

**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 26 years, encompassing over 1 million interviews with more than 100,000 survey participants. Respondents participate in up to 11 interviews over a four 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 September 2021. However, CMS is requesting a revision to the clearance now in order to implement improvements beginning in Winter 2020 with the Round 86 interviews. These changes will add new measures that will either capture more accurate data or close key data gaps.

#### ***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://CMS Research Statistics Data and Systems MCBS bibliography 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, alcohol use, home care, disability trends, treatments for dementia, depression, beneficiary knowledge, informal assistance, use of durable medical equipment, and falls. 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 the existing MCBS clearance, which will extend the collection for an additional three years as a result. 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 a slight decrease in respondent burden as compared to the current clearance due to fewer projected completed cases each round starting in 2020. The reduced number of completed interviews is due to slightly fewer completes from the past three years, which then continue to impact completes in future rounds due to the longitudinal nature of the survey. The current OMB clearance projects an annual respondent burden of 44,165 hours and this revision brings the annual respondent burden down to 42,610 hours. The changes in estimated annual respondent burden are summarized 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.

While the result of implementing all 2020 revisions will result in a net reduced annual respondent burden due to slightly fewer completed interviews per round, this revision requests additions to the Community interview starting in Winter round 2020. The revisions themselves amount to an average of 6.2 minutes to the Community instrument annually (including estimated time for interviewers to provide further help if a respondent asks for more information in order to respond). The average time per response per round is based on actual timing data from 2017 plus the 6.2 minutes needed for the new questions. Because the median minutes per round was decreased in 2017, adding these new questions (and taking into account the 6.2 minutes to administer them) will not result in a longer interview. The actual timing data in 2017 was shorter for multiple reasons including highly experienced and productive interviewers, continued improvements and efficiencies in survey administration (such as skip patterns that result in varying lengths of interviews dependent on the respondent's health status and costs of care), and the continued improvement in the speed of the CAPI instrument. In this case, adding several new questions to the survey does not result in a net longer interview. The proposed additions are described below:

- Revise Beneficiary Knowledge and Information Needs (KNQ) to add five questions on review of existing insurance coverage and comparison of available Medicare plans. These items will be administered to Community interviews only in the Winter round. This change will result in an increase of 1.3 minutes for the Winter round. The items ask whether the respondent reviewed their insurance coverage during the last open enrollment period to see if there were any expected changes in monthly premiums, deductibles, and other expenses; whether they reviewed their insurance to see if the treatment and services covered their needs; whether they compared their plan with other plans that are available; and the different types of Medicare plans they may have compared. These items are being added to obtain information on cost transparency for the CMS Administrator's initiative, and were developed by the CMS Office of Communications. CMS has used the items on insurance review and plan comparisons on the CMS Open Enrollment Survey.

- Revise the Usual Source of Care Questionnaire (USQ) to add two care coordination and patient centered care items. These items will be administered to Community interviews only in the Winter round. This change will result in an increase of 0.4 minutes for the Winter round (including estimated time for interviewers to provide clarifying information that might be requested by the respondent). The Center for Medicare and Medicaid Innovation (CMMI) has a number of models in operation and in planning stages that could benefit from knowing how many beneficiaries are currently receiving coordinated care and to be able to track these trends overtime. CMMI models incentivize care coordination, patient centered care, and team-based care. While CMMI collects information on these efforts through focus groups with beneficiaries and patient experience surveys, there are no figures on the overall receipt of coordinated care across Medicare beneficiaries (those within and outside of CMMI models) with which to compare to.
- Revise USQ to add one item on innovative provider health care initiatives. This item will be administered to Community interviews only in the Winter round. This change will result in an increase of 0.5 minutes for the Winter round including estimated time for interviewers to provide clarifying information that might be requested by the respondent. Respondents will be asked whether their healthcare provider is associated with an innovative health care initiative such as an accountable care organization or a patient centered medical home. The goal of the item is to measure provider communication about innovative model participation, i.e., whether the provider told the respondent that they are part of an innovative model at a visit, or to measure beneficiary knowledge of providers' innovative model participation, i.e., whether the respondent knows if their provider participates, irrespective of where they got the information. CMS will use this item to track awareness of Medicare beneficiaries about their participation in an innovative health care initiative over time. As these concepts get picked up by providers, health systems, and other payers beyond CMMI/Medicare, CMS thinks it would be useful to understand the frequency of encountering this type of care model among the general Medicare population. Similarly, we do not have global estimates of the number of beneficiaries already receiving care from providers participating in alternative payment models or other value-based care delivery programs. As the number of alternative payment models being tested by CMMI continues to increase (as well as among other payers), CMS believes it would be useful to measure beneficiary awareness within one of these models and track this information over time for operational and model planning purposes.
- Revise USQ to add eleven electronic health records (EHR) items and remove one existing EHR item from KNQ. These items will be administered to Community interviews only in the Winter round. This change will result in an increase of 2.7 minutes for the Winter round. CMS is executing an agency-wide initiative to reduce clinician burden, with a goal of improving the processes and experiences of care for clinicians and beneficiaries. An identified source of clinician burden is attributed to the use of the Electronic Health Record (EHR). Feedback from clinician and beneficiary stakeholders asserts that the clinician's task-driven attention to the EHR during the patient visit impairs the quality and therefore the effectiveness of clinician-patient engagement. Starting in Winter 2020, the MCBS will add eleven items to USQ to measure provider use of computers and EHRs.
- Revise Preventive Care Questionnaire (PVQ) to add one wellness benefit item. This item will be administered to Community interviews only in the Fall round. This change will

result in an increase of 0.8 minutes for the Fall round. In 2006, Medicare introduced the “Welcome to Medicare” preventive visit as a one-time service for newly-enrolled beneficiaries, as well as the “Annual Wellness Visit”, a yearly office visit focused on preventive health. Both services are provided at no cost to patients. However, these Medicare prevention and wellness benefits are not as widely used by older Americans as they could be; in 2013, only 6.8% of new Medicare enrollees took advantage of the Welcome to Medicare visit<sup>1</sup>, and in 2014, approximately 16% of Medicare recipients had an Annual Wellness Visit; only an estimated 7% of Medicare beneficiaries receive all recommended preventive services. The U.S. Department of Health and Human Services established improving the rates of the Welcome to Medicare visits as an important *Healthy People 2020* objective. To monitor utilization of this benefit, the MCBS will add one question to the Fall round interview, beginning in Fall 2020, to ask respondents whether they received either the Welcome to Medicare or Annual Wellness Visit in the past 12 months. Results from this item will be used by CMS to compare the uptake of this benefit and identify messaging strategies needed to encourage beneficiaries to use the benefit.

- Add two oral health items to PVQ. These items will be administered to Community interviews only in the Fall round. This change will result in an increase of 0.3 minutes for the Fall round. Poor oral health is often a source of chronic pain and can lead to depression and other social and emotional conditions. It also leads to other health complications including heart and lung disease and stroke. Tooth loss can lead to issues with nutrition, digestion, communication, additional oral bone loss and can be a determinant of overall health status. Beginning in Fall 2020, the MCBS will address this health concern by including new items on oral health. The items will be asked annually as part of the Fall round interview. Respondents will be asked whether they have ever had an exam for oral cancer in which the doctor or dentist pulls on their tongue. If they answer “yes”, they will be asked if the oral exam took place within the past year, 1 to 3 years ago, or more than 3 years ago. In subsequent Fall rounds, Baseline respondents will be asked if they “ever” had an exam for oral cancer while Continuing respondents will be asked if they had an exam for oral cancer since the date of the last Fall round interview. Only Baseline respondents will be asked the follow-up item on when the oral exam took place, since the time period for the exam for Continuing respondents will be assumed to have taken place since the last Fall round interview. These items are taken from the CDC’s National Health and Nutrition Examination Survey (NHANES) where they are asked
- Add one oral health item to Health Functioning and Status Questionnaire (HFQ). This item will be administered to Community interviews only in the Fall round. This will result in an increase of 0.2 minutes for the Fall round. Respondents will be asked whether they have lost all their upper and lower permanent teeth as part of HFQ in the Fall data collection round. This item is asked as part of the adult National Health Interview Survey (NHIS). Respondents who report having lost all their teeth will not receive the question in subsequent Fall rounds.

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<sup>1</sup> U.S. Department of Health and Human Services. Healthy people 2020: older adults. Washington, DC: US Department of Health and Human Services; 2016. <https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-C31-OA.pdf>.

In brief, these changes support the goals of CMS and will close important data gaps as summarized below:

- Beneficiary Knowledge and Information Needs (KNQ) to add five questions on review of existing insurance coverage and comparison of available Medicare plans. They will provide CMS information about changes in key beneficiary metrics over time, specifically access to and satisfaction with Medicare programs.
- Revise the Usual Source of Care Questionnaire (USQ) to add two care coordination and patient centered care items and one item on innovative provider health care initiatives. These questions will provide information on the Medicare beneficiary population that is not available in CMS administrative data that helps to evaluate or report on characteristics associated with beneficiaries treated in innovative payment and service delivery models.
- Revise the Usual Source of Care Questionnaire (USQ) to add 11 Electronic Health Records items will provide information on Medicare beneficiary population that is not available in CMS administrative data that helps to evaluate or report on an agency-wide initiative to reduce clinician burden, with a goal of improving the processes and experiences of care for clinicians and beneficiaries.
- Revise the Preventive Care Questionnaire (PVQ) to add a wellness question that will support Healthy People goals and provide a measure of beneficiary participation in this important benefit.
- Provide two Oral Health Items to the Preventive Care Questionnaire (PVQ) and one Oral Health Item to HFQ to provide information about changes in key beneficiary metrics over time, specifically access to and satisfaction to oral health. Oral health is tied to overall health; numerous programs at CMS promote oral health and these questions will close a gap in measurement of access to and satisfaction to oral health as well as oral health status.

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

**Table A-1: Burden Associated with Revisions to Community Instrument**

<b>Community Additions</b>	<b>Section</b>	<b>Winter 2020 Round 86</b>	<b>Summer 2020 Round 87</b>	<b>Fall 2020 Round 88</b>	<b>Total Annual Increase</b>
Cost Transparency Initiative	KNQ	1.3	-	-	1.3 minutes
Care Coordination and Patient Centered Care	USQ	0.4	-	-	0.4 minutes
Innovative Provider Health Care Initiatives	USQ	0.5	-	-	0.5 minutes
Electronic Health Records (EHR) items	USQ	2.7	-	-	2.7 minutes
Wellness Benefit	PVQ	-	-	0.8	0.8 minutes
Oral Health items	PVQ	-	-	0.3	0.3 minutes
Oral Health item	HFQ	-	-	0.2	0.2 minutes
<b>Total Minutes Added</b>		<b>4.9 minutes</b>	<b>-</b>	<b>1.3 minutes</b>	<b>6.2 minutes</b>
<b>Net Effect Increase in Community Burden</b>					<b>6.2 minutes</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 facility staff.

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

As part of the currently approved clearance, CMS revised the longitudinal design in 2018 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 did not provide essential cost and use information and therefore, was eliminated.

By re-interviewing the same respondents a total of 11 times during a four 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 planner and asked to record all visits to health care providers and health care expenditures; they are also asked to retain all statements including private insurance documents, 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 January 31, 2019 (84 FR 731). 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 was published on April 16, 2019 (84 FR 15617). 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. The Income and Assets (IAQ) section also 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 estimates of the annual respondent burden, based on timing data from 2017 plus the net additions 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). In addition to being a longitudinal panel survey, the MCBS design calls for one panel to be retired during each winter round, and a new panel selected to replace it each fall round. Response rates per round and annually are carefully monitored and reviewed to determine the size of the next Incoming Panel. The size of the new panel is designed to provide a stable number of respondents across all panels participating in the survey annually and this size changes annually depending on prior year response rates and the number of active participants still engaged in the survey. Annually, the projected number of completes changes which in turn, changes the estimated burden since burden is derived both from the length of the interview and the total number of respondents that complete an interview. Mostly, the estimated number of completes changes based on the response rates of prior rounds; it also changes based on the sample size of the new Incoming Panel that is selected each Fall; the size of the Incoming Panel minimally fluctuates depending on resources and the attrition of other panels in the field. Thus, beginning in January 2020, we currently estimate that our annual burden will be 42,610 hours for the survey, 1,555 hours less than the estimate in the current clearance. This is not based on a shorter interview but rather, is based on fewer respondents estimated to complete the interview in 2020. .

Community Component: While the requested revisions to this clearance amount to an average increase of 6.2 minutes to the Community interview annually, the time per response (based on actual timing data plus the 6.2 minutes for the new questions) still comes to the same estimated time per response. As mentioned earlier, this is due to multiple reasons including highly experienced and productive interviewers, as well as continued improvements and efficiencies in survey administration (including skip patterns and taking into account that the health status and reporting of health events varies annually depending on the composition of the panels) and the speed of the CAPI instrument. In this case, adding several new questions to the Community

interview does not result in a net longer interview. We do project slightly fewer completed interviews over the next three years, resulting in a net reduction in overall burden, as indicated in Table B-12a below. The reduced number of completed interviews is due to slightly fewer Community and Facility completed interviews compared to the past three years, which then continue to impact the expected number of completed interviews in future rounds due to the longitudinal nature of the MCBS.

The Baseline interview takes about 70 minutes and is only conducted in the fall round and only with respondents from the Incoming Panel. 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. These estimates are unchanged from the currently approved clearance.

**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. 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 2020 (Winter Round 86, Summer Round 87, and Fall Round 88). These estimates are unchanged from the currently approved clearance.

**Table B-12a: Estimates of the Annual Respondent Burden in 2020**

	<b>Time per Response</b>	<b>Number of Interviews</b>	<b>Expected Number of Completed Interviews Per Round</b>	<b>Burden Hours</b>
<b>Community Rounds 86-88</b>				
- Winter Round 86 Continuing	67 minutes	1	11,071	12,363
- Summer Round 87 Continuing	75 minutes	1	8,020	10,025
- Fall Round 88 Baseline Interview	70 minutes	1	5,749	6,707
- Fall Round 88 Continuing Interview	98 minutes	1	6,888	11,250
<b>Field Manager follow-up with 5% of Completed Interviews</b>	5 minutes		1,586	132
<b>Facility Rounds 86-88</b>				
- Winter Round 86 Continuing	45 minutes	1	951	713
- Summer Round 87 Continuing	45 minutes	1	714	536
- Fall Round 88 Baseline Interview	60 minutes	1	202	202
- Fall Round 88 Continuing Interview	60 minutes	1	409	409
- Fall Round 88 Baseline Interview for Cases with Admin	30 minutes	1	135	68

- Fall Round 88 Continuing Interview for Cases with Admin	45 minutes	1	273	205
<b>Total Expected Number of Completed Interviews</b>			<b>35,998</b>	
<b>Total Annual Hours</b>				<b>42,610</b>
<b>Total Estimate – Rounds 86-94 (3 Years)</b>				<b>127,831</b>

Table B-12b below shows the estimated changes in burden between the currently approved clearance and the proposed revisions to the clearance. As indicated above, while the requested revisions to this clearance amount to an average increase of 6.2 minutes to the Community interview annually, the time per response in this clearance is unchanged from the prior clearance. Even though the new questions contained in this clearance are estimated to take 6.2 minutes to administer, actual timing data from 2017 revealed that the total interview time had dropped by 6 minutes; hence, adding these questions does not add time to the interview length. The estimated decrease in annual burden from 44,165 hours to 42,610 hours is due to fewer projected completed interviews per round over the next three years. Response rates per round and annually are carefully monitored and reviewed to determine the size of the next Incoming Panel to replace the retiring panel. The size of the new panel is designed to provide a stable number of respondents across all panels participating in the survey annually and this size changes annually depending on prior year response rates and the number of active participants still engaged in the survey.

**Table B-12b: Changes in Annual Respondent Burden: Currently Approved Clearance and Proposed Revisions to Clearance**

	<b>Expected Number of Completed Interviews in 2019 (Currently Approved Clearance)</b>	<b>Expected Number of Completed Interviews in 2020 (Revisions to Clearance)</b>	<b>2019 Annual Burden Hours (Currently Approved Clearance)</b>	<b>2020 Annual Burden Hours (Revisions to Clearance)</b>	<b>Net Change in Annual Burden Hours (from 2019 as currently approved to projected hours in 2020)</b>
<b>Community Rounds</b>					
- Winter Round Continuing Interview	11,155	11,071	12,456	12,363	-93
- Summer Round Continuing Interview	8,611	8,020	10,764	10,025	-739
- Fall Round Baseline Interview	6,098	5,749	7,114	6,707	-407
- Fall Round Continuing Interview	6,948	6,888	11,348	11,250	-98

<b>Field Manager follow-up with 5% of Completed Interviews</b>	1,640	1,586	137	132	-5
<b>Facility Rounds</b>					
- Winter Round Continuing Interview	1027	951	770	713	-57
- Summer Round Continuing Interview	828	714	621	536	-85
- Fall Round Baseline Interview	210	202	210	202	-8
- Fall Round Continuing Interview	450	409	450	409	-41
- Fall Round Baseline Interview for Cases with Admin Data	140	135	70	68	-2
- Fall Round 88 Continuing Interview for Cases with Admin Data	300	273	225	205	-20
<b>Total Annual</b>	<b>37,407</b>	<b>35,998</b>	<b>44,615</b>	<b>42,610</b>	<b>-1555 hours</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 2018<sup>2</sup>) and multiplied it to the Total Annual Hours for Rounds 86-88 (42,610), for a Total Annual Cost Burden in terms of dollars of roughly \$308,924.

**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>2</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 2020: Data collection and analysis: \$23,347,008  
 FY 2021: Data collection and analysis: \$24,215,710  
 FY 2022: Data collection and analysis: \$24,215,710<sup>3</sup>

These costs include all labor hours, materials and supplies, reproduction, postage, telephone charges and indirect costs. The average cost for the FY 2020 through FY 2022 is \$488,053.

CMS personnel involved in MCBS include approximately 12 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	4.0	\$129,869	\$519,476
GS15 step 5	1.0	\$152,760	\$152,760
			\$1,464,160

CMS staff costs are approximately \$1,464,160. 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 \$1,472,160.

**A15. Explanation for Burden Changes (Program Adjustments)**

As noted earlier, there are new items being added to the Community instrument; however, fewer completed interviews per round are projected, resulting in a net reduction in burden. The MCBS design calls for one panel to be retired during each winter round, and a new panel selected to replace it each fall round. Response rates per round and annually are carefully monitored and reviewed to determine the size of the next Incoming Panel. The size of the new panel is designed to provide a stable number of respondents across all panels participating in the survey annually and this size changes annually depending on resources available, prior year response rates and the number of active participants still engaged in the survey. The goal of the MCBS is to produce for each calendar year a MCBS Cost Supplement File with a target size between 9,000 and 11,000 responding beneficiaries. The number of beneficiaries in the file varies from year to year because it is comprised of 4 years of panels participating in the survey – attrition, death, and loss of Medicare eligibility all impact response rates and projections of completed interviews. The estimated number of completed annual interviews for this clearance is lower than in the currently approved clearance. As a result, the total burden has decreased to 42,610 from the previously approved total burden of 44,165.

<sup>3</sup> This amount will change depending on the next contract award expected in December 2021.

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

### **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 86 (Winter 2020) through Round 94 (Fall 2022). See Table B-16a for data collection rounds and plans for data dissemination.

**Table B-16a: Annual schedule for information collection and dissemination, January 2020 - December 2022**

#### Data collection schedule

01/08/2020	Data collection starts for Winter 2020 Round 86
05/07/2020	Data collection starts for Summer 2020 Round 87
07/21/2020	Data collection starts for Fall 2020 Round 88
01/06/2021	Data collection starts for Winter 2021 Round 89
05/05/2021	Data collection starts for Summer 2021 Round 90
07/20/2021	Data collection starts for Fall 2021 Round 91
01/06/2022	Data collection starts for Winter 2022 Round 92
05/07/2022	Data collection starts for Summer 2022 Round 93
07/20/2022	Data collection starts for Fall 2022 Round 94

#### Data dissemination schedule

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.
07/15/2022	Limited Data Set available for 2020 Survey File.
10/15/2022	Limited Data Set available for 2020 Cost Supplement File.
10/15/2022	Microdata Public Use File for 2020 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 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. CMS regularly posts the Chartbook and data tables online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables.html>.

***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), as displayed in Attachment 7. 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.