

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 a nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by CMS and directed by the Office of Enterprise Data and Analytics (OEDA). Interviews are usually conducted in-person using computer-assisted personal interviewing (CAPI); however, conducting interviews by phone is also permitted on the MCBS and has been since its origin.

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.

Impact of the 2020 Public Health Emergency on the MCBS

On January 31, 2020, the Secretary of the Department of Health and Human Services, determined that a Public Health Emergency (PHE) exists for the United States to aid the nation's healthcare community in responding to the novel "severe acute respiratory syndrome coronavirus 2" ("SARS-CoV-2") virus and the disease it causes, "coronavirus disease 2019" ("COVID-19"); this determination was most recently renewed on January 21, 2021¹.

¹ <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>

Older people and people of all ages, apparently due to the strength of their immune systems and the likelihood of severe chronic medical conditions — like heart disease, lung disease and diabetes, for example — seem to be at higher risk of developing serious COVID-19 illness². With the emergence of the COVID-19 pandemic in the U.S., CMS implemented a number of changes to the MCBS to ensure the health and safety of both respondents and field interviewers while continuing data collection. These changes which were submitted to OMB for clearance (see below), included pausing in-person data collection in both community and facility settings. Field interviewers have conducted MCBS interviews by telephone since that time.

The current plan is to continue administering the MCBS by phone until at least April 30, 2021 when the Winter 2021 Round 89 ends. At least some phone administration will likely continue into Summer 2021 Round 90 and Fall 2021 Round 91, depending upon the course of the pandemic. Because MCBS respondents are at elevated risk for more severe COVID-19 complications, even after a vaccine is available CMS may continue survey administration by phone for a period of time. Nearly all sections of the MCBS questionnaire can continue to be administered by phone. CMS continues to monitor potential impacts on survey operations and data quality via comprehensive analyses of paradata and response patterns from data collected via phone in 2020 (see Supporting Statement B for more information). Thus far, phone administration has not had an impact on data dissemination plans. However, physical measures (including measured height, weight, sit/stand, balance, gait speed, and grip strength) cannot be implemented over the phone and will be on hold until in-person interviewing resumes.

When in-person interviewing resumes, field interviewers will be provided with essential personal protective equipment. These include face coverings, face shields, gloves, shoe coverings, sanitizer fluids and wipes. They will also be trained on social distancing, hand washing and proper sanitization procedures to use.

Advance mail materials have been developed for interviews conducted in person as well as interviews conducted by phone. They are included in Attachment 2 for Community and Attachment 6 for Facility.

Addition of COVID-19 measures to the MCBS

The following summarizes MCBS data collected to date on COVID-19.

MCBS Generic Clearance 0938-1275

On May 7, 2020, OMB approved CMS-10549 GenIC#7 MCBS COVID-19 Rapid Response Supplement Testing under the MCBS Generic Clearance (0938-1275). The field test was conducted with MCBS respondents living in the community from June 10 to July 15, 2020. The data were collected in parallel with the MCBS Summer 2020 Round 87 production. The first goal of the field test was to determine whether conducting a standalone supplemental interview simultaneous to main MCBS data collection would be successful, both in terms of response to the supplement and not causing harm to the main MCBS data collection. The findings presented a strong case for utilizing standalone supplemental interviews to meet urgent policy issues such as COVID-19. The total sample size for the Summer 2020 COVID-19 Supplement Test was 14,332 cases. Of these, 11,114 sampled beneficiaries were interviewed; the calculated overall

² Centers of Disease Control and Prevention. “People at Increased Risk for COVID-19”. Updated Nov. 30, 2020. Available from: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html>

response rate was 78.9 percent, calculated using the guidelines specified in the American Association for Public Opinion Research (AAPOR) and OMB.

The second goal of the field test was to assess the performance of the COVID-19 items via regular monitoring of interview timings, content frequencies, interviewer feedback, and a limited number of observations. Findings demonstrated that the questions worked as intended, the burden was slightly less than estimated, and the flow and administration by phone was smooth. CMS released data from the supplement in a special public use file (PUF) in October 2020³. These data will also be provided to users as part of a MCBS 2019 Limited Data Set scheduled for release in summer 2021. Results from the field test are also included in Attachment 8; data users may also be interested in documentation about the test described in the PUF Data User's Guide found on the CMS MCBS website⁴.

MCBS Emergency Clearance 0938-1379

Based on the initial success of the items and methodology used in the Summer 2020 COVID-19 Supplement, CMS then requested OMB approval to continue COVID-19 Supplement collection in Fall 2020 Round 88. The items and methodology included in the Fall 2020 COVID-19 Supplement were mostly the same as those used by the COVID-19 Supplement Test (0938-1275), with two main differences. First, some terminology and questions were changed to align with other Federal surveys or to meet additional needs of CMS and Centers for Disease Control and Prevention (CDC) collaborators (see full crosswalk of changes in Attachment 9). Additionally, the Fall 2020 request expanded the data collection to MCBS respondents living in long term care facilities. Through an emergency clearance, OMB approved CMS' request on August 7, 2020 (0938-1379, expiration 02/28/2021). The emergency clearance also specified CMS' intention to continue collection of these data into 2021 with the submission of a revision to the main MCBS clearance package (0938-0568). Collection of the Fall COVID-19 Supplement began October 5, 2020 and ended December 31, 2020. For the portion of the sample living in the community, a total of 9,686 sampled beneficiaries were interviewed during the field period, with a calculated overall response rate of 72.6 percent. CMS released data from the Fall 2020 Community COVID-19 Supplement in a special PUF in January 2020⁵. Both the community and facility data will also be released as part of a MCBS 2020 Limited Data Set scheduled for release in summer 2022.

MCBS Main Clearance (0938-0568)

This current request revises the main MCBS clearance (0938-0568) to add the COVID-19 questions to the MCBS beginning in Winter 2021. As described in the above section, results from the Summer 2020 COVID-19 Supplement Test were used to inform modifications to the COVID-19 questions fielded in the Fall 2020 COVID-19 Supplement to align with other Federal surveys and meet the additional needs of CMS and CDC collaborators (see Attachment 9). Data collection was also expanded to assess the impact of the pandemic on facilities serving Medicare beneficiaries. Based on preliminary monitoring of interview timings, content frequencies, and

³ Available from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MCBS-Public-Use-File>

⁴ Available from: <https://www.cms.gov/files/document/2020mcbscovidpufsummerdug.pdf>

⁵ Available from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MCBS-Public-Use-File>

interviewer feedback from the Fall 2020 COVID-19 Supplement, all items appear to be performing well and were consistent with the Summer 2020 COVID-19 Supplement test. For CMS to continue collecting these data in 2021, it is necessary for CMS to submit this request to revise the main MCBS clearance to add the COVID-19 questions. Since the Winter 2021 Round is conducted from January through April, 2021, the latest the Winter 2021 COVID-19 Supplement can commence fielding is March 1, 2021. OMB approval is needed by February 11, 2021 to finalize instrument programming. Therefore, the COVID-19 questions included in this package are the same as those approved by OMB in an emergency clearance request (0938-1379) on August 7, 2020 for administration in Fall 2020 Round 88.

This request also includes three new questions to add to the MCBS – two to the Housing Characteristics Questionnaire (HAQ) and one new question to the Health Status and Functioning Questionnaire (HFQ). And, it includes a one-time request to administer the COVID-19 items in Winter 2021 to a separate cohort of Medicare beneficiaries aligned to a provider that participates in the Next Generation Accountable Care Organization (NextGen ACO) Model.

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. Within CMS, there is also collaboration with the CMS Office of Minority Health to improve MCBS survey measures used to track social risk factors and health disparities.

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.

In addition, while developing the COVID-19 questions, CMS reviewed multiple surveys underway covering various dimensions of the COVID-19 pandemic. CMS consulted with

the National Center for Health Statistics to align some of the proposed questions with the RANDS COVID-19 items (0920-1298) and the National Health Interview Survey (0920-0214). We also reviewed the Census Bureau's Household Pulse Survey (0607-1013) and the Data Foundation's COVID Impact Survey ([available at https://www.covid-impact.org/](https://www.covid-impact.org/)).

- 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 primarily includes adding COVID-19 questions to the Community and Facility instruments. Adding the COVID-19 questions increases the burden by 15 minutes per round; the timing was borne out in the first fielding of these questions in Summer 2020 (approved by OMB on May 7, 2020 under the generic clearance 0938-1275) and is the same as the burden identified in the Fall 2020 COVID-19 supplement (approved by OMB on August 7, 2020 under emergency clearance 0938-1379). In addition, three new questions, only asked in the fall round, are planned which will add 1 minute of burden to the fall round of data collection. The current OMB clearance projects an annual respondent burden of 44,363 hours and this revision brings the annual respondent burden to 54,426 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:

- Add the COVID-19 questions to the Community and Facility instruments. With the emergence of the COVID-19 pandemic in the U.S., CMS was uniquely positioned to quickly collect vital information on how the pandemic is impacting the Medicare population by utilizing the MCBS. MCBS beneficiaries, are at elevated risk for more severe COVID-19 complications. Since the MCBS has a sample size sufficient for estimation, it provides a ready source to obtain high quality data on this important population. Administrative records, such as Fee for Service (FFS) claims and Medicare Advantage Encounter data, only collect information about actual health care utilization and cost related to COVID-19 (i.e., services rendered and received by the beneficiaries). These administrative records do not provide data about care not received or offered or the ability of the beneficiaries to receive such services by particular service delivery methods. The impact of COVID-19 on the lives of Medicare beneficiaries, such as

availability of telehealth services among their providers, the ability to receive telehealth services by the beneficiaries, deferred medical care due to the pandemic, and consequences for their behavior and well-being cannot be measured by the administrative records. The collected information allows CMS to assess the impact of forgone care, the differential impact of new ways of delivering services to beneficiaries, as well as what services may not be offered by their providers. MCBS collects information on all types of healthcare, not just care covered by Medicare in order to measure the full cost and impact of healthcare delivery system changes on the beneficiary. Additionally, administrative data do not have detailed covariates to understand the differential impact of COVID-19 on minority and disadvantaged/low income populations. On August 7, 2020, CMS received emergency OMB approval (0938-1379) for COVID-19 items to be administered by telephone during Fall 2020 Round 88 as a Supplement to the main MCBS. Previously, these items were tested in Summer 2020 under CMS-10549 GenIC#7 MCBS COVID-19 Rapid Response Supplement Testing, which was approved by OMB on May 7, 2020 under the MCBS Generic Clearance (0938-1275). The methods and questionnaires used for the Fall COVID-19 Supplement were mostly the same as those used in the COVID-19 Supplement Test with two main differences: (1) some terminology and questions were changed to align with other Federal surveys or to meet additional needs of CMS and CDC collaborators and (2) some questions have been added for Facility administration. Please refer to Attachment 9 for a full crosswalk of changes documenting the differences from the Summer 2020 COVID-19 Supplement to the Fall 2020 COVID-19 Supplement items.

As indicated in the justification to the emergency clearance, starting in Winter 2021 Round 89, CMS plans to continue fielding the COVID-19 items each round in the Community and Facility instruments, as long as it is relevant to do so, depending on the trajectory of the pandemic. As with other questionnaire sections, the Community and Facility COVID-19 questions will be contained in a COVID-19 Questionnaire (CVQ) and will contain parallel items tailored to each data collection setting. For the CVQ in the Community questionnaire, the questionnaire content will be specific to the impact of COVID-19 on the respondent's life, such as availability of telehealth, deferred medical care, COVID-19 testing and health consequences, and the impact of the pandemic on their behavior and well-being. Working with the Centers for Disease Control and Prevention (CDC), questions about vaccine uptake or likelihood of getting a vaccine have also been added. These items include important data points, such as dosage and dates of vaccination receipt, which are not covered by COVID-19 vaccination items found on other Federal surveys, such as the Census Bureau's Household Pulse Survey⁶. Further, comprehensive COVID-19 vaccination data for a representative sample of the Medicare population are not available from claims data. Fielding these items via the MCBS allows for the collection of comprehensive, representative COVID-19 vaccination estimates that can be analyzed alongside other key covariates released in the MCBS Limited Data Set files and Public Use File. Inclusion of questions on the MCBS about the month/year date of COVID-19 vaccination and number of doses received will allow evaluation of series completion by detailed race/ethnicity and other sociodemographic and health care access

⁶ Available from: https://www2.census.gov/programs-surveys/demo/technical-documentation/hhp/Phase3_Questionnaire_01_06_21_English.pdf

related factors not available with the doses administered data provided by vaccinators to states or CDC or with the CMS administrative FFS claims and MA encounter data. COVID-19 vaccine providers are required to report limited sociodemographic information (i.e., age, sex, race/ethnicity), but reporting of race/ethnicity is incomplete or missing, and other sociodemographic factors such as income and health care access is only available on the MCBS. The collection of these data points on the MCBS allows for evaluation of the association of COVID-19 vaccination with a much broader set of sociodemographic and health care access variables than would be available with Medicare administrative data. Additionally, having data on timing of vaccination will help in pooling data over time for more detailed analysis. Addressing inequities in COVID-19 vaccination administration is a priority as outlined in the new administration's COVID-19 national strategy⁷.

For the COVID-19 Questionnaire administered in facility interviews, the questionnaire content includes several facility-level measures covering the following topics: suspension of health services (both covered and non-covered Medicare services including vision, hearing, and dental services); use of telemedicine; measures to prevent and control the spread of COVID-19 at the facility; changes in staffing and providers; and efforts to address mental health and loneliness among residents. These topics were requested by CMS' Chief Medical Officer to assess key ways in which COVID-19 has impacted facilities that serve Medicare beneficiaries; this information is not available from other sources, particularly since they encompass facility-level metrics that cannot be assessed by individual-level data sources such as claims data. Further, while some information about COVID-19 infections, COVID-19 testing, and personal protective equipment and hand hygiene supplies at facilities are required by the National Healthcare Safety Network (NHSN), this information is not redundant with items asked in the MCBS COVID-19 Supplement. The NHSN reporting requirements only apply to nursing homes and do not include other facility types, such as assisted living facilities. MCBS Facility data collection encompasses any facility type where MCBS beneficiaries may reside, including both Medicare-certified nursing homes and non-Medicare-certified assisted living facilities, group homes, etc. which are not required to report COVID-19 information to the NHSN⁸. There are also several beneficiary-level topics, similar to the community questionnaire: COVID-19 testing and treatment; services with additional provider types due to COVID-19 diagnosis; CDC COVID-19 vaccine items; and mental health (e.g., Patient Health Questionnaire or PHQ-9). As is always done on the MCBS, facility data collection is conducted with facility staff knowledgeable about the facility's protocols and the beneficiary's health status.

In Winter 2021, CMS plans to leverage the MCBS data collection infrastructure to administer the COVID-19 items to a separate cohort of Medicare beneficiaries participating in a new type of accountable care organization (ACO) model launched by CMS in 2016, called the Next Generation ACO Model (NGACO Model). The Model seeks to provide enhanced care coordination to beneficiaries aligned with a NGACO provider. Prior to the outbreak of COVID-19, the NGACO Model offered ACOs

⁷ Available from <https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf>

⁸ Additional information available from: <https://www.cdc.gov/nhsn/pdfs/covid19/lctf/cms-covid19-req-508.pdf>

flexibility in delivering telehealth services through the Telehealth Expansion Waiver from 2016 and onwards, making it the first shared savings model to do so. Other CMS Innovation Center models offered telehealth expansion waivers for specific episodes of care alone while for shared savings ACO models in CMS' Pathways to Success, telehealth expansion was offered from the beginning of 2020. ACOs also are familiar with their enrollees from the beginning of the year, and use population health strategies to proactively manage these beneficiaries' health. These population health management strategies include data analytics (to identify and target those with high-risk of hospitalizations) and care management (to address their patients' care needs). While the main MCBS sample includes ACO enrollees, administering the COVID-19 items in parallel to the main MCBS sample and a separate cohort of the NGACO population will enhance CMS' ability to analyze differences for these two populations in a timely, comparable way for a variety of outcomes related to the COVID-19 pandemic. With care coordination and increased access to telehealth among the goals of the NGACO Model, the COVID-19 items present an opportunity to assess its success on those fronts. Further, these items provide an opportunity to descriptively compare experiences of beneficiaries in organizations with years of experience with care coordination and telehealth (such as NGACOs) with the experiences of beneficiaries in Fee for Service Medicare. Because COVID-19 items will be administered to a representative cohort, results from this one-time survey may be generalized to other NGACO enrollees.

The Community and Facility COVID-19 Questionnaires will be administered in Winter 2021 Round 89, Summer 2021 Round 90, and Fall 2021 Round 91, as long as it is relevant to do so. This change will result in an increase in 15 minutes to the Community and Facility instruments each round that the COVID-19 items are fielded. The one-time administration of COVID-19 items to a new cohort of NGACO enrollees will only be included during Winter 2021 data collection and will result in an increase in 15 minutes for the 5,000 completed cases. The questions are the same as those approved by OMB on August 7, 2020 under the emergency clearance request (0938-1379).

- Revise the Housing Characteristics Questionnaire (HAQ) to add two items about housing insecurity. During each fall round, the MCBS asks about housing characteristics. However, the section does not include questions about housing insecurity, which is important to consider in the context of public health. The Healthy People 2020 summary of housing insecurity suggests that people who are cost burdened (those who spend more than 30% of their income on housing) and those who are severely cost burdened (those who spend more than 50% of their income on housing) may be more likely to live in housing that includes mold exposure, inadequate heating or cooling systems, and environmental pollutants that pose health risks. Additionally, severely cost-burdened families are more likely to live in housing that includes overcrowd rooms or homes, which can affect mental health, stress levels, and sleep, as well as increase the risk of infectious diseases like COVID-19. In addition to a dwelling itself being a risk factor, the neighborhood where a dwelling is located can affect a person's health and can lead to differences in outcomes such as prevalence of obesity and prevalence of diabetes.

Working with the CMS Office of Minority Health (OMH) and in consultation with a Technical Expert Panel (TEP) including members from the U.S. Department of Housing

and Urban Development (HUD), two housing insecurity questions from the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool are planned for the MCBS. The questions have been demonstrated to have 97% sensitivity and 83% specificity in a validation study. The AHC Screening Tool was developed by a panel of interdisciplinary experts that reviewed evidence-based ways to measure Social Determinants of Health (SDOH), such as housing instability⁹. While other SDOH included on the AHC Screening Tool, such as food insecurity, transportation barriers, and financial strain are already measured by existing items in the MCBS questionnaire, adding these two questions on housing insecurity will increase CMS' ability to analyze health disparities in Medicare, which is critically important for quality improvement and responsiveness to public health emergencies like COVID-19. Medicare providers currently submit some social risk data to CMS through claims, in the form of ICD-10-CM Z codes. However, analysis performed by the CMS OMH Data and Policy Analytics Group (DPAG) group on Z code utilization and reported in a Data Highlight¹⁰, shows only limited reporting via this mechanism. In addition, some social risk data is collected through providers participating in the AHC model, and some information will be collected by providers through Post-Acute Care assessment tools. However, this data collection is only for certain patients and does not allow for an analysis across health care settings. The additional information from the MCBS questions will supplement research on the impact housing insecurity has on Medicare beneficiaries and which Medicare populations this is impacting the most. Additionally, the Beneficiary Care Management Program (a QIO initiative) is assisting Medicare beneficiaries with discharge planning which is very challenging when patients are experiencing housing insecurity. Since the MCBS does not currently measure housing insecurity, we do not know the magnitude of the problem to aid in this essential planning.

An ASPE commissioned report titled “Accounting for Social Risk Factors in Medicare Payment¹¹” recognized that social risk factors (including inadequate housing) contribute to health disparities. Furthermore, the IMPACT Act recognized that social risk factors play a major role in health, even requiring additional research related to social risk in Medicare's value-based payment programs. The social isolation and housing insecurity questions would provide additional data on large set of Medicare beneficiaries, providing a source for additional research and policy guidance. This subset of items was selected specifically because these two elements are of critical importance to assessing the impact of social risk factors and are represented in the AHC screening tool and in other IMPACT Act-related analysis and research, and are not already collected in some way through the MCBS. The HAQ items will be administered only in the Fall round. This change will result in an increase in 40 seconds for the Fall round.

- Revise the Health Status and Functioning Questionnaire (HFQ) to add one item about social isolation. Distinct from loneliness, social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area. Social isolation tends to increase with age, is a risk factor for physical and mental illness, and is

⁹ More information about the AHC Screening Tool is available on the model webpage at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>.

¹⁰ Available from: <https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf>

¹¹ Available from: <https://www.nap.edu/catalog/23635/accounting-for-social-risk-factors-in-medicare-payment>

also a predictor of mortality. This measure is currently part of the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool in the Family and Community Support domain. The AHC question was selected from the Patient-Reported Outcomes Measurement Information System (PROMIS®) question Bank on Emotional Distress. The AHC Screening Tool was developed by a panel of interdisciplinary experts that reviewed evidence-based ways to measure SDOH, such as social isolation¹².

While the MCBS questionnaire already includes similar items from the AHC Screening Tool related to mental health, substance use, and assistance with activities of daily living and instrumental activities of daily living, adding a new measure on social isolation will improve CMS' ability to analyze health disparities in Medicare, which is critically important for quality improvement and responsiveness to public health emergencies like COVID-19. A recent JAMA article¹³ titled "Social Isolation and Loneliness: Imperatives for Health Care in a Post-COVID World" reports that social determinants (including social isolation), have been found to be responsible for 80%-90% of health outcomes. Due to COVID-19, there is an increase in housing instability and homelessness related to difficulty paying rent and mortgages, and increased risk of adverse COVID-19 effects related to housing instability and homelessness. The pandemic has also led to unprecedented social distancing, quarantines and isolation procedures that have had a profound effect on social isolation. These factors disproportionately impact minority populations and further exacerbates underlying health disparities. Eliminating racial and ethnic disparities is one of the foundational principles of the legacy CMS Quality Strategy, and the CMS Meaningful Measures framework establishes eliminating disparities as a cross-cutting criteria to be applied to any area of measurement. Additionally, the Network of Quality Improvement and Innovation Contractors' 12th Scope of Work includes a significant focus on behavioral health and discharge planning, which is integrally tied to social determinants around housing instability and homelessness and social isolation, for CMS quality improvement contractors across health care settings.

Closing gaps in data collection and improving our understanding of individuals' social risk factors can help protect our most vulnerable beneficiaries, especially during the pandemic. It is critically important that CMS improve its understanding of beneficiaries' social risk factors in order to protect health and ensure beneficiaries get the right care, in the right place, at the right time. This HFQ item will be administered only in the Fall round. This change will result in an increase of 20 seconds for the Fall round.

In brief, these changes extend the collection of COVID-19 measures and add three new questions to close important data gaps.

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

¹² More information about the AHC Screening Tool is available on the model webpage at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>.

¹³ Available from: <https://jamanetwork.com/channels/health-forum/fullarticle/2774708>

Table A-1: Burden Associated with Revisions to Community and Facility Instruments

Community Additions	Section	Winter 2021 Round 89	Summer 2021 Round 90	Fall 2021 Round 91	Total Annual Increase
COVID-19 Questionnaire	CVQ	15	15	15	45 minutes
Housing Insecurity	HAQ	-	-	0.66	0.66 minutes
Social Isolation	HFQ	-	-	0.33	0.33 minutes
Total Minutes Added		15 minutes	15 minutes	16 minutes	46 minutes
Net Annual Effect Increase in Community Burden					46 minutes

Facility Additions	Section	Winter 2021 Round 89	Summer 2021 Round 90	Fall 2021 Round 91	Total Annual Increase
COVID-19 Questionnaire	CVQ	15	15	15	45 minutes
Total Minutes Added		15 minutes	15 minutes	15 minutes	45 minutes
Net Annual Effect Increase in Facility Burden					45 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 usually 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. During the 2020 Public Health Emergency, in-person interviewing ceased in March 2020 and phone interviews are being conducted with community and facility respondents. Interviewers still use their CAPI laptops to administer the interview by phone.

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.

Further, in 2015-2016, the Department of Health and Human Services (DHHS) underwent an intensive review of health surveys to align like questions, reduce duplication, and ensure that

official estimates were being provided by the appropriate survey¹⁴. The DHHS review determined that data collected by the MCBS are unique even though similar topics are asked by the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES), and other federal surveys. Although NHIS, for example, asks similar questions about health insurance coverage, the usage of MCBS data is different, particularly given the ability to link MCBS survey data to Medicare administrative data and cost related data. Unlike other federal surveys, CMS uses health insurance information collected by the MCBS to determine the cost burden of premiums paid by beneficiaries as well as to determine the cost of additional supplemental plans paid for the Medicare covered and non-covered medical expenses. Using the MCBS, CMS examines the cost of reported medical events, and determines with Medicare administrative data and cost information collected from the beneficiary what the true out of pocket costs are to the beneficiary. CMS also uses the information to see whether private plans such as employer provided plans are paying for the Medicare premiums for Part D and/or Part C for currently employed beneficiaries as well as retired beneficiaries.

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.

¹⁴ HHS Data Council Co-Chairs memorandum to the Secretary of the Department of Health and Human Services, May 11, 2016

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 September 15, 2020 (85 FR 57215). 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](https://www.cms.gov/MCBS) and [Research Statistics Data and Systems MCBS](https://www.cms.gov/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 December 07, 2020 (85 FR 78853).

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) mailed to the respondent for in person and telephone interviewing 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 during in person interviews 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 via in person or telephone interviews, 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 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 54,426 hours for the survey, 10,063 hours more than the estimate in the current clearance.

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	83 minutes	1	11,071	15,315
- Winter 2021 COVID-19 Items Administered to Oversample of NGACO Beneficiaries	15 minutes	1	5,000	1,250
- Summer 2021 Round 90 Continuing Interview	95 minutes	1	8,020	12,698
- Fall 2021 Round 91 Baseline Interview	93 minutes	1	5,749	8,911
- Fall 2021 Round 91 Continuing Interview	116 minutes	1	6,888	13,317
Field Manager follow-up with 5% of Completed Interviews	5 minutes		1,586	132
Facility Rounds 89-91				
- Winter 2021 Round 89 Continuing Interview	60 minutes	1	951	951
- Summer 2021 Round 90 Continuing Interview	60 minutes	1	714	714
- Fall 2021 Round 91 Baseline Interview	75 minutes	1	202	253
- Fall 2021 Round 91 Continuing Interview	75 minutes	1	409	511
- Fall 2021 Round 91 Baseline Interview for Cases with Admin Data	45 minutes	1	135	101
- Fall 2021 Round 91 Continuing Interview for Cases with Admin Data	60 minutes	1	273	273
Total Expected Number of Completed Interviews Annually			35,998	
Total Annual Burden Hours				54,426
Total Estimated Burden Hours – Rounds 89-97 (3 Years)				160,778

Below provides a summary of the annual burden change from the current clearance, reflecting the increased burden of adding the COVID-19 questions plus the three new questions during the fall round; it also includes the one-time collection of COVID-19 questions from the NGACO sample.

Total annual burden hours – previous clearance	44,363
Total annual burden hours – new clearance	54,426
Total annual burden hours – difference	10,063

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 2020¹⁵) and multiplied it to the Total Annual Hours for Rounds 89-91 (54,426), for a Total Annual Cost Burden in terms of dollars of roughly \$394,589.47.

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 data collection 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.

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

FY 2022: Survey development, operations, processing and analysis: \$24,215,710¹⁶

FY 2023: Survey development, operations, processing and analysis: \$24,215,710⁵

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

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 ¹⁷
GS13 step 6	7.0	\$119,775	\$838,425
GS14 step 5	4.0	\$137,491	\$549,964
GS15 step 5	1.0	\$161,230	\$161,230
			\$1,549,619

¹⁵ <https://www.dol.gov/general/topic/wages/minimumwage>

¹⁶ Amounts for FY 2022 and FY 2023 will change depending on available funds.

¹⁷ <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf>

CMS staff costs are approximately \$1,549,619. 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 \$1,557,619.

A15. Explanation for Burden Changes (Program Adjustments)

As noted earlier, the COVID-19 items are estimated to add 15 minutes to the Community and Facility instruments each round starting in 2021; in addition, 1 minute of burden will be added to each Fall interview beginning in Fall 2021 Round 91 due to the addition of 3 new questions, 2 on housing insecurity and 1 on social isolation. Last, the burden reflects the one-time collection of COVID-19 questions (15 minutes per interview) for the NGACO sample. As a result, the total burden has increased to 54,426 from the previously approved total burden of 44,363. This is a net increase of 10,063 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.

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

01/31/2021	Microdata Public Use File for Fall 2020 COVID-19 data.
06/30/2021	Microdata Public Use File for Winter 2021 COVID-19 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.
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 advance mail materials. It is also displayed on the MCBS website. When conducting in person interviews, 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.