SUPPORTING STATEMENT

Part A

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

Version: September 10, 2018

Agency of Healthcare Research and Quality (AHRQ)

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A. Justification

This request is for renewal of the OMB clearance for the data collections of the Household and Medical Provider Components of the Medical Expenditure Panel Survey (MEPS). The MEPS Household Component (MEPS-HC) and Medical Provider Component (MEPS-MPC) are two of three components of the MEPS. The total estimated annual burden hours for the MEPS have been decreased from 86,702 hours in the previous clearance to 77,666 hours in this clearance request, a decrease of 9,036 hours.

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

This request is for the MEPS-HC and MEPS-MPC only. The OMB Control Number for the MEPS-HC and MPC is 0935-0118, which was last approved by OMB on May 9, 2018, and will expire on May 31, 2019. This submission is a request for a three year extension, June 1, 2019 to May 31st, 2022.

Since the previous OMB Clearance request for the MEPS, the MEPS-HC has had a number of changes to the survey instrument itself and the survey administration in an effort to increase data quality, decrease respondent burden and to simplify instrument administration. These changes include the following (please see Attachment 1 for more details):

1) Reduce redundancy within the survey instrument
2) Eliminate questions of little analytic utility
3) Simplify respondent reporting
4) Simplify survey administration
5) Reduce cognitive burden of the respondent
6) Focus data collection on policy and research relevant data

These changes removed a small number of seldom used variables from the public use analytic files, largely those variables collecting information outside of the MEPS reference period. While we expect some reduction in public burden on account of these changes, it is too soon to estimate the impact as the streamlined administration may yield better recall and result in a little net change in burden. We will update OMB over the coming months on the impact of these changes on public burden.

The total estimated annual burden hours for the MEPS has decreased from 86,702 hours in the previous clearance to 77,666 hours in this clearance request, a decrease of 9,036 hours. This burden reduction is due to a reduction in sample size necessary to accommodate the new NHIS design while maintaining the precision level necessary for MEPS estimates.

In addition, the MEPS derives its sample from the National Health Interview Survey (NHIS) which changed its sample design and survey design in recent years. Part B discusses the impact of those changes on MEPS.

1. Circumstances that make the collection of information necessary

The mission of the Agency for Healthcare Research and Quality (AHRQ) is to produce evidence to make health care safer, higher quality, more accessible, equitable and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

AHRQ shall promote health care quality improvement by:

1. collecting data on and producing measures of the quality, safety, effectiveness, and efficiency of American health care and health care systems; and

2. fostering the development of knowledge about improving health care, health care systems, and capacity; and

3. partnering with stakeholders to implement proven strategies for health care improvement.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

2. Purpose and Use of Information

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

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

- annual estimates to track disparities in health care use and access

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

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

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

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

Given the twin problems of nonresponse and response error of some household reported data, information is collected directly from medical providers in the MEPS-MPC to improve the accuracy of expenditure estimates derived from the MEPS-HC. Because of their greater level of precision and detail, we also use MEPS-MPC data as the main source of imputations of missing expenditure data. Thus, the MEPS-MPC is designed to satisfy the following analytical objectives:

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

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

Medical Expenditure Panel Survey (MEPS) Household Component (HC)

For over thirty years, results from the MEPS and its predecessor surveys have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses and health policy.

The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment,

income, health insurance and health status over two years. The use of the NHIS as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

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

The MEPS-HC has the following goal:

- To provide nationally representative estimates for the U.S. civilian noninstitutionalized population for:
  - health care use, expenditures, sources of payment
  - health insurance coverage (annual only)
    - annual health insurance estimates are the only published MEPS health insurance estimates currently; MEPS point in time health insurance estimates were last published with 2014 MEPS data[1]
    - MEPS plans to add new health insurance verification questions based on CPS health insurance verification questions. These questions were cognitive tested in 2017.

The total estimated annual burden hours for the MEPS has decreased from 86,702 hours in the previous clearance to 77,666 hours in this clearance request, a decrease of 9,036 hours. This burden reduction is due to a reduction in sample size necessary to accommodate the new NHIS design while maintaining the precision level necessary for MEPS estimates.

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

1. **Household Component Core Instrument.** The core instrument collects data about persons in sample households. Topical areas asked in each round of interviewing include priority condition enumeration, health status, health care utilization including prescribed medicines, expenses and

[1] In 2015, ASPE convened a workgroup to compare health insurance estimates across national surveys. AHRQ, NCHS, Census and others participated in discussions over the better part of a year. My recollection is that the report was presented to the Secretary and signed by her in the middle of 2016. That report (attached) had two major recommendations for MEPS: 1) that we stop publishing point-in-time estimates (we have stopped publishing estimates although we still release the public use file for others to use); and 2) that we explore adding an insurance verification question series. The last point-in-time .insurance estimates from MEPS were published in 2014

In April of 2017, we submitted a request to do some cognitive testing of health insurance verification questions under Control Number 0935-0124. At the time, a complete evaluation of the MEPS insurance section was off the table because of cost and time. We needed to get the CAPI application into a commercial, open source product to avoid security problems and we .knew a ground-up evaluation of the health insurance section would be time consuming and costly

The CPS verification module was used as a model for the MEPS verification series in terms of both its structure and, when possible, question wording. As noted in the attached side-by-side comparison, we did need to deviate from the CPS model in .a number of places to put the questions into the context of MEPS

payments, employment, and health insurance. Other topical areas that are asked only once a year include access to care, income, assets, satisfaction with providers, and children's health. While many of the questions are asked about the entire reporting unit (RU), which is typically a family, only one person normally provides this information. All sections of the current core instrument are available on the AHRQ website at http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp (Attachments 29 to 71).

2. **Adult Self-Administered Questionnaire**. A brief self-administered questionnaire (SAQ) will be used to collect self-reported (rather than through household proxy) on health opinions and satisfaction with health care, and information on health status, preventive care and health care quality measures for adults 18 and older. The Adult Female SAQ/Adult Male SAQ (PSAQ) (Attachment 19 and 20) was not included in the previous OMB clearance package for the MEPS Household Component and Medical Provider Component but received clearance on May 9, 2018 in a subsequent OMB submission. The Adult SAQ (SAQ) has not changed from the previous MEPS Household Component and Medical Provider Component OMB submission that received clearance on December 15, 2015.

3. **Veteran SAQ**. MEPS includes a new self-administered questionnaire for spring of 2019 data collection targeting the veteran population. The questionnaire asks questions in the following domains of interest: if a veteran is eligible for VA health care; if a Veteran is enrolled in VA health care; coordination of care in and out of the VA health care system, services provided to Veterans in and out of the VA health care system, and VA eligibility priority groups, for Veterans enrolled in VA health care and for Veterans eligible for VA health care. To assist in the correct identification of priority groups, the questionnaire includes items assessing the following: presence of service-connected disability; service-connected disability rating; presence of presumptive-conditions; timing and era of active duty; and VA receipt of disability compensation benefits. AHRQ worked with the Veterans Health Administration to develop the questionnaire content (Attachment 21).

VA SAQ Consultants

Name	**Affiliation**
Leslie Hausmann, PhD	VA Pittsburgh Health Care System
Denise Hynes, PhD, RN	VA Information Resource Center, Hines, IL
Todd Wagner, PhD	VA Palo Alto Health Care System
Andrew Mulcahy, PhD	The RAND Corporation
Joseph Francis, MD, MPH	Veterans Health Administration
Carolyn Stoesen	Veterans Health Administration
Jim Schafer	Veterans Health Administration

4. **Diabetes Care SAQ**. There are no change in this instrument. A brief self-administered paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during rounds 3 and 5) to persons identified as having diabetes. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or

insulin. This questionnaire is unchanged from the previous OMB clearance (Attachments 22 and 23).

5. **Authorization forms for the MEPS-MPC Provider and Pharmacy Survey**. There is no change in this instrument. As in previous panels of the MEPS, we will ask respondents for authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies (Attachments 24 and 25).

6. **MEPS Validation Interview**. There is no change in this instrument. Each interviewer is required to have at least 15 percent of his/her caseload validated to insure that the computer assisted personal interview (CAPI) questionnaire content was asked appropriately and procedures followed, for example the use of show cards. Validation flags are set programmatically for cases pre-selected by data processing staff before each round of interviewing. Home office and field management may also request that other cases be validated throughout the field period. When an interviewer fails a validation their work is subject to 100 percent validation. Additionally, any case completed in less than 30 minutes is validated. A validation abstract form containing selected data collected in the CAPI interview is generated and used by the validator to guide the validation interview (Attachment 26).

Medical Expenditure Panel Survey (MEPS) Medical Provider Component (MPC)

The MEPS-MPC will contact medical providers (hospitals, physicians, home health agencies and institutions) identified by household respondents in the MEPS-HC as sources of medical care for the time period covered by the interview, and all pharmacies providing prescription drugs to household members during the covered time period. The MEPS-MPC is not designed to yield national estimates as a stand-alone survey. The sample is designed to target the types of individuals and providers for whom household reported expenditure data was expected to be insufficient.

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

- Dates on which medical encounters during the reference period occurred
- Data on the medical content of each encounter, including ICD-10 codes
- Data on the charges associated with each encounter, the sources paying for the medical care-including the patient/family, public sources, and private insurance, and amounts paid by each source

Data collected from pharmacies include:

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

The MEPS-MPC has the following goal:

- To serve as an imputation source for and to supplement/replace household reported expenditure and source of payment information.

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

1. **MPC Contact Guide/Screening Call.** There is no change in this instrument. An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS-MPC, the appropriate MEPS-MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of these seven provider types in the MEPS-MPC, except for the two home care provider types which use the same screening form (Attachments 72 to 77).

2. **Home Care Provider Questionnaire for Health Care Providers.** There is no change in this instrument. This questionnaire is used to collect data from home health care agencies which provide medical care services to household respondents. Information collected includes type of personnel providing care, hours or visits provided per month, and the charges and payments for services received. Some HMOs may be included in this provider type (Attachment 78).

3. **Home Care Provider Questionnaire for Non-Health Care Providers.** There is no change in this instrument. This questionnaire is used to collect information about services provided in the home by non-health care workers to household respondents because of a medical condition; for example, cleaning or yard work, transportation, shopping, or child care (Attachment 82).

4. **Medical Event Questionnaire for Office-Based Providers.** There is no change in this instrument. This questionnaire is for office-based physicians, including doctors of medicine (MDs) and osteopathy (DOs), as well as providers practicing under the direction or supervision of an MD or DO (e.g., physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff model HMOs are included (Attachment 83).

5. **Medical Event Questionnaire for Separately Billing Doctors.** There is no change in this instrument. This questionnaire collects information from physicians identified by hospitals (during the Hospital Event data collection) as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital (Attachment 87).

6. **Hospital Event Questionnaire.** There is no change in this instrument. This questionnaire is used to collect information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the hospital; doctors that do bill separately from the hospital will be contacted as part of the Medical Event Questionnaire for Separately Billing Doctors. HMOs are included in this provider type (Attachment 91).

7. **Institutions Event Questionnaire.** There is no change in this instrument. This questionnaire is used to collect information about institution events, including nursing homes, rehabilitation facilities and skilled nursing facilities. Institution data are collected not only from the billing

department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay. In many cases, the institution's administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the institution itself. Some HMOs may be included in this provider type (Attachment 96).

8. **Pharmacy Data Collection Questionnaire.** There is no change in this instrument. This questionnaire requests the NDC and when that is not available the prescription name, strength and form as well as the date prescription was filled, payments by source, the quantity, and person for whom the prescription was filled. When the NDC is available, we do not ask for prescription name, strength or form because that information is embedded in the NDC; this reduces burden on the respondent. Most pharmacies have the requested information available in electronic format and respond by providing a computer generated printout of the patient's prescription information. If the computerized form is unavailable, the pharmacy can report their data to a telephone interviewer. Pharmacies are also able to provide a CD-ROM with the requested information if that is preferred. HMOs are included in this provider type (Attachment 98).

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

This study is being conducted by AHRQ through its contractors, Westat and RTI International, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the cost and use of health care services and with respect to health statistics and surveys. 42 U.S.C. 299a(a)(3) and (8); 42 U.S.C. 299b-2.

3. Use of Improved Information Technology

As in previous panels of the MEPS-HC, a CAPI instrument will be used (except the SAQs). Beginning in 2018, a new, modernized CAPI instrument was used for data collection. Programmed in Version 4.8 of Blaise commercial off the shelf (COTS), the new instrument is designed to streamline administration of the CAPI interview, simplify the response task for both the respondent and interviewer, and increase respondent reporting while maintaining or reducing costs (Attachment 1). The mode of administration for the MEPS-MPC (including the pharmacy component) varies based on the preferences of the provider and includes phone interviews, mail and electronic submission of information. Starting with the 2009 MEPS-MPC data collection, a computer-assisted system was developed for both interviewing and record abstraction. This Integrated Data Collection System (IDCS) supported the effort to recruit providers by telephone and to interview medical records and billing staff of medical facilities. For providers that prefer to send hard copy records, the IDCS is used to abstract information from medical records and patient accounts. The IDCS consists of two main systems: 1) a Web component in ASP.Net in which the MEPS-MPC forms (Contact Guides and Event Forms) are programmed for either data entry either during telephone calls or record abstraction and 2) a Case Management System (CMS) that manages the medical providers and associated forms for call scheduling, contact information, appointment times, and event/status information. More recently, to reduce burden for providers the MPC has begun offering data transfer options such as downloading record files through secure File Transfer Protocol (FTP), and has implemented a secure email process for encrypted record files. A secure web portal for submission of authorization forms to point of contact (POCs) and for POCs to provide records back to data collectors has also been developed.

4. Efforts to Identify Duplication

There is no other survey that is now or has been recently conducted that will meet all of the objectives of the MEPS. Some federal surveys do collect health insurance information from households (Survey of Income and Program Participation, NHIS); however these surveys do not collect the depth of information on health care use and expenses available in the MEPS.

5. Involvement of Small Entities

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

6. Consequences if Information Collected Less Frequently

The design of the MEPS-HC in which households are contacted 5 times over the course of 2 years enables the gathering of medical use data at the event level and permits the estimation of expenditures and payments for persons by event type. Reducing the number of rounds in which the data are collected would hamper the availability and quality of information due to long recall periods. MEPS-MPC respondents are contacted at least once during the calendar year for the preceding data collection year. Sometimes a follow up contact is necessary to clarify ambiguous or collect missing information. Contacts on a less frequent basis than the envisioned timetable jeopardizes the access of the study to information from records that could otherwise be destroyed or archived.

7. Special Circumstances

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

8. Federal Register Notice and Outside Consultations

8.a. Federal Register Notice

As required by 5 CFR 1320.8(d), notices were published in the Federal Register on June 4th, 2018, for 60 days (see Attachment 105) and again September 4th, 2018 on page 44877 for 30 days. No substantive comments were received.

8.b. Outside Consultations

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

Table 1. MEPS Consultants

Name	Affiliation
Stephen Blumberg, Ph.D.	National Center for Health Statistics, Division of Health Interview Statistics
J. Michael Brick, Ph.D.	Westat
Ralph DiGaetano, Ph.D.	Westat
Hongji Liu, Ph.D.	Westat
Roger Tourangeau, Ph.D.	Westat

Ting Yan, Ph.D.	Westat

9. Gifts/Payments to Respondents

MEPS-HC respondents will be offered a monetary incentive as a token of appreciation for their participation in the MEPS. An incentive has been offered to respondents at the end of each round since the inception of MEPS in 1996; the current amount of $50 per round has been in place since 2011 (OMB approval obtained January 26, 2010 version 1). For household respondents, participation includes not only time being interviewed, but also keeping track of their medical events and expenditures between interviews. Household respondents will be informed of the incentive at the first in-person contact and all eligible respondents will be given the same amount. No incentive will be offered to respondents to the Adult SAQs, Diabetes Care SAQ, or Veteran SAQ.

10. Assurance of Confidentiality

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

11. Questions of a Sensitive Nature

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

12. Estimates of Annualized Burden Hours and Costs

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS-HC and the MEPS-MPC.

The MEPS-HC Core Interview will be completed by 13,338* (see note below Exhibit 1) "family level" respondents, also referred to as RU respondents. Since the MEPS-HC consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS-HC core requires an average response time of 92 minutes to administer. The Adult Female SAQ (PSAQ) and Adult SAQ (SAQ) will be completed once a year by each female person in the RU that is 18 years old and older, an estimated 12,984 persons (Attachment 20 and Attachment 18). The Adult Male SAQ (PSAQ) and Adult SAQ (SAQ) will be completed once a year by each male person in the RU that is 18 years old and older, an estimated 11,985 persons (Attachment 19 and Attachment 18). The Adult SAQs each require an average of 7 minutes to complete. The Diabetes care SAQ will be completed once a year by each person in the RU identified as having diabetes, an estimated 2,072 persons, and takes about 3 minutes to complete. The Veteran SAQ will be completed once by each in-scope person who is a veteran of the U.S. military identified in the Round 1, Panel 24; Round 3, Panel 23; and Round 5, Panel 22 interviews, an estimated 1,350 persons. The Veteran SAQ requires an average of 15 minutes to complete. The authorization form for the MEPS-MPC Provider Survey will be completed once for each medical provider seen by any RU member. The 12,804 RUs in the MEPS-HC will complete an average of 5.4 forms, which require about 3 minutes each to complete. The authorization form for the MEPS-MPC Pharmacy Survey will be completed once for each pharmacy for any RU member who has obtained a prescription medication.

RUs will complete an average of 3.1 forms, which take about 3 minutes to complete. About one third of all interviewed RUs will complete a validation interview as part of the MEPS-HC quality control, which takes an average of 5 minutes to complete. The total annual burden hours for the MEPS-HC are estimated to be 60,278 hours.

All medical providers and pharmacies included in the MEPS-MPC will receive a screening call and the MEPS-MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 2 to 19 minutes to complete. The total annual burden hours for the MEPS-MPC are estimated to be 17,388 hours. The total annual burden for the MEPS-HC and MPC is estimated to be 77,666 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS-HC is estimated to be $1,467,167; the annual cost burden for the MEPS-MPC is estimated to be $298,580. The total annual cost burden for the MEPS-HC and MPC is estimated to be $1,765,746.

The MEPS-MPC interviewer will be authorized to offer remuneration to providers who present cost as a salient objection to responding or if a flat fee is applied to any request for medical or billing records. Based on the past cycle of data collection fewer than one third of providers will request remuneration. Exhibit 3 shows the total and average per record remuneration by provider type, based on the 2016 data collection, the most recent year for which data is available. For those providers that required remuneration the average payment per medical record was $37.80, this compares to $32.98 in 2010.

Exhibit 1. Estimated annualized burden hours

Form Name	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
MEPS-HC				
MEPS-HC Core Interview	13,338*	2.5	92/60	51,129
Adult Female SAQ (PSAQ) - Years 2019 and 2021; Adult SAQ (SAQ) - Year 2020	12,984	1	7/60	1,515
Adult Male SAQ (PSAQ) - Years 2019 and 2021; Adult SAQ (SAQ) -Year 2020	11,985	1	7/60	1,398
Diabetes care SAQ	2,072	1	3/60	104
Veteran SAQ	1,350	1	15/60	338
Authorization form for the MEPS-MPC Provider Survey	12,804	5.4	3/60	3,457
Authorization form for the MEPS-MPC Pharmacy Survey	12,804	3.1	3/60	1,985
MEPS-HC Validation Interview	4,225	1	5/60	352
Subtotal for the MEPS-HC	71,562	na	na	60,278
				MEPS-MPC
MPC Contact Guide/Screening Call**	36,598	1	2/60	1,220

Home care for health care providers questionnaire	635	1.53	9/60	146
Home care for non-health care providers questionnaire	11	1	11/60	2
Office-based providers questionnaire	11,210	1.65	10/60	3,083
Separately billing doctors questionnaire	12,397	3.46	13/60	9,294
Hospitals questionnaire	5,310	3.26	9/60	2,597
Institutions (non-hospital) questionnaire	116	2.05	9/60	36
Pharmacies questionnaire	6,919	2.92	3/60	1,010
Subtotal for the MEPS-MPC	73,196	na	na	17,388
Grand Total	144,758	na	na	77,666

* While the expected number of responding units for the annual estimates is 12,804, it is necessary to adjust for survey attrition of initial respondents by a factor of 0.96 (13,338=12,804/0.96).
** There are 6 different contact guides; one for office based, separately billing doctor, hospital, institution, and pharmacy provider types, and the two home care provider types use the same contact guide.

The total estimated annual burden hours for the MEPS has decreased from 86,702 hours in the previous clearance to 77,666 hours in this clearance request, a decrease of 9,036 hours. This burden reduction is due to a reduction in sample size necessary to accommodate the new NHIS design while maintaining the precision level necessary for MEPS estimates.

Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate	Total Cost Burden
MEPS-HC				
MEPS-HC Core Interview	13,338	51,129	$24.34*	$1,244,480
Adult Female SAQ (PSAQ) - Years 2019 and 2021; Adult SAQ (SAQ) - Year 2020	12,984	1,515	$24.34*	$36,875
Adult Male SAQ (PSAQ) - Years 2019 and 2021; Adult SAQ (SAQ) -Year 2020	11,985	1,398	$24.34*	$34,027
Diabetes care SAQ	2,072	104	$24.34*	$2,531
Veteran SAQ	1,350	338	$24.34*	$8,227
Authorization forms for the MEPS-MPC Provider Survey	12,804	3,457	$24.34*	$84,143
Authorization form for the MEPS-MPC Pharmacy Survey	12,804	1,985	$24.34*	$48,315
MEPS-HC Validation Interview	4,225	352	$24.34*	$8,568
Subtotal for the MEPS-HC	71,562	60,278	na	$1,467,167

MEPS-MPC				
MPC Contact Guide/Screening Call	36,598	1,220	$ 17.25**	$ 21,045
Home care for health care providers questionnaire	635	146	$ 17.25**	$ 2,519
Home care for non-health care providers questionnaire	11	2	$ 17.25**	$ 35
Office-based providers questionnaire	11,210	3,083	$ 17.25**	$ 53,182
Separately billing doctors questionnaire	12,397	9,294	$ 17.25**	$ 160,322
Hospitals questionnaire	5,310	2,597	$ 17.25**	$ 44,798
Institutions (non-hospital) questionnaire	116	36	$ 17.25**	$ 621
Pharmacies questionnaire	6,919	1,010	$ 15.90***	$ 16,059
Subtotal for the MEPS-MPC	73,196	17,388	na	$298,580
Grand Total	144,758	77,666	na	$1,765,746

* Mean hourly wage for All Occupations (00-0000)
** Mean hourly wage for Medical Secretaries (43-6013)
*** Mean hourly wage for Pharmacy Technicians (29-2052)
Occupational Employment Statistics, May 2017 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics.
https://www.bls.gov/oes/current/oes_nat.htm#b29-0000

Exhibit 3. Total and Average Remuneration by Provider Type for the MEPS-MPC

Provider Type	Number of Records with Payment	Average Payment	Total Remuneration
Hospital	1,718	$ 43.99	$ 75,575
Office Based Providers	678	$ 33.88	$ 22,971
Institutions	1	$ 63.71	$ 64
Home Care Provider (Health Care Providers)	4	$ 78.50	$ 314
Home Care Provider (Non-Health Care Providers)	0	$0	$0
Pharmacy	10,305	$ 35.69	$ 367,785
Separately Billing Doctors	412	$ 70.60	$ 29,087
Total MPC	13,118		$ 495,796

13. Estimates of Annualized Respondent Capital and Maintenance Costs

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

14. Estimates of Annualized Cost to the Government

Exhibit 4 shows the total and annualized cost of this information collection. The cost associated with the design and data collection of the MEPS-HC and MEPS-MPC is estimated to be $51,382,086 in each of the three years covered by this information collection request. Exhibits 5 and 6 show the total and annualized cost of MEPS-HC and MEPS-MPC oversight, respectively.

Exhibit 4. Estimated Total and Annualized Cost

Cost Component	Total Cost	Annualized Cost
Sampling Activities	$2,393,808	$ 797,936
Interviewer Recruitment and Training	$9,338,400	$3,112,800
Data Collection Activities	$103,713,948	$34,571,316
Data Processing	$13,621,824	$4,540,608
Production of Public Use Data Files	$14,353,020	$4,784,340
Project Management	$10,725,258	$3,575,086
Total	$154,146,258	$51,382,086

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

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management Support: GS-15, Step 5 average	2	$152,760	50.0%	$152,760
Survey/Statistical Support: GS-14, Step 5 average	3	$129,869	33.3%	$129,869
Research Support: GS-13, Step 5 average	4	$109,900	50.0%	$219,800
Research Support: GS-12, Step 5 average	2	$92,421	75.0%	$138,632
Total				$641,061

Exhibit 6: Annual Cost to AHRQ for MEPS-MPC Oversight

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management Support: GS-15, Step 5 average	2	$152,760	33.3%	$101,840
Survey/Statistical Support: GS-14, Step	2	$129,869	50.0%	$129,869

5 average				
Research Support: GS-13, Step 5 average	1	$109,900	50.0%	$54,950
Research Support: GS-12, Step 5 average	1	$92,421	33.3%	$30,807
Total				$317,466

Annual salaries based on 2018 OPM Pay Schedule for Washington/DC area:
https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf

15. Changes in Hour Burden

The total estimated annual burden hours for the MEPS have been decreased from 86,702 hours in the previous clearance to 77,666 hours in this clearance request, a decrease of 9,036 hours. This burden reduction is due to a reduction in sample size necessary to accommodate the new NHIS design while maintaining the precision level necessary for MEPS estimates.

16. Time Schedule, Publication and Analysis Plans

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

To the extent possible we have endeavored to release public use files from this project as soon as possible.

17. Schedule for Data Collection

Data collection for the MEPS under this request begins in early January 2019. Rounds 1, 3, and 5 of the MEPS-HC start in January and continue through mid-July. Rounds 2 and 4 begin in July of each year and continue through early December. Data collection for the MEPS-MPC will begin in February 2019.

18. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments:

Attachment 1 – MEPS-HC Section Summary and Changes
Attachment 2 – HC Why is Participation in MEPS so Important?
Attachment 3 – HC MEPS: A Survey of Health Care Use and Spending
Attachment 4 – HC What MEPS tells us about…Charts
Attachment 5 – HC About the MEPS-MPC Authorization Form
Attachment 6 – HC Data protection is word ONE with MEPS
Attachment 7 – HC Respondent Recruitment Video
Attachment 8 – HC Important Information About Your Participation in MEPS

Attachment 9 – HC MEPS Data Example & FAQs
Attachment 10 – HC Respondent Letters, Postcards and Notes
Attachment 11 – HC MEPS FAQs Brochure
Attachment 12 – HC MEPS Monthly Planner
Attachment 13 – HC MEPS Record Keeper
Attachment 14 – HC Showcards
Attachment 15 – HC Validation Letter
Attachment 16 – HC Certificate of Appreciation
Attachment 17 – HC Who Uses MEPS Data
Attachment 18 – HC Adult SAQ (SAQ) – Your Health and Health Opinions
Attachment 19 – HC Adult SAQ – Male (PSAQ) – Your Health and Health Choices
Attachment 20 – HC Adult SAQ – Female (PSAQ) – Your Health and Health Choices
Attachment 21 – HC Veteran SAQ
Attachment 22 – HC Diabetes SAQ – Proxy
Attachment 23 – HC Diabetes SAQ – Self
Attachment 24 – HC Authorization Form for the MEPS-MPC – Pharmacy
Attachment 25 – HC Authorization Form for the MEPS-MPC – Provider
Attachment 26 – HC MEPS Validation Interview Form
Attachment 27 – HC MEPS Tip Sheet
Attachment 28 – HC Tips for Making Your MEPS Interview Easier
Attachment 29 – HC Access to Care Section
Attachment 30 – HC Event Enumeration Section
Attachment 31 – HC Assets Section
Attachment 32 – HC Calendar Section
Attachment 33 – HC Additional Healthcare Section
Attachment 34 – HC Closing Section
Attachment 35 – HC Start/Re-start Section
Attachment 36 – HC Charge Payment Section
Attachment 37 – HC Flat Fee Section
Attachment 38 – HC Child Preventive Health Supplement Section
Attachment 39 – HC Institutional Care Section
Attachment 40 – HC Dental Care Section
Attachment 41 – HC Event Driver Section
Attachment 42 – HC Employment (EM) Section
Attachment 43 – HC Review of Employment Information (RJ) Section
Attachment 44 – HC Employment Driver (OE) Section
Attachment 45 – HC Employment Wage (EW) Section
Attachment 46 – HC Emergency Room Section
Attachment 47 – HC Event Roster Section
Attachment 48 – HC Health Status Section
Attachment 49 – HC Help Text
Attachment 50 – HC Home Health Section
Attachment 51 – HC Health Insurance (HX) Section
Attachment 52 – HC Private Health Insurance Detail (HP) Section
Attachment 53 – HC Time Covered Detail (HQ) Section
Attachment 54 – HC Managed Care (MC) Section
Attachment 55 – HC Old Employment Health Insurance (OE) Section

Attachment 56 – HC Old Public Related Insurance (PR) Section
Attachment 57 – HC Hospital Stay Section
Attachment 58 – HC Income Section
Attachment 59 – HC Medical Provider Section
Attachment 60 – HC Other Medical Expense Section
Attachment 61 – HC Outpatient Department Section
Attachment 62 – HC Quality (Priority Conditions) Supplement Section
Attachment 63 – HC Respondent Forms Section
Attachment 64 – HC Priority Conditions Enumeration Section
Attachment 65 – HC Prescribed Medicines Section
Attachment 66 – HC Provider Probes Section
Attachment 67 – HC Provider Roster Section
Attachment 68 – HC Reenumeration Subsection A
Attachment 69 – HC Reenumeration Subsection B
Attachment 70 – HC RU Information Screener
Attachment 71 – HC Event Follow Up Section
Attachment 72 – MPC Hospital Contact Guide
Attachment 73 – MPC Office-Based Doctor Contact Guide
Attachment 74 – MPC Home Care Contact Guide
Attachment 75 – MPC Institution Contact Guide
Attachment 76 – MPC Pharmacy Contact Guide
Attachment 77 – MPC Separate Billing Doctor Contact Guide
Attachment 78 – MPC Home Care Provider Questionnaire for Health Care Providers
Attachment 79 – MPC Home Care Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 80 – MPC Home Care Provider Authorization Form Package, Records to be provided via Fax Anticipated
Attachment 81 – MPC Home Care Provider Overflow Patient List
Attachment 82 – MPC Home Care Provider Questionnaire for Non-Health Care Providers
Attachment 83 – MPC Office-Based Doctor Provider Questionnaire
Attachment 84 – MPC Office-Based Doctor Provider Authorization Form Package, Records to be provided via Fax Anticipated
Attachment 85 – MPC Office-Based Doctor Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 86 – MPC Office-Based Doctor Provider Overflow Patient List
Attachment 87 – MPC Separately Billing Doctor Provider Questionnaire
Attachment 88 – MPC Separately Billing Doctor Provider Authorization Form Package, Records to be provided via Fax Anticipated
Attachment 89 – MPC Separately Billing Doctor Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 90 – MPC Separately Billing Doctor Provider Overflow Patient List
Attachment 91 – MPC Hospital Provider Questionnaire
Attachment 92 – MPC Hospital Provider Authorization Form Package, One Point of Contact for Medical and Patient Account Records
Attachment 93 – MPC Hospital Provider Authorization Form Package, Point of Contact for Medical Records

Attachment 94 – MPC Hospital Provider Authorization Form Package, Point of Contact for Patient Account Records
Attachment 95 – MPC Hospital Provider Overflow Patient List
Attachment 96 – MPC Institution Provider Questionnaire
Attachment 97 – MPC Letters, Email Templates, and Other Documents
Attachment 98 – MPC Pharmacy Provider Questionnaire
Attachment 99 – MPC Pharmacy Provider Authorization Form Package, Records to be provided via Fax Anticipated
Attachment 100 – MPC Pharmacy Provider Authorization Form Package, Phone Data Collection Anticipated
Attachment 101 – MPC Pharmacy Provider Overflow Patient List
Attachment 102 – MPC Durable Medical Equipment Provider Authorization Form Package
Attachment 103 – MPC Pharmacy Provider Letters, Email Templates, and Other Documents
Attachment 104 – MPC Veterans Affairs Authorization Form Package
Attachment 105 – 60 Day Federal Register Notice