

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

**Medicare Current Beneficiary Survey (MCBS)**

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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. CMS plays 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 supporting innovative approaches to improving quality, accessibility, and affordability in healthcare. CMS also aims to put patients first in the delivery of their health care needs.

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 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, combined with CMS administrative data, complete the picture of a beneficiary's health care experience and provide a vital component in the development and evaluation of 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). 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 25 years, encompassing over 1 million interviews with more than 100,000 survey participants. Respondents participate in up to 11 interviews over a three and a half year period. 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, experiences and perceptions of quality with their health care system, and their family living circumstances.

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 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 and other health related questionnaire sections are administered to the panel. The panel exits the survey after its 11<sup>th</sup> interview which occurs in the Winter round.

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 CMS 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 June 2019. However, CMS is requesting a revision to the clearance now in order to reflect revised burden estimates based on the most recent timing data from 2017 data collection as well as to implement improvements beginning in Winter 2019 with the Round 83 interviews. Some of these changes will add new measures that will either capture more accurate data or close key data gaps; other changes will substantially reduce respondent burden and streamline data collection. For purposes of

developing burden estimates in A12, implementation of improvements is assumed to begin Winter 2018 Round 83.

### **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. However, the current administrative information collected by CMS does not 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. For example, the MCBS is used by CMS 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.

As mentioned earlier, while the administrative data available to CMS is rich in its breadth and accuracy, it does not contain important information that can only be obtained by interviewing beneficiaries. In particular, CMS must survey beneficiaries to obtain information about out of pocket health care costs not covered by Medicare. In addition, the MCBS panel design provides essential longitudinal data to measure change over time. Last, a unique feature of the MCBS -- the capacity to follow individuals from the community into and out of nursing homes and hospitals-- provides critical data including the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care, as well as the care transitions that occur across the various care providers.

### **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 Medicare, with an emphasis on supporting CMS 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 CMS models or other CMS programs. Other areas that can only be captured by using survey data along with the CMS administrative data include changes to Part D coverage, changes to cost-sharing and premiums, and the use and knowledge of existing and new Medicare-covered preventive services.

MCBS data will also continue to be used by CMS to assess the impact of major policy innovations and health care reform on Medicare beneficiaries (pre and post implementation). MCBS data 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, and integration of patient care. 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 4,500 research articles and citation using the MCBS to date, over 250 MCBS Limited Data Set (LDS) files purchased and shipped to researchers each year, and over 75 MCBS Public Use File (PUF) downloads per month. 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*.

- Within CMS. Survey results have been and will continue to be used by various organizations within the CMS. CMS analysts 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 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.

CMS provides an annual bibliography that includes research using MCBS data. This is a helpful resource to CMS staff, other government analysts, and the research community at large. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Bibliography.html>.

- 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, Robert Wood 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 beginning with data collected in the 2013 Medicare Current Beneficiary Survey (MCBS), a public use file (PUF) and accompanying documentation is available free for download. Topics of other research include: chronic disease, effects of Medicare drug coverage, 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.

### **Requested Revisions to Currently Approved Collection:**

This is a request to revise and extend the existing MCBS clearance for an additional three years. This revised clearance request encompasses all aspects of the MCBS: the Community Baseline and Continuing instruments and the Facility screener, Baseline and Continuing instruments. When implemented, the revision to this OMB package will result in an overall reduction in respondent burden as compared to the current clearance. Taken all together, these revisions reduce the respondent burden by 27%; specifically on an annual basis, the current OMB clearance projects an annual respondent burden of 60,103 hours and this revision brings the annual respondent burden down to 44,165 hours. The new estimate of annual respondent burden is contained in



Table B-12b (under section A12 below). All of these changes are described below and are referred to in Supporting Statement, Part B as well.

Changes to the burden based on actual timing data from 2017:

- The MCBS questionnaire underwent a major re-programming of the entire Community instrument beginning in 2014 and ending in 2016. Because various sections of the questionnaire were undergoing reprogramming and interviewers were being trained on the new software and case management system, the current clearance relied on the most recent burden estimates as of 2013. Since all reprogramming efforts were completed prior to the onset of 2017, data collection burden for that year provides the most current measure of respondent burden. Table B-12a shows the burden as of 2013 and Table B-12b shows the burden based on 2017 timing data as well as the net result of other changes described below.

Changes that will **reduce** respondent burden are:

- Improved processing speed and functionality of the Community CAPI instrument, more advanced and faster look up tools, and streamlined question flows, resulting in a reduced burden of approximately 10 minutes per round.
- Elimination of two questionnaire sections – Address Verification (AVQ) and Closing Questionnaire (CLQ), taking advantage of improved case management automation, resulting in a reduced burden of 4 minutes in the Fall round, 3.5 minutes in the Summer round, and 3.5 minutes in the Winter rounds. The information previously collected in the AVQ and CLQ in the CAPI instrument is now being collected by field interviewers in the MCBS case management system, to facilitate real-time updates to respondent contact information. Field interviewers collect this information either before or after administering the MCBS questionnaire. These items are for survey administration purposes only and are not health related content reported to the public.
- Elimination of Health Insurance and Prescribed Medicine summary sections (HIS and PMS) and the Patient Activation (PAQ) section. The summary sections previously allowed respondents to review information about health insurance plans and prescribed medicines that was reported from prior rounds and change their responses. The sections have been removed as part of an effort to remove questionnaire sections in which field interviewers can edit data entered in prior rounds. The current questionnaire allows for the collection of the most accurate data and therefore, administering HIS and PMS questions that were asked previously is redundant and burdensome. The PAQ section was eliminated because it was duplicative of improved items previously added to the Usual Source of Care/Patient Perceptions of Integrated Care (USQ/PPIC) section and some other items that had previously been moved into Satisfaction of Care (SCQ) sections of the questionnaire. There is no impact to data users as a result of these changes. These changes result in a reduced burden as follows:
  - 0.5 minutes for the 83% of respondents who answered HIS
  - 1 minute for the 77% of respondents who answered PMS
  - 5 minutes for the 90% of respondents who answered PAQ
- Discontinue the 12<sup>th</sup> interview as had previously been collected in the Summer round for

the exiting panel. This results in an elimination of the respondent burden associated with completing the summer round exit interview. The original design of the MCBS called for a 12<sup>th</sup> interview during each Summer round for the panel that was exiting. It was thought that this round would be needed to provide final cost and utilization information from health care events that occurred the prior year. A careful review of data collection and delivery revealed that cost and utilization information is not collected during this interview except for rare ongoing inpatient utilization (IP) events. In addition, Exit panel cases do not receive a positive Survey File or Cost Supplement weight for the calendar year in which they exit. For example, 2013 panel members exited in Summer 2017 Round 78; they will not have weights for 2017 files, but they can have weights for the previous data year, 2016. The original design of the MCBS included the 11<sup>th</sup> and 12<sup>th</sup> interviews in order to collect additional information based on the prior year's cost and utilization; that is, the 11<sup>th</sup> and 12<sup>th</sup> interview questions have a reference period of the prior year and did not include collecting current costs and utilization. An analysis of the questionnaire and associated data revealed that respondents were being unnecessarily burdened with having to participate in the 12<sup>th</sup>, Exit interview. Instead, all necessary information to complete costs and utilization from the prior year can be (and have been historically) collected in the 11<sup>th</sup> interview. Removing the 12<sup>th</sup> interview is a reduction in respondent burden since the 11<sup>th</sup> interview is already accounted for in annual burden estimates and no additional content has been added to the 11<sup>th</sup> interview based on this design change. Therefore, we are able to eliminate this interview in its entirety. This 11<sup>th</sup> interview will end the respondent's participation in the MCBS and save an estimated 15 minutes for the approximately 1,800 12<sup>th</sup> interview Exit panel respondents each Summer round.

- Starting in Fall 2019 Round 85, reduce the content of data collection in Facility interviews for those facilities that are Medicare certified. A change to the flow of the Facility instrument such that portions of the Facility Questionnaire (FQ), Health Status (HS), Background Questionnaire (BQ), Health Insurance (IN), and Expenditures (EX) sections of the Facility instrument are not administered when data from the Long-Term Minimum Data Set (MDS) and Certification and Survey Provider Enhanced Reporting (CASPER) administrative data are available for a MCBS facility-dwelling beneficiary. These data instead will be provided through administrative data from the MDS and CASPER data. This results in a reduction of 30 minutes for Baseline respondents in the Fall round and 15 minutes for Continuing respondents in all other rounds.
- Discontinue collection of prescribed medicine data during the Facility interview starting in Winter 2019 Round 83. Analysis revealed that prescribed medicine data collected via the Facility interview were not incorporated into data products that are shared with users. Further, analysis revealed that this information can be provided via other sources such as the Medicare Part D claims data, which are currently included in the Cost Supplement file. Elimination of the Prescribed Medicine (PM) section from the Facility interview will result in a reduced burden of 15 minutes in the Winter and Summer rounds and 10.2 minutes in the Fall round.

Changes that will **increase** respondent burden starting in January 2019 are:

- Modify the collection of utilization data by expanding the current Dental Utilization Questionnaire (DUQ) to include parallel measures for vision and hearing. The expanded section will be renamed from DUQ to Dental, Vision, and Hearing Care Utilization

Questionnaire (DVH). Vision and hearing utilization is already collected via various items in the Medical Provider Utilization Questionnaire (MPQ), the Other Medical Expenses Questionnaire (OMQ), and the Health Status and Functioning Questionnaire (HFQ) sections. However, given the structure of existing items, vision and hearing events are currently indistinguishable from other types of medical provider visits. The DVH section will capture analogous details for dental, vision, and hearing provider visits, such as provider name, specialization, visit date, and procedures and/or medicines prescribed during each visit. Migrating collection of vision and hearing events to DVH will facilitate streamlined, comprehensive data collection on vision and hearing utilization and will allow data users to identify these types of visits for analysis. In sum, these are not new questions but rather, have been moved to a specific section that will help distinguish vision and hearing utilization from other medical utilization. They will follow the same format as the dental utilization questions which have successfully been in the field for years.

Based on existing MCBS data, it is expected that at least 15% of respondents will report a vision or hearing event in a given round. For these respondents, migrating collection of vision and hearing utilization from existing sections to the DVH section will result in an increased burden of two minutes. For the remaining 85% of respondents, who will likely not report a vision or hearing event in a given round, changes to the DVH section will result in an increased burden of one minute. The increased burden is due to respondents being asked detailed follow-up questions about their vision and hearing events in DVH while also still being asked about other medical provider visits in MPQ and OMQ. By designating vision and hearing utilization as a ‘health care event’, it triggers the same set of questions asked for all the other health care events, just as a visit to a primary care doctor. It is the ‘event’ that causes a few additional questions to be asked for those respondents reporting a vision or hearing event, thus increasing burden slightly.

- Revise the Preventive Care Questionnaire (PVQ) to add questions on HIV testing. Claims-based analyses have suggested very low uptake by beneficiaries on obtaining some important screening services including screening for HIV. Many national health surveys include screenings for HIV; as CMS continues to modernize the MCBS, these data gaps can be addressed by adding a few questions on HIV screening.

Given the potential benefits of these preventive services to Medicare beneficiaries, CMS recommends adding HIV screening items to generate survey-based estimates of the frequency with which they are administered. CMS has both current models and new models in development involving primary care providers offering preventive care and chronic care management that could benefit from understanding responses to these survey items. The HIV testing items include two from the National Health Interview Survey (NHIS) and two from the National HIV Behavioral Surveillance System (NHBS). The first item will be administered to all respondents in Fall 2019 and will ask whether the respondent has ever been tested for HIV. For those who respond yes, they will be asked for the date of their most recent HIV test. For those who respond no, they will be asked for the main reason they have not been tested. In total, each respondent will receive two items about HIV testing in Fall 2019.

Continuing respondents who have not previously been tested for HIV will receive a modified item asking if they have been tested for HIV since the date of the last interview. If

they respond yes, they will be asked for the date of their most recent HIV test. For those who respond no, they will be asked for the main reason they have not been tested. Continuing respondents who previously reported receiving a test for HIV will skip all items about HIV testing.

These items will be administered to Community interviews in the fall round. This change will result in an increase of 0.8 minutes. While these questions have not been cognitively tested for the MCBS, they have been fielded in national surveys in their current format since the mid – 1980s when HIV testing measures emerged as an important behavioral health outcome. The only change in these questions from their early testing and survey administration was to replace the reference to AIDS with HIV.

- Revise the Health Status and Functioning Questionnaire (HFQ) to add three new physical measures and one recall question to measure cognitive functioning. Measuring the prevalence of functional limitations in the Medicare population is important to measuring the impact of physical and cognitive functioning on current and future health care costs<sup>1</sup>. Performance on physical measures, such as a timed walk or chair stand, can be an early predictor of developing future difficulties with activities of daily living (ADLs)<sup>2,3</sup>. Similarly, mild cognitive impairment is linked with increased difficulties with ADLs and Instrumental Activities of Daily Living (IADLs)<sup>4</sup>, but the signs of cognitive impairment may be present before the respondent self-reports any functional limitations<sup>5</sup>. The addition of four well-

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<sup>1</sup> Centers for Medicare and Medicaid Services (2014, July). Are Medicare Beneficiaries Getting the Help They Need with Home -Based Care? (M CBS Data Brief 002).

<sup>2</sup> ADLs are routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

<sup>3</sup> Gill, T, et al. (1995). Assessing Risk for the Onset of Functional Dependence among Older Adults: The Role of Physical Performance. *Journal of American Geriatric Society*. 43:603-609, 1995.

<sup>4</sup> IADLs are activities related to independent living and are valuable for evaluating persons with early-stage disease, both to assess the level of disease and to determine the person's ability to care for himself or herself.

<sup>5</sup> Puente, A, et al. (2014) Functional Impairment in Mild Cognitive Impairment Evidenced Using Performance-Based Measurement. *Journal of Geriatric Psychiatry and Neurology*. December 2014 vol. 27 no. 4 253-258.

established physical and cognitive measures into the MCBS protocol will provide researchers with data both to understand the trajectory of functional dependence and to explore the relationship of these early indicators to health care utilization and costs.

The following physical and cognitive measures are scheduled to be added to the MCBS in the Health Status and Functioning (HFQ) section of the Community instrument beginning in Fall 2019. While these questions have not been cognitively tested for the MCBS, the physical measures were successfully tested and implemented on the National Social Life, Health, and Aging Project (NSHAP) and the cognitive measures were successfully tested and implemented on the Health and Retirement Study (HRS). Both NSHAP and HRS are surveys of the older adult population, making CMS confident that these measures will perform as expected in the MCBS and that MCBS field interviewers can be successfully trained to administer the measures in the field.

The source of the physical measures for gait speed and balance test is from the NIH Toolbox. The six-year development process of the Toolbox had two phases. Phase I employed qualitative methods, including two online requests for information from experts (n=232 and 143); interviews with clinicians and scientists (n=44); and two in-person consensus meetings, to identify the sub-domains for inclusion in the NIH Toolbox, along with the criteria affecting instrument selection, creation, and norming. Extensive literature and database reviews were then conducted and revealed a limited set of existing measures that met the NIH Toolbox criteria. Existing measures were modified to meet the criteria and new instruments were developed, using [Item Response Theory](#) (IRT) methods when applicable. In Phase II, candidate measures underwent pilot testing (e.g., for feasibility across the age range) and initial evaluation of psychometric properties. This evaluation included calibration of IRT-based measures, [validation](#) against gold standard and other measures, and assessment of test-retest reliability. This process has been described in special issues of [Neurology](#), and, for the Cognition measures, in the [Monographs of the Society for Research in Child Development](#) and the [Journal of the International Neuropsychological Society](#)<sup>1</sup>

The chair stand test has been administered in national surveys including NSHAP, and was adapted from a short battery of physical performance tests developed by Guralnick.<sup>2</sup> The cognitive measures were tested and implemented on the HRS by the HRS Health Working Group.<sup>3</sup>

○ Physical measures:

- Gait speed: Respondents are asked to walk a short distance (e.g., 8-10 feet) at their usual pace. The time needed to cover the specified distance is recorded using a stopwatch and entered into the CAPI instrument.
- Balance test: Respondents are asked to stand in a series of particular positions for a given amount of time; most common is a progressively difficult set of positions (side-by-side, semi-tandem, tandem). The qualitative outcome of each position is recorded (i.e., whether the respondent was able to maintain each pose).
- Chair Stand Test: First, the respondent completes a single chair stand, in which he/she stands from a seated position while keeping his/her arms folded across the chest, and returns to a seated position; the qualitative outcome of the single chair stand is recorded (e.g., respondent used arms, respondent unable to do, etc.). Second, the respondent completes five chair stands as quickly as possible; the time needed to complete five chair stands is recorded using a stopwatch.

<sup>1</sup> <http://www.healthmeasures.net/explore-measurement-systems/nih-toolbox/measure-development-and-research>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pubmed/8126356>

<sup>3</sup> <http://hrsonline.isr.umich.edu/sitedocs/userg/dr-006.pdf>

- o Cognitive recall measure. This measure involves the following four tasks:
  - Backwards Counting: Respondents are asked to count backwards starting at 20 or 86 for 10 continuous numbers.
  - Date Naming: Respondents are asked to name today's date.
  - Object Naming: Respondents are asked to answer two questions: “What do you usually use to cut paper?” and “What do you call the kind of prickly plant that grows in the desert?”
  - President/Vice President Naming: Respondents are asked to name the current President/Vice President.

These items will be administered to Community interviews conducted in the Fall round. Their addition will result in an increase of 9.5 minutes.

- Add a new section, the Chronic Pain Questionnaire (CPQ), that will be asked in the Summer round to measure chronic pain prevalence and management among Medicare beneficiaries. The Interagency Pain Research Coordinating Committee (IPRCC) is a Federal advisory committee created by the Department of Health and Human Services to enhance pain research efforts and promote collaboration across the government, with the ultimate goals of advancing the fundamental understanding of pain and improving pain-related treatment strategies<sup>6</sup>. To increase the quantity and quality of what is known about chronic pain within the U.S. population, the IPRCC created the National Pain Strategy (NPS). The NPS recommends specific steps to increase the precision of information about chronic pain prevalence overall, for specific types of pain, and in specific population groups and to track changes in pain prevalence, impact, and treatment over time in order to enable evaluation of population-level interventions and identification of emerging needs.

The NPS Interagency Working Group has addressed this emerging public health concern by developing questions to be included in federal surveys such as the National Health Interview Survey (NHIS) and other relevant federal surveys where the understanding and measurement of pain will assist researchers in developing this strategy. The Interagency Working Group developed a set of questions which will be included in a pain supplement for the 2018 NHIS (OMB clearance 0920-0214). Information on the development and testing of these items is contained in the 2018 NHIS supplements OMB clearance package. CMS has also been asked to include these questions on the MCBS to assist in the identification of and prevalence of pain in both the disabled and elderly Medicare populations, which can then be used with administrative claims data and prescription medicine data to enhance analysis. While these items have not been cognitively tested for the MCBS, the National Center for Health Statistics (NCHS) has tested and fielded these questions on the NHIS and therefore, additional cognitive testing would be resource intensive and unnecessary. Adding these questions to the MCBS as soon as possible will assist in understanding the prevalence of pain in the elderly and the disabled Medicare populations and assist in the identification of current treatment modalities for beneficiaries reporting chronic pain, including the use of opioids and alternative medical interventions.

These items will be administered to Community interviews conducted in the Summer round.

Respondents who receive the CPQ section will first be asked if they have experienced pain in the past three months. For those who respond affirmatively, they will be administered the rest of the CPQ section. For those who respond no, they will skip the

remaining CPQ section questions. This results in an increase of 1.8 minutes.

One other change in this revision is burden neutral. The sample design will be modified by reducing three Primary Sampling Units in Puerto Rico and expanding Hispanic data collection in the continental U.S. As with many federal surveys, when the survey was developed in 1991, the MCBS Hispanic sample was predominantly drawn from PSUs in Puerto Rico and Puerto Rican beneficiaries residing in the continental U.S. As the Hispanic population has changed drastically over the past 25 years, and the Puerto Rico health care system and Medicare experience is completely different from that of individuals in the continental U.S., the MCBS began an oversample of CONUS Hispanics beginning in Fall 2015 (Round 73) continuing with Fall 2018 (Round 82) to realign the Hispanic population of the survey to be consistent with the population in the continental U.S. and to allow for reliable estimates of this vulnerable elderly population. As the Puerto Rico PSUs were not self-representing, they were never designed to produce estimates for the territory of Puerto Rico. CMS had intended to stop data collection in Puerto Rico in 2018. However, with Hurricane Maria devastating the Puerto Rico infrastructure, extended periods without electricity, and the difficulty in tracking those respondents who relocated, discontinuing the Puerto Rico PSUs took place in Fall 2017 (Round 79) instead of in Fall 2018 (Round 82). The Puerto Rico PSU respondents were replaced with additional CONUS Hispanic beneficiaries by additional oversampling when releasing cases to the field, as much as possible mid-operation.

**Table A-1 summarizes the revisions requested to the Community and Facility instruments and their associated effect on burden (minutes).**

Community Deletions	Section	Winter 2019 Round 83	Summer 2019 Round 84	Fall 2019 Round 85	Total Annual
Streamlined programming	Multiple	10.0	10.0	10.0	30.0
Elimination of Address Verification and Closing Questionnaire sections	AVQ/CLQ	3.5	3.5	4.0	11.0
Elimination of Health Insurance Summary section	HIS	0.5	0.5	0.5	1.5
Elimination of Prescribed Medicine Summary section	PMS	0.7	0.7	0.7	2.1

<sup>6</sup> [Interagency Pain Research Coordinating Committee](#)

<b>Community Deletions</b>	<b>Section</b>	<b>Winter 2019 Round 83</b>	<b>Summer 2019 Round 84</b>	<b>Fall 2019 Round 85</b>	<b>Total Annual</b>
Elimination of Patient Activation section	PAQ		2.9		2.9
Eliminate 12 <sup>th</sup> interview in Summer Round (Exit panelists only)*	N/A		15.0*		15.0*
<b>Total Minutes Reduced</b>	<b>All</b>	<b>14.7</b>	<b>17.6</b>	<b>15.2</b>	<b>47.5</b>

<b>Community Additions</b>	<b>Section</b>	<b>Winter 2019 Round 83</b>	<b>Summer 2019 Round 84</b>	<b>Fall 2019 Round 85</b>	<b>Total Annual</b>
Vision/Hearing	DVH	1.2	1.2	1.2	3.6
HIV Screening Items	PVQ			0.8	0.8
Physical/cognitive measures	HFQ			9.5	9.5
Chronic Pain	CPQ		1.8		1.8
<b>Total Minutes Added</b>	<b>All</b>	<b>1.2</b>	<b>3</b>	<b>11.5</b>	<b>15.7</b>
<b>Net Effect on Community Burden</b>		<b>-13.5</b>	<b>-14.6</b>	<b>-3.7</b>	<b>-31.8</b>

\*excluded from calculations because the change only affects the exiting panel, not all respondents in the round.

<b>Facility Deletions</b>	<b>Section</b>	<b>Winter 2019 Round 83</b>	<b>Summer 2019 Round 84</b>	<b>Fall 2019 Round 85</b>	<b>Total Annual</b>
Use of Administrative Data	All			7.9	2.9
Elimination of Prescribed Medicine section	PM	15.0	15.0	10.2	13.2
<b>Total Minutes Reduced</b>	<b>All</b>	<b>0</b>	<b>0</b>	<b>18.1</b>	<b>16.2</b>

### **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. Additionally, 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, approximately 800 to 1,100 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**

CMS is revising the current longitudinal design by reducing the number of rounds respondents participate in from 12 interviews to 11 interviews. Analysis of data collected in the 12<sup>th</sup> interview revealed that this ‘exit’ interview does not provide essential cost and use information and therefore, has been eliminated.

By re-interviewing the same respondents a total of 11 times over a 3 and one-half year period, the MCBS supports longitudinal as well as cross-sectional analyses. Longitudinal data provide the basis 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. For example, the MCBS data allow us 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 that collect 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 respondent is provided with a calendar and asked to record all visits to health care providers and expenditures; they are also asked to retain all statements including private insurance, prescription drug documents and Medicare statements/bills. After the initial Baseline interview, the recall period for the MCBS is since the time of the last interview (usually not greater than four months).

In addition, the MCBS administers some sections only once a year which allows for important information to be collected, but reduces respondent burden by collecting the information less frequently.

#### **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 March 16, 2018 (83 FR 11752). 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. The 30-day Federal Register notice published on May 23, 2018 (83 FR 23916). **No comments were received.**

#### **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 to stimulate cooperation. Respondents are provided with a planner to record all health events and provider visits for easy reference during future interviews.

#### **A10. Assurances of Confidentiality Provided to Respondents**

On February 14, 2018, CMS published in the Federal Register a notice of a modified or altered System of Record (SOR) (System No. 09-70-0519). The notice was published in 83 Federal Register 6591.

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 (Attachment 2) 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 prohibitions on submitting personally identifiable information through electronic mail submission.

The Facility Advance Letter (Attachment 6), 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 6), 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 6) 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 (IAQ) to be sensitive. Also, the MCBS Income and Assets (IAQ) section 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 instrument asks for 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. In addition, there are a few questions that ask about alcohol use, obesity screening, mental health screening, and HIV testing

that some respondents might perceive as sensitive.

## A12. Estimates of Annualized Burden Hours and Costs

Table B-12a shows the estimated annual respondent burden in the current clearance. The time per response for each survey round is based on timing data from 2013.

**Table B-12a: Estimates of the Annual Respondent Burden**

	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	60 minutes	1	5,743	5,743
-Fall Round 76 Continuing Interview	90 minutes	1	9,328	13,992
-Winter Round 77 Interview	90 minutes	1	13,705	20,558
-Summer Round 78 Exit Interview	15 minutes	1	1,909	477
-Summer Round 78 Continuing Interview	90 minutes	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>	60 minutes	3	1,000	3,000
<b>Total Annual Hours</b>				60,103
<b>Total Estimate – Rounds 76-83 (3 Years)</b>				180,310

Table B-12b shows the revised estimates of the annual respondent burden, based on timing data from 2017 plus the net additions and deletions requested in this clearance request. The CAPI instrument provides interview start and end times. On average, 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 11 rounds of data collection). We currently estimate that our annual burden will be 44,165 hours for the survey.

Community Component: The Baseline interview takes about 70 minutes and is only conducted in the fall round. The Continuing interview, which is conducted each round for all respondents other than Incoming Panel respondents, averages 67 minutes in the Winter round, 75 minutes in the Summer round, and 98 minutes in the Fall round.

Facility Component: The Baseline interview takes about 60 minutes. For the Continuing interview, it takes an average of 60 minutes in the Fall round and approximately 45 minutes in the Winter and Summer round. Note that one of the revisions to this clearance is to reduce the burden for Facility interviews. For those Facilities eligible for the shorter interview by utilizing administrative data, the interview will take approximately 30 minutes to administer for the Winter and Summer round Continuing interviews and Fall round Baseline interviews, and 45 minutes for the Fall round Continuing interview. The table below includes the round designations for 2019 (Winter Round 83, Summer Round 84, and Fall Round 85).

**Table B-12b: Estimates of the Annual Respondent Burden in 2019**

	Time per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
<b>Community Rounds 83-85</b>				
- Winter Round 83 Continuing Interview	67 minutes	1	11,155	12,456
- Summer Round 84 Continuing Interview	75 minutes	1	8,611	10,764
- Fall Round 85 Baseline Interview	70 minutes	1	6,098	7,114
- Fall Round 85 Continuing Interview	98 minutes	1	6,948	11,348
<b>Field Manager follow-up with 5% of Completed Interviews</b>	5 minutes		1,640	137
<b>Facility Rounds 83-85</b>				
- Winter Round 83 Continuing Interview	45 minutes	1	1027	770
- Summer Round 84 Continuing Interview	45 minutes	1	828	621
- Fall Round 85 Baseline Interview	60 minutes	1	210	210
- Fall Round 85 Continuing Interview	60 minutes	1	450	450
- Fall Round 85 Baseline Interview for Cases with Admin Data	30 minutes	1	140	70
- Fall Round 85 Continuing Interview for Cases with Admin Data	45 minutes	1	300	225
<b>Total Annual Hours</b>				<b>44,165</b>
<b>Total Estimate – Rounds 83-91 (3 Years)</b>				<b>132,495</b>

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 2017<sup>7</sup>) and multiplied it to the Total Annual Hours for Rounds 83-85 (44,165 for a Total Annual Cost Burden in terms of dollars of roughly \$320,196.

### **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.

<sup>7</sup> <https://www.dol.gov/general/topic/wages/minimumwage>

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

FY 2019: Data collection and analysis	\$23,788,191
FY 2020: Data collection and analysis	\$23,347,008
FY 2021: Data collection and analysis	\$24,215,710

These costs include all labor hours, materials and supplies, reproduction, postage, telephone charges and indirect costs. The average cost for the FY 2019 through FY 2021 is \$23,783,636.

CMS personnel involved in MCBS include approximately 11 FTEs broken out by pay grade in Table B-14.

**Table B-14: CMS Personnel**

Grade	FTE	2018 Annual Salary	Cost to Government <sup>4</sup>
GS13 step 6	7.0	\$113,132	\$791,924
GS14 step 5	3.0	\$129,869	\$389,607
GS15 step 3	1.0	\$143,774	\$143,774
			\$1,325,305

CMS staff costs are approximately \$1,325,305. In addition, staff travel is budgeted for \$8,000. The MCBS releases its documentation as downloadable files on its public website and also on CD Rom thus eliminating its printing budget. Thus, in-house CMS cost will be \$1,333,305.

**A15. Explanation for Program Changes or Adjustments**

As noted earlier, there are new items being added to the Community instrument. For Facility data collection, administrative data will be used for certain measures and the instrument will be reduced accordingly. Most notably, the annual respondent burden for the MCBS will be reduced due to the elimination of the 12<sup>th</sup> interview for respondents completing their exit interview. These respondents will complete their exit interview during their 11<sup>th</sup> interview.

**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 83 (Winter 2019) through Round 91 (Fall 2021). See Table B-16a for data collection rounds and plans for data dissemination.

**Table B-16a: Annual schedule for information collection and dissemination beginning January 2019 - December 2021**

- 01/09/2019 Data collection starts for MCBS Round 83
- 05/08/2019 Data collection starts for MCBS Round 84
- 07/22/2019 Data collection starts for MCBS Round 85
- 01/08/2020 Data collection starts for MCBS Round 86
- 05/07/2020 Data collection starts for MCBS Round 87
- 07/21/2020 Data collection starts for MCBS Round 88
- 01/06/2021 Data collection starts for MCBS Round 89

<sup>4</sup> <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf>

05/05/2021	Data collection starts for MCBS Round 90
07/20/2021	Data collection starts for MCBS Round 91
07/15/2019	Limited Data Set available for 2017 Survey File.
10/15/2019	Limited Data Set available for 2017 Cost Supplement File.
10/15/2019	Microdata Public Use File for 2017 data.
07/15/2020	Limited Data Set available for 2018 Survey File.
10/15/2020	Limited Data Set available for 2018 Cost Supplement File.
10/15/2020	Microdata Public Use File for 2018 data.
07/15/2021	Limited Data Set available for 2019 Survey File.
10/15/2021	Limited Data Set available for 2019 Cost Supplement File.
10/15/2021	Microdata Public Use File for 2019 data.

The Survey File contains data collected directly from respondents and supplemented by administrative items plus facility (non-cost) information and Medicare Fee-for-Service claims. The Cost Supplement File contains both individual event and summary files and can be linked to the Survey File to conduct analyses on health care cost and utilization.

An MCBS Chartbook is issued with each annual release of the data by CMS. It provides the public with a collection of charts and tables presenting estimates from both the Survey File and Cost Supplement File. The current version of the Chartbook is the 2015 MCBS Chartbook - Survey File Sections, which CMS released on March 26, 2018. Beginning with data year 2015, the Chartbook will be updated annually to publicly disseminate current estimates for the Medicare population. The charts and tables in the Chartbook are cross-sectional and describe 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 within a given year. The Chartbook is intended as a reference for persons interested in using MCBS data to analyze the health and health care of the Medicare population. Most of the estimates in the Chartbook were included in the previous two sourcebook (data tables) series: the Health and Health Care of the Medicare Population, and The Characteristics and Perceptions of the Medicare Population. CMS posts the Chartbook and data tables online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables.html>. See Table B-16b below for the expected Chartbook release dates under this clearance request.

**Table B-16b: Schedule for MCBS Chartbook release dates, 2015 through 2019**

<b>Chartbook Version</b>	<b>Estimated Release Date</b> _____
2015 MCBS Chartbook- Cost Supplement File Sections	10/30/2018
2016 MCBS Chartbook- Survey File Sections	01/2/2019
2016 MCBS Chartbook- Cost Supplement File Sections	3/30/2019
2017 MCBS Chartbook- Survey File Sections	10/1/2019
2017 MCBS Chartbook- Cost Supplement File Sections	01/2/2020
2018 MCBS Chartbook- Survey File Sections	10/1/2020
2018 MCBS Chartbook- Cost Supplement File Sections	01/2/2021
2019 MCBS Chartbook- Survey File Sections	10/1/2021
2019 MCBS Chartbook- Cost Supplement File Sections	01/2/2022

**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. While field interviewers are instructed not to share their CAPI screens with the respondents during the interview, the OMB expiration date is displayed in the CAPI instrument on the first screen (introductory script and consent) and on the last screen (thank you script). CMS would like an exemption from displaying the expiration date on each screen of the Community and Facility instruments, 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.