and November 2015 to implement changes to the Community instruments for Round 73 and Round 74.

This is a request to revise and extend the existing MCBS clearance for an additional three years. The present clearance request encompasses all aspects of the MCBS: the Community baseline and core questionnaires; the Facility screener, baseline and core questionnaires; and modules such as Income and Assets, Access to Care, and so forth. The revision to this OMB package includes the following modifications to the sampling design and substantive changes to the Community questionnaire sections. These are described in further detail in Supporting Statement, Part B:

- Modify the sample design permanently by increasing the sample size to achieve additional Hispanic completed cases (beginning in fall 2016), as well as additional dual-eligible (Medicare/Medicaid) completed cases (beginning in 2017).
- Addition of a new section on Use of Nicotine and Alcohol (NAQ).
- Updating the Health Status and Functioning (HFQ) section.
- Reducing the number of items asked in the Patient Perceptions of Integrated Care /Usual Source of Care (PPIC/USQ) section.
- Adding a question to the Demographics and Income (DIQ) section that measures English literacy among respondents with Limited English Proficiency.

A1. Circumstances Making the Collection of Information Necessary

As described in the **Background**, CMS collects administrative information on the Medicare population through its claims records. Unfortunately, the current administrative information collected by CMS fails to provide the complete picture needed for CMS to evaluate its programs and comply with legislative mandates found in both:

- a. Section 1115A of the Social Security Act, as established by Section 3021 of the Affordable Care Act (ACA) of 2010; and
- b. Section 723 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

The MCBS supports CMS' program evaluation and legislative mandate compliance by providing data to determine expenditures and sources of payment for all services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to trace processes over time, such as changes in health status and "spending down" to Medicaid eligibility and the impacts of program changes, satisfaction with care, and usual source of care. These unique design features of the MCBS enable it to support a variety of CMS functional areas in addressing both Section 3021 of ACA and Section 723 of MMA. For example, the MCBS is used by CMMI analysts to assess the potential number of beneficiaries eligible for proposed new care and payment models, their baseline utilization and patterns of usual care, and the decisional factors that help determine when and where beneficiaries seek care.

## A2. Purpose and Use of Information Collection

The MCBS continues to provide unique insight into the Medicare program and helps both CMS and external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. In the past, MCBS data have been used to assess potential changes to the Medicare program. For example, the MCBS was

instrumental in supporting the development and implementation of the Medicare prescription drug benefit by providing a means to evaluate prescription drug costs and out-of-pocket burden for these drugs to Medicare beneficiaries.

Moving forward, the MCBS will continue to play a critical role in the monitoring and evaluation of key provisions of the Affordable Care Act (ACA), with an emphasis on supporting CMMI efforts to test innovative payment and service delivery models ability to reduce costs and improve quality. For example, the longitudinal and comprehensive nature of the MCBS provide the opportunity for both pre/post and observational studies (with a control and comparison group) for beneficiaries involved with CMMI models or new CMS programs (e.g., Accountable Care Organizations, Medical Homes). Other areas that will be covered include changes to Part D coverage, changes to cost-sharing and premiums, and the use and knowledge of new Medicare-covered preventive services.

MCBS data will also be used by CMS to continue to assess the impact of major policy innovations and health care reform on Medicare beneficiaries (pre and post implementation). MCBS users continue to monitor delivery of services, sources of payment for Medicare covered and non-covered services, beneficiary cost sharing and financial protection, and satisfaction with and the access to health care services. Analysts can relate the dynamics of future aging patterns to age-specific rates of use of health care services. MCBS data also allow accurate measurement of total health care expenditures for enrollees and changes in private health insurance benefits (including long-term care insurance). The capacity to follow individuals into and out of nursing homes and hospitals provides analysts the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care.

Analysts are able to assess the aggregate cost of short stays and long stays in nursing homes, and of combined hospital/nursing home stays. In addition, the MCBS data can be used to forecast the need and settings for selected chronic disease care and long-term care services by examining trends in the use of health care services, linked with morbidity, disability and mortality data

The comprehensive nature of the MCBS makes its data appealing to a broad spectrum of users. In addition to CMS use, the MCBS consistently provides value and unique data to external users, as demonstrated by more than 3,000 research articles published using the MCBS to date and over 200 MCBS files purchased and shipped to researchers each year. MCBS survey data are also vital in the production of highly regarded publications, including the Kaiser Family Foundation *Medicare Chartbook* and the Medicare Payment Advisory Commission's (MedPAC) annual *Data Book*. There are three separate categories of data users, briefly discussed below.

- Within CMS. Survey results have been and will continue to be used by various organizations within the CMS. CMMI analysts, for example, have frequently used the data collected by the MCBS for a variety of purposes, including to assess the potential number of beneficiaries eligible for proposed new care and payment models, their baseline utilization and patterns of usual care, and the decisional factors that help determine when and where beneficiaries seek care.



The MCBS is also used by the CMS Office of the Actuary to track trends in out-of-pocket spending and monitor Medicare supplemental insurance (Medigap), and is a major source of information for the annual Trustees' Report. MCBS data have also been used to track beneficiary's knowledge and sources of information about Medicare, especially following the implementation of a new program or services (e.g. Part D, "Welcome to Medicare" benefits, etc.). Self-reported MCBS data on immunizations and preventive screenings are used to track whether CMS is meeting population health objectives.

Analysis of the facility component also allows CMS to examine expenditures that are covered by Medicaid, the shifts between private pay and Medicaid, and the cost implications for both Medicare and Medicaid in the areas of spending down assets and spousal impoverishment.

In other examples, the CMS Office of Communication uses the MCBS to track beneficiaries' knowledge and sources of information about Medicare as well as population out of pocket spending in the Plan Finder tool. The Office of Financial Management and Office of Clinical Standards and Quality use immunization data to track whether CMS is meeting GPRA objectives.

- Other Governmental / quasi-governmental, outside CMS. The MCBS is a major source of information for the Medicare Payment Advisory Commission (MedPAC) to monitor access to health care and beneficiary financial protection. The MCBS data have been routinely included in MedPAC's Annual Reports and data collected by the MCBS have been used both in descriptive statistics and simulation.

The MCBS is also a major source of information for the Government Accountability Office (GAO) to monitor the impact that different types of insurance coverage have on beneficiary health care expenses.

Several other agencies that have developed a partnership in using MCBS data include the Congressional Budget Office, Public Health Service, Centers for Disease Control and Prevention, National Institute of Mental Health, National Institute on Aging, and Advisory Council on Social Security. Foundations such as Kaiser Family Foundation, R W Johnson, and the Commonwealth Fund also use MCBS data for policy analyses.

- Other researchers. Data are available to academic researchers through data use agreements. Additionally MCBS is planning on creating a Public Use File (PUF) with limited content for research. This effort is currently in the development and approval stages. Topics of their research include: chronic disease, effects of Medicare drug coverage, racial and ethnic disparities in service use, use of preventive services, underuse of medications, hospital readmission, body mass and aging, assistance with activities of daily living, obesity, quality of care, medication use in nursing homes, alcohol use, home care, veterans' care, disability trends, treatments for dementia, depression, beneficiary knowledge, informal assistance, use of durable medical

equipment, falls, depression, and self-management for chronic disease. These are just a few examples of actual uses of MCBS data for policy research.

CMS is requesting changes to the Community questionnaire in the existing clearance beginning in fall 2016 with the Round 76 interviews. The goal of most of these changes is to streamline some sections, add a few new measures, and update the wording of questions and response categories. As a whole, these revisions do not change the respondent burden. Most of the revised questions reflect an effort to bring the MCBS questionnaire in line with other national surveys that have more current wording of questions and response categories with well-established measures. In addition, the HHS Data Council has issued guidelines and new standards for measurement of certain topics which require revisions to the MCBS<sup>1</sup>.

In summary, most of the questionnaires as currently approved by OMB are unchanged. The revision to this OMB package includes the following sections which have changes; the net changes to the questionnaire are neutral to respondent burden. These are described in further detail in Supporting Statement, Part B:

- The addition of a new section on Use of Nicotine and Alcohol (NAQ). This new section incorporates current measures of nicotine and alcohol use, updates wording, and moves the measures into a single module.
- Updating the Health Status and Functioning (HFQ) module to use more current terminology and improve mental health measures as specified in the DHHS standards.
- Moving some items from HFQ into Preventive Care (PVQ) and updating terminology.
- Reducing the number of items asked in the Patient Perceptions of Integrated Care /Usual Source of Care (PPIC/USQ) section.
- Adding a question to the Demographics and Income (DIQ) module that measures English literacy among respondents with Limited English Proficiency.

As noted above, the changes to the questionnaire do not result in any changes to the estimated annual respondent burden. The addition of two oversamples to improve analysis of health disparities is included in this submission: (1) an oversample of Hispanic beneficiaries in 2016 and (2) the planned 2017 oversample of dual eligible beneficiaries (Medicare/Medicaid). By oversampling these populations, additional analyses can be accomplished both by CMS and the data users interested in these populations. The main goals of the oversampling are to increase the number of Hispanics and dual eligible beneficiaries in the MCBS enough to allow for precise estimates in the analysis of Medicare cost and use for these two population groups. These additions to the sample are anticipated to result in an increased total burden from the currently approved clearance. The new estimate of annual respondent burden is contained in Table B-12 (under section A12 below).

It is likely that some Community and Facility questionnaire sections and modules will be redesigned during the 3-year clearance period, including moving, deleting, and consolidating items and modules, with the goal of reducing burden. Most of these changes will be minor, reflecting improved wording of questions and response categories; many of the changes will substitute current MCBS questions with similar questions taken from other national surveys. Any

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<sup>1</sup> HHS Data Council Co-Chairs memorandum to the Secretary of the Department of Health and Human Services, May 11, 2016.

of these non-substantive changes will be submitted to OMB for approval. If the questionnaire changes are deemed substantive, CMS will submit a new request for revision of the currently approved collection.

### A3. Use of Information Technology and Burden Reduction

The MCBS takes full advantage of advances in survey methodology by administering the survey electronically. Respondents living in the community are administered a personal, face to face interview using computer-assisted personal interviewing (CAPI). Though respondents residing in long-term care facilities are not administered a personal, face-to-face interview, the CAPI instrument is used in interviewing the designated proxy (i.e., facility staff). CAPI, which functions with programmed edit checks, reduces respondent burden by minimizing the potential for double reporting and inconsistent responses. CAPI enables the interviewer to move through complex skip patterns quickly, which reduces respondent burden by shortening the interview and eliminating the need for call backs to correct errors. CAPI also greatly increases the efficiency of the interview in the following ways:

- a. CAPI tailors the sequence of questions to the responses of the interviewee, resulting in few – if any – interviewer skip errors. The natural flow of the interview is maintained even when the pattern of questions is complex.
- b. CAPI automatically provides “fills”, or word choices within questions. One keystroke can insert “you”, “he”, or “she”, as appropriate, for the duration of the interview. The sample person’s name, date of the last interview, and other items can also be filled as needed.
- c. CAPI maintains rosters or lists created during the interview, such as household members, health insurance plans, medical conditions, providers, visit dates, prescription drugs, and people who help with daily activities. These rosters can be used to structure questions, e.g., cycling through a series of doctor visits and checking for missing information. Interviewers can select items from a roster, add items, or correct them. Rosters are carried over from one interview to the next.
- d. CAPI edits entries for range and consistency. The interviewer can make corrections immediately. Information missing from a previous round can be inserted in the questionnaire.
- e. CAPI allows instantaneous calculations to be made, such as the amount remaining to be paid on a medical bill after totaling several payments.
- f. Interviewers use the computer to electronically transmit completed cases to the central office.

MCBS data collection also takes advantage of sophisticated technologies for efficient sampling as well as data editing and processing. Also, locating of respondents utilizes available technologies that have reduced on-the-ground searches.

### A4. Efforts to Identify Duplication and Use of Similar Information

This information collection is unique and does not duplicate any other effort and the same information cannot be obtained from any other source. This is especially true due to the unique panel design which follows respondents over a four year period both in the community as well as in long term care facilities. This design enables CMS to capture more complete data associated with costs and utilization of health care.

During the development and initial administration of the MCBS, a number of people inside and outside the Federal government were consulted. This consultation included issues of design, content, and statistical methodology and analysis. This effort was reexamined in 2013 using an independent contractor. In both instances, none of the people contacted were aware of duplicative information, nor were they aware of any other survey that duplicates the efforts of MCBS. In addition, CMS has undertaken exhaustive reviews of the literature and other data sources. In no instance have we identified another source of data that would be an effective substitute for the MCBS.

#### A5. Impact on Small Businesses and Other Small Entities

Most of the data collected for the MCBS will be from individuals in households. However, in any given round, about 1,000 sample persons will reside in government-sponsored, non-profit, and for-profit institutions such as nursing and personal care homes. Some of these institutions likely qualify as small businesses. For data collected on sample persons in these institutions, their employees serve as proxies for each sample person in their care.

Interviewers in long-term settings make every effort to determine, for each type of question, which staff members are most able to answer them. The data collection procedures are designed to minimize the burden on these proxies, with skip instructions so that they are asked only questions that apply to them.

#### A6. Consequences of Collecting the Information Less Frequently

By re-interviewing the same respondents a total of 12 times over a 4 year period, the MCBS supports longitudinal as well as cross-sectional analyses. Longitudinal data provide the material for models that analyze quantitative change over time. Policy changes can only be effectively understood by modeling the consequences of those changes on the same individuals over time. The four year panels, while relatively short in duration, allow us for instance to understand how changes in copays or coverage affect the type of physicians a beneficiary may choose or the type of services a beneficiary seeks. Additionally, three interviews a year in addition to providing a vehicle for collecting full cost and event data allow CMS to assess rapid individual changes in health and wellbeing in an elderly population.

In the first round of interviewing in the MCBS, the sample person in the community is provided with a calendar and asked to record all visits to health care providers, expenditures and to retain all statements including private insurance and Medicare statements/bills. Thus after the initial round, the recall period for the MCBS is since the time of the last interview.

In addition, the MCBS design employs the use of topic based modules which allow for important information to be collected, but less frequently. Having these modules permits

the inclusion of new and emerging topics that can assess legislative and program changes or measure changing phenomena.

A7. Special Circumstances Relating to Guidelines of 5 CFR 1320.5

None of the special circumstances listed by OMB apply to the MCBS.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside Agencies

The 60-day Federal Register Notice was published on February 24, 2016. No comments were received. CMS also regularly solicits input on questionnaire content from a large listserv as well as notification of opportunities to comment on the website) (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html>). Also, CMS participates in interagency working groups as well as research conferences to consult with a wide variety of data users and policy officials interested in MCBS data.

A9. Explanation of Any Payment or Gift to Respondents

The MCBS does not provide payments or gifts as incentives to respond. The most important incentive we use is to persuade the respondent that his or her participation is a service to the future of Medicare. We use standard refusal conversion techniques, letters, and newsletters. Respondents are provided with a planner to record all health events and provider visits as well as a bag to conveniently store all medical statements for easy reference during future interviews.

A10. Assurances of Confidentiality Provided to Respondents

The Community Advance Letter (Attachment 2) to the respondent includes the following statement regarding confidentiality of data:

All of your information will be kept private to the extent permitted by law, as prescribed by The Federal Privacy Act of 1974.

The Community brochure (Attachment 2), which is mailed to all newly added sample members each fall round, contains the following on respondent rights and privacy:

The information you provide will be kept private to the extent permitted by law, as prescribed by the Privacy Act of 1974. The information you give will only be used for research and statistical purposes.

The At the Door Sheet (Attachment 2) provided to the Community respondent at the door and the facility administrator and proxy respondents contains a statement of privacy protection consistent with the Privacy Act of 1974. In fielding the Community questionnaire Income and Assets module, an additional handout sheet is provided explaining its purpose and restating the Privacy Act.

Interviewer training stresses the importance of maintaining confidentiality and project protocols are documented within the Field Interviewer manual. Field outreach and contacting procedures have been established to maintain and ensure confidentiality. These include the utilization of standard computer security procedures (dual authentication password protection for each interviewer laptop) and restrictions on submitting PII through electronic mail submission.

The Facility Advance Letter (Attachment 7), sent to any new facility participating in the MCBS, includes the following statement:

No residents of your facility will be contacted directly. All of the information your organization provides will be kept private to the extent permitted by law, as prescribed by The Federal Privacy Act of 1974. Your participation is voluntary, and your relationship with programs administered by CMS will not be affected in any way by whether or not you participate.

Participating facilities also receive a HIPAA Letter (Attachment 7), which includes the following regarding the Health Insurance Portability and Accountability Act (HIPAA) regulations:

I am writing to address any concerns you may have about your facility's participation in the Medicare Current Beneficiary Survey (MCBS) as it relates to the Health Insurance Portability and Accountability Act (HIPAA) regulations. Please be assured that the standards of privacy of protected individually identifiable health information implemented under the HIPAA privacy regulation do not affect the data being collected for MCBS. Specifically, your cooperation with the MCBS will not violate the HIPAA privacy regulations. Nor will it require any additional privacy disclosure record keeping.

Under the HIPAA regulations, your facility does not need an individual's authorization to disclose their protected health information to a health plan, such as the Medicare program, when the information is being disclosed for receiving organization's health care operations activities. This holds if both your facility and the Medicare program has or had a relationship with the individual whose protected health information is being requested, and the protected information pertains to such relationship. See 45 CFR § 164.506(c) (4). Furthermore, participating in the MCBS will not impose additional disclosure record keeping burdens on your facility. Disclosures under 45 CFR § are explicitly exempt from the HIPAA disclosure accounting provisions. See 45 CFR § 164.528 (a) (1) (i).

The Resident Consent Form (Attachment 7) contains the following statement:

The information collected for MCBS will be protected by NORC at the University of Chicago, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study. Identifiable information will not be disclosed or released to anyone except those involved in research without the consent of the individual or the establishment except as required under the Privacy Act of 1974 (Public Law 93-579).

Any data published will exclude information that might lead to the identification of specific individuals (e.g., ID number, claim numbers, and location codes). CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to the individual privacy or other personal or property rights of the

individual.

All MCBS survey staff directly involved in MCBS data collection and/or analysis activities are required to sign a Non-Disclosure Agreement as well as a NORC confidentiality agreement.

#### A11. Justification for Sensitive Questions

In general, the MCBS does not ask sensitive questions. However, for a small number of respondents, there may be some questionnaire items that are considered to be sensitive. All interviewers are trained on how to handle respondent concerns about questions being sensitive.

For example, some respondents view any questions regarding income and assets to be sensitive. Also, the MCBS Income and Assets (IAQ) module now includes the USDA Economic Research Service's six standard questions on Food Security. These questions ask whether respondents may have skipped meals or gone hungry due to lack of money. Answering these questions may be sensitive for lower income respondents.

The Community interview includes asking respondents' perception of their health care, including any issues they may have experienced with their health care providers. These items may be considered sensitive for some respondents, depending on their health care experiences. It also includes some questions about activities of daily living, such as whether the respondent needs help bathing. Some respondents view these kinds of questions in a sensitive manner.

A12. Estimates of Annualized Burden Hours and Costs

Table B-12 shows estimates of the annual respondent burden. The annual burden for the MCBS is based on three interviews per respondent. The number of respondents changes every year and in part, depends on the response rate (both initially and through the life of their participation over 12 rounds of data collection). We currently estimate that our annual burden will be 60,103 hours for the survey. A Community interview should take roughly an hour and a half to complete and a facility interview roughly an hour.

	Time per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
<b>Community Rounds 76-78</b>				
-Fall Round 76 Supplemental Interview	1.0 hour	1	5,743	5,743
-Fall Round 76 Continuing Interview	1.5 hour	1	9,328	13,992
-Winter Round 77 Interview	1.5 hour	1	13,705	20,558
-Summer Round 78 Exit Interview	15 minutes	1	1,909	477
-Summer Round 78 Continuing Interview	1.5 hour	1	10,764	16,146
<b>Field Manager follow-up with 5% of Completed Interviews</b>	5 minutes		750	188
<b>Facility Rounds 76-78</b>	1.0 hour	3	1,000	3,000
<b>Total Annual Hours</b>				60,103
<b>Total Estimate – Rounds 76-83 (3 Years)</b>				180,310

The MCBS oversamples both the under 65 and the 85 and over populations. In order to provide an estimate of the cost of participating in this survey, we must select an hourly rate to use which is then multiplied by the burden hours of the respondent. We selected the U.S. minimum wage (\$7.25 for 2015) and multiplied it to the Total Annual Hours for Rounds 76-78 (60,103) for a Total Annual Cost Burden in terms of dollars of roughly \$435,749. The MCBS survey methodology is designed to reduce burden on the survey respondents in the community and facility setting. In the community setting logical skip patterns and rotating modules limit the time per response.

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record

Keepers All costs associated with this effort are reported in Items 12 and 14.



A14. Annualized Costs to the Federal Government

The estimated cost to the government for collecting these data includes the NORC contract, and direct CMS expenses for labor and travel.

The estimated cost for the planning, sampling, data collection and analysis for the MCBS in each year is: (The following estimated costs per Fiscal Year are approximated amounts based on the current MCBS contract).

FY 2016: Data collection and analysis	\$22,711,310
FY 2017: Data collection and analysis	\$23,280,937
FY 2018: Data collection and analysis	\$22,637,010

These costs include all labor hours, materials and supplies, reproduction, postage, telephone charges and indirect costs.

CMS personnel involved in MCBS include approximately 14 FTEs broken out by pay grade in Table B-14.

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Table B-14: CMS Personnel

Grade	FTE	2016 Annual Salary	Cost to Government
GS13 step 6	9.0	\$107,502	\$967,518
GS14 step 5	4.0	\$119,775	\$479,100
GS15 step 3	1.0	\$136,622	\$136,622
			\$1,583,240

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CMS staff costs are approximately \$1,583,240. In addition, staff travel is budgeted for \$8,000. The MCBS releases its documentation on CD Rom thus eliminating its printing budget. Thus, in-house CMS cost will be \$1,591,240.

A15. Explanation for Program Changes or Adjustments

As noted earlier, the addition of the oversample of Hispanic beneficiaries starting in 2016 and the planned oversample of dual eligible beneficiaries (Medicare/Medicaid) starting in 2017 are anticipated to result in an increased total burden from the currently approved clearance.

A16. Plans for Tabulation and Publication and Project Time Schedule

Data files will continue to be prepared over the course of the survey. This clearance request covers data collection beginning in Round 76 (Fall 2016) through Round 84 (Summer 2019). See Table B-16 for data collection rounds and plans for data dissemination.

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Table B-16: Annual schedule for information collection and dissemination

09/01/2016	Data collection starts for MCBS Round 76
01/01/2017	Data collection starts for MCBS Round 77
05/01/2017	Data collection starts for MCBS Round 78
09/01/2017	Data collection starts for MCBS Round 79
01/01/2018	Data collection starts for MCBS Round 80
05/01/2018	Data collection starts for MCBS Round 81
09/01/2018	Data collection starts for MCBS Round 82
01/01/2019	Data collection starts for MCBS Round 83
05/01/2019	Data collection starts for MCBS Round 84
04/30/2016	Microdata Public Use File for 2013 data.
12/01/2016	Limited Data Set available for 2013 Cost and Utilization series.
02/28/2017	Limited Data Set available for 2015 Access to Care series
12/01/2017	Limited Data Set available for 2015 Cost and Utilization series.
02/28/2018	Limited Data Set available for 2016 Access to Care series
12/01/2018	Limited Data Set available for 2016 Cost and Utilization series.
02/28/2019	Limited Data Set available for 2017 Access to Care series
12/01/2019	Limited Data Set available for 2017 Cost and Utilization series.

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There are two special reports being issued with each annual release of the data by CMS, Health and Health Care of the Medicare Population Data from the Medicare Current Beneficiary Survey and Characteristics and Perceptions of the Medicare Population: Data from the Medicare Current Beneficiary Survey. These reports or “chart books” contain a comprehensive set of statistical tables describing the Medicare population in terms of its demographic and socioeconomic characteristics, use of and expenditures on health care, perceived health and functional status, and access to and satisfaction with health care. The tables, which were created from Cost and Use and Access to Care files (respectively) released to the public, are intended as references for persons interested in using MCBS data to analyze the health and health care of the Medicare population. CMS posts these chart books online at [www.cms.hhs.gov/mcbs](http://www.cms.hhs.gov/mcbs).

Annual updates to the two chart books are available for the following years. (For years where the chart books are still unavailable an asterisk is used as a denotation and an estimated date of completion follows.)

Health and Health Care of the Medicare Population: Data from the MCBS

1992 – 2009, 2011, 2012 (May 2016), 2013 (April 2017)

Characteristics and Perceptions of the Medicare Population: Data from the MCBS

1995 – 2011, 2012 (May 2014) and 2013 (December 2015)

The data in the chart books are largely cross-sectional and describe the Medicare population

within a given year. CMS is planning the development of a new graphic chart book that explicitly illustrates important trends over time. The first version of the graphic chart book will cover the years 2010 – 2013, and will be updated annually with the newest estimates.

A17. Display of OMB Expiration Date

The OMB expiration date is displayed on the hardcopy respondent materials, including the Community advance letter, Facility advance letter, and brochure. It is also displayed on the MCBS website. CMS would like an exemption from displaying the expiration date on the Community and Facility questionnaires, as the collection of the MCBS is administered by interviewers using a computer (Computer Assisted Personal Interviewing, or CAPI). There is no hard copy questionnaire or document to display the OMB expiration date.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to this certification statement.