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, Medicaid payments and eligibility, and Medicare Advantage encounter records) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for nearly 30 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' health care use, charges, insurance coverage, and payments over time. Respondents are asked about their sources of health care coverage and payment, their demographic and housing characteristics, their health and work history, and their experiences and perceptions of quality with their health care system.

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 11th 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 August 31, 2022. However, CMS is requesting a revision to the clearance now in order to implement improvements beginning in Winter 2021 with the Round 89 interviews. These changes will add a few 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 utilization and patterns of usual care over time, 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. The bibliography is available at CMS MCBS Bibliography.

- 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 found in annual bibliographies of MCBS data 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; bibliographies by year can be found at CMS MCBS Bibliography.

Requested Revisions to Currently Approved Collection:

This is a request to revise the existing MCBS clearance beginning in 2021, which will extend the collection for an additional three years as a result. This revised clearance request includes several changes to the Community Baseline and Continuing instruments; there are no revisions proposed to Facility. When implemented, the revision to this OMB package will result in a slight increase in respondent burden as compared to the current clearance. The new questions are projected to add 8.9 minutes to the Community questionnaire each year starting in 2021. The current OMB clearance projects an annual respondent burden of 42,610 hours and this revision brings the annual respondent burden to 44,573 hours. The changes in estimated annual respondent burden are summarized in Table B-12 (under section A12 below). All of these changes are described below and are referred to in Supporting Statement, Part B as well.

The proposed additions are described below:

- Revise the Beneficiary Knowledge and Information Needs Questionnaire (KNQ) to add items on the use of the internet for health care related information and access. Beneficiaries will be asked about the use of the internet to renew a prescription, schedule an appointment with a health care provider, or communicate with a health care provider. These items are being added for programmatic considerations within CMS regarding streamlining and access to beneficiary's own health data as well as online Medicare enrollment/re-enrollment. As more health providers and plans are driving the consumer to the internet, it is important to understand how it may be a barrier for Medicare beneficiaries. The KNQ is only administered in the Winter round. The items will be administered to respondents who say they use the internet directly or seek the help of a friend or relative to use the internet. The questions were taken from the National Health Interview Survey. This change to the KNQ will result in an increase of 0.7 minutes for the Winter round.
- Revise the Health Status and Functioning Questionnaire (HFQ) to add five items on the self-management of chronic conditions. Over 65 percent of Medicare beneficiaries have two or more chronic conditions. The Department of Health and Human Services' *Framework for Addressing Multiple Chronic Conditions* recognizes the importance of self-management in preventing and managing multiple chronic conditions. The MCBS survey currently asks questions about self-management of diabetes but does not ask a parallel series for other chronic conditions. In addition, the survey does not have questions that ask about the presence or utilization of community supports for beneficiaries who report having chronic conditions. Therefore, there is currently no systematic way to measure how much self-management or self-management support is occurring among Medicare beneficiaries. To fill this measurement gap, the Centers for Medicare & Medicaid Innovation (CMMI), in consultation with the Centers for Disease Control and Prevention, collaborated on a new set of self-management measures that would be administered to respondents who report a chronic condition. Because these items were new, CMS undertook cognitive testing before requesting approval to implement on the MCBS; note that the cognitive testing was conducted under the MCBS Generic Clearance, 0938-1275. The HFQ is only administered in the Fall round. This change to the HFQ will result in an increase of 1.1 minutes for the Fall round.
- Add five items about malnutrition to the HFQ, including three items about the use of dietary supplements and two items about unintentional weight loss. These questions will provide useful information to CMS as well as the National Institutes of Health, Office of Dietary Supplements (NIH-ODS) on the prevalence of dietary supplement use in the Medicare population, which has a very high use of supplements as well as of prescription and over-the-counter drugs, raising risks of drug-supplement interactions[1]. The inclusion of these items will also allow for the assessment of how dietary supplement use changes over time and provide an opportunity to examine associations between dietary supplement use and health outcomes. Two questions on malnutrition will help to better assess the prevalence of unintentional weight loss, a major component of frailty. This

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[1] Gahche, J.J., et al., *Dietary Supplement Use Was Very High among Older Adults in the United States in 2011-2014.* J Nutr, 2017. **147**(10): p. 1968-1976.

information combined with other data from Medicare records will allow researchers to assess the prevalence of unintentional weight loss and its association with adverse health outcomes in this population. These data can also be used to assess if malnutrition is documented in Medicare records and potentially the associations between treatment for malnutrition and improvement in health outcomes. The three items about dietary supplements are from the US National Health and Nutrition Examination Survey (NHANES) and the National Institutes of Health, National Cancer Institute, Diet History Questionnaire (DHQ) Versions I and III; the two questions on malnutrition (undernutrition) screening were taken from the Canadian Nutrition Screening Tool (CNST). These HFQ items will be administered only in the Fall round. This change will result in an increase of 1.7 minutes for the Fall round.

- Revise the Physical Measures Questionnaire (PXQ)[2] to include measures of grip strength for the right and left hands. Grip strength is a key measure of overall muscle strength in older adults, and tests of grip strength have been linked to health-related prognoses[3]. Low grip strength has been associated with falls, disability, length of hospital stays, and mortality[4]. In the grip strength test, a dynamometer is used to measure the amount of force the respondent is able to apply with each hand. These measures are the cornerstone of screeners for frailty such as the Fried frailty phenotype assessment[5]and will allow for more definitive identification of physical frailty in the MCBS. The MCBS will incorporate the NIH-Toolbox (NIH-TB) protocol for measuring grip strength. The protocol will be administered to Baseline Community interviews only in the Fall round and will be administered to Continuing Community interviews only in the Summer round. This change will result in an increase of 2.7 minutes for the Fall round and 2.8 minutes for the Summer round.

In brief, these changes support the goals of CMS and will close important data gaps.

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

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[2] Physical measures items in the PXQ were migrated from HFQ into their own questionnaire section for ease of administration and data processing. PXQ now contains five previously approved physical measures that were part of the HFQ. They are gait speed, balance, sit/stand, and measured height and weight. Separating these questions into a new questionnaire section did not result in any increase in burden.

[3] Sasaki H, Kasagi F, Yamada M, and Fujita S. 2007. “Grip Strength Predicts Cause-Specific Mortality in Middle-Aged and Elderly Persons.” The American Journal of Medicine, 120: 337-342.

[4] Roberts HC, Denison HJ, Martin HJ, Patel HP, Syddall H, Cooper C, Sayer AA. 2011. “A Review of the Measurement of Grip Strength in Clinical and Epidemiological Studies: Towards a Standardised Approach. Age and Ageing, 40(4):423-429. doi: 10.1093/ageing/afr051

[5] Fried, L.P., et al., *Frailty in older adults: evidence for a phenotype.* J Gerontol A Biol Sci Med Sci, 2001. **56**(3): p. M146-56.

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

Community Additions	Section	Winter 2021 Round 89	Summer 2021 Round 90	Fall 2021 Round 91	Total Annual Increase
Internet Use for Health Information	KNQ	0.7	-	-	0.7 minutes
Self-Management of Chronic Conditions: Courses/Classes	HFQ	-	-	1.1	1.1 minutes
Malnutrition Items	HFQ	-	-	1.7	1.7 minutes
Measured Grip Strength	PXQ	-	2.8	2.7	5.4 minutes
Total Minutes Added		**0.7 minutes**	**2.8 minutes**	**5.5 minutes**	**8.9 minutes**
Net Effect Increase in Community Burden					**8.9 minutes**

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). In cases where an in-person interview cannot be conducted, interviewers are permitted to administer the survey by phone using their laptop. 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 displays questions with identical question stems and response options in a grid-style format instead of displaying each question on separate screens.

e. 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.

f. CAPI allows instantaneous calculations to be made, such as the amount remaining to be paid on a medical bill after totaling several payments.

g. CAPI allows for the instrument to be pre-loaded with responses recorded from previous data collection rounds and from administrative records to reduce respondent burden and provide for more accurate reporting of subsequent responses.

h. Interviewers use the computer to electronically transmit completed cases to the central office, and the central office uses automated management processes to balance interviewer caseload in order to provide for data collection efficiency in the field.

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 who collect data on beneficiaries living in facilities 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 by utilizing as much administrative data as possible to streamline the data collection process.

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 12th 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 calendar 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 14, 2020 (85 FR 2137). 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 (CMS.gov/MCBS).

(Research Statistics Data and Systems MCBS). 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, 20, 2020 (85 FR 21858).

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 calendar 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:

> "…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).
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> 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 the projected number of completed interviews per round and the estimated length of each interview (including the net additions requested in this clearance). 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. In January 2021, we currently estimate that our annual burden will be 44,573 hours for the survey, 1,963 hours more than the estimate in the current clearance. This burden estimate reflects an addition to the survey of 8.9 minutes per respondent in 2021.

Table B-12: Estimates of the Annual Respondent Burden in 2021

	Time per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Community Rounds 89-91				
- Winter 2021 Round 89 Continuing Interview	68 minutes	1	11,071	12,547
- Summer 2021 Round 90 Continuing Interview	80 minutes	1	8,020	10,693
- Fall 2021 Round 91 Baseline Interview	78 minutes	1	5,749	7,474
- Fall 2021 Round 91 Continuing Interview	101 minutes	1	6,888	11,595
Field Manager follow-up with 5% of Completed Interviews	5 minutes		1,586	132
Facility Rounds 89-91				
- Winter 2021 Round 89 Continuing Interview	45 minutes	1	951	713
- Summer 2021 Round 90 Continuing Interview	45 minutes	1	714	536
- Fall 2021 Round 91 Baseline Interview	60 minutes	1	202	202
- Fall 2021 Round 91 Continuing Interview	60 minutes	1	409	409

	Time per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
- Fall 2021 Round 91 Baseline Interview for Cases with Admin Data	30 minutes	1	135	68
- Fall 2021 Round 91 Continuing Interview for Cases with Admin Data	45 minutes	1	273	205
Total Expected Number of Completed Interviews Annually			**35,998**	
Total Annual Burden Hours				**44,573**
Total Estimated Burden Hours – Rounds 89-97 (3 Years)				**133,719**

Below provides a summary of the burden change from the current clearance.

Total annual burden hours – previous clearance	42,610
Total annual burden hours – new clearance	44,573
Total annual burden hours - difference	1,963

CMS also notes that a multiyear Content Evaluation Program has begun. A key objective of this effort is to identify ways that burden can be reduced. We anticipate that future revisions will also include reductions to the survey content in order to offset burden increases.

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 2019[6]) and multiplied it to the Total Annual Hours for Rounds 89-91 (44,573), for a Total Annual Cost Burden in terms of dollars of roughly $323,154.

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

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

A14. Annualized Costs to the Federal Government

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

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

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[6] https://www.dol.gov/general/topic/wages/minimumwage

FY 2021: Survey development, operations, processing and analysis: $24,215,710

FY 2022: Survey development, operations, processing and analysis: $24,215,710[7]

FY 2023: Survey development, operations, processing and analysis: $24,215,710[7]

These costs include all labor hours, materials and supplies, reproduction, postage, telephone charges and indirect costs. The average cost for the FY 2021 through FY 2023 is approximately $72,647,130.

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	2019 Annual Salary	Cost to Government[8]
GS13 step 6	7.0	$115,699	$809,893
GS14 step 5	4.0	$132,818	$531,272
GS15 step 5	1.0	$156,228	$156,228
			$1,497,393

CMS staff costs are approximately $1,497,393. 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 which are estimated to add 8.9 minutes to the Community questionnaire each year starting in 2021. As a result, the total burden has increased to 44,573 from the previously approved total burden of 42,610. This is a net increase of 1,963 burden hours annually.

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 89 (Winter 2021) through Round 97 (Fall 2023). See Table B-16a for data collection rounds and plans for data dissemination.

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[7] Amounts for FY 2022 and FY 2023 will change depending on available funds.

[8] https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf

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

Data collection schedule

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
01/08/2023	Data collection starts for Winter 2023 Round 95
05/07/2023	Data collection starts for Summer 2023 Round 96
07/21/2023	Data collection starts for Fall 2023 Round 97

Data dissemination schedule

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.
07/15/2023	Limited Data Set available for 2021 Survey File.
10/15/2023	Limited Data Set available for 2021 Cost Supplement File.
10/15/2023	Microdata Public Use File for 2021 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. The Microdata Public Use File (PUF) includes data related to Medicare beneficiaries' access to care, health status, other information regarding beneficiaries’ knowledge of, attitudes toward, and satisfaction with their health care, as well as demographic data and information on all types of health insurance coverage. Disclosure protections have been applied to the PUF, including de-identification and other methods. CMS posts the PUF online at CMS MCBS Public Use File.

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 CMS MCBS Data Tables.

An MCBS Early Look is issued with each annual release of the Survey File Limited Data Set by CMS. It presents preliminary estimates for demographics and selected health status and functioning, access to care, and satisfaction with care measures relevant to the community-dwelling Medicare population in advance of the MCBS Survey File release. CMS posts the Early Look online at CMS MCBS Data Briefs.

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.